Defense Health Agency
Uniform Business Office

Denials Management and ABACUS Capabilities

17 December 2019 0800 – 0900 EST
18 December 2019 1400 – 1500 EST

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Objectives

- Review relevant legislation
- What is a Denial?
- Importance of Denials Management
- Learn how to read and interpret an Explanation of Benefits (EOB)
- Identify reasons for claim denials
- Types of claim denials
- Learn how to effectively communicate with payers and MTF staff
- Discuss processes for handling claim denials
- Learn ways to track and manage claim denials and appeals in ABACUS
- Where and how to use information located in ABACUS

- Title 10, United States Code, Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries

- Title 32, Code of Federal Regulations, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Certain payers excluded from Third Party Collection Program
    - Applicable charges
    - Rights and obligations of beneficiaries
    - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

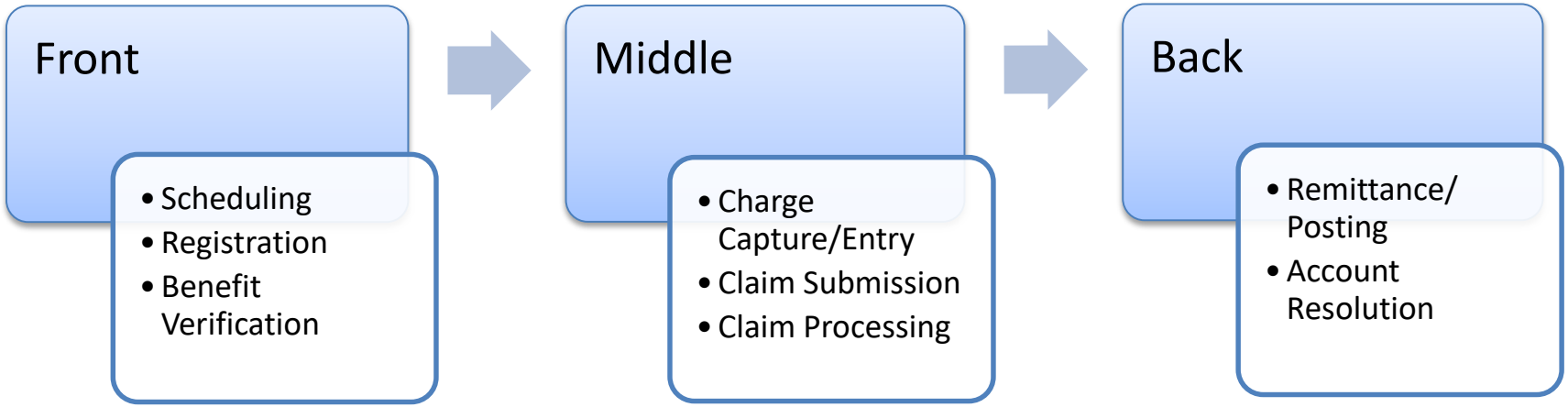
What is a Claim Denial?

- Health care industry does not have one universal definition of a claim denial:
  - "Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided." (HFMA)
  - "A claim line item or service line item that results in no payment including rejected claims."*

*Denial Management: Key Tools and Strategies For Prevention and Recovery, Pam Waymack

- Why Is Denials Management So Difficult?
  - Complexity of third-party denials
  - Denial information provided by third-party payers is not standardized
  - Perceived inability to capture the denial data
  - Constantly changing information
  - Requires coordination throughout the revenue cycle
  - Challenging appeals process

Claim Denials Across Revenue Cycle



• Member Not Eligible	• Missing/Incorrect Modifiers	• Duplicate Claims
• Coverage Termed	• Not Medically Necessary	• Previously Paid Claim
• Non-Covered Charges	• Missing Claim Information	• Additional Claims Information Required
• Out-of-Network Provider	• Additional Clinical Information Required	• Incorrect Denials
• Member Cannot Be Identified		

The Importance of Denials Management

- Why are effective denials management processes so important?
  - Denials have increased significantly as the electronic billing and remittance process becomes increasingly sophisticated
    - Claims have less “human” contact
    - Computer based payment algorithms search for key information according to payer contract requirements
  - The average cost to rework a claim is $25.00 (HFMA)
  - Failing to rework denials results in a loss of revenue that supports your MTF’s operation and maintenance budget
  - Manageable accounts receivable

The Importance of Denials Management, cont.

- In 2015, the DoD Inspector General (IG) performed a review of 6 MTFs to determine if compliance audits of their TPCP were being conducted to monitor missed collection opportunities.
  - Finding: the audits **were not** being conducted; additionally, these specific actions were not being performed*:
    - Initial follow up – 64,345 claims worth $17.3M
    - Documenting write-off rationale – 67,047 claims worth $11.9M
    - Forwarding claims to legal office for collection – 45,812 claims worth $9.2M
    - Obtain pre-certification or pre-authorization - 19,632 claims worth $10.3M
    - Total: 144,930 claims, $112,518,396 billed, $21,685,169 remained uncollected
  - DoD IG Recommendations
    - Conduct an analysis to determine the sufficient time needed to conduct adequate follow up on billed claims for TPCP.
    - Review Uniform Business Office (UBO) resource issues
    - Refer outstanding TPCP claims to legal office as required
    - Update the UBO Manual
    - Establish a quality assurance program that monitors the TPCP and follow up requirements
    - Establish agreements with payers to accept claims for 90-day prescriptions

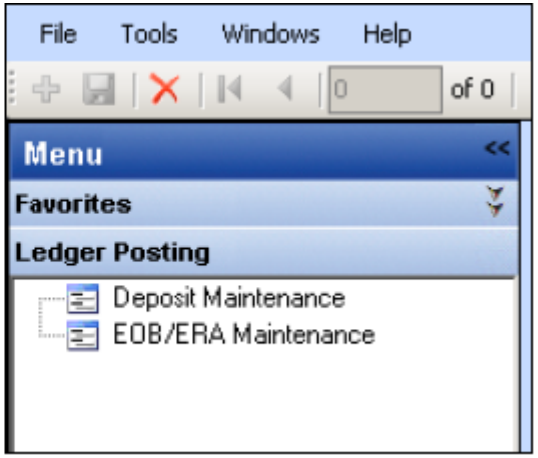
*FY 2012 – FY 2014 outpatient claims data

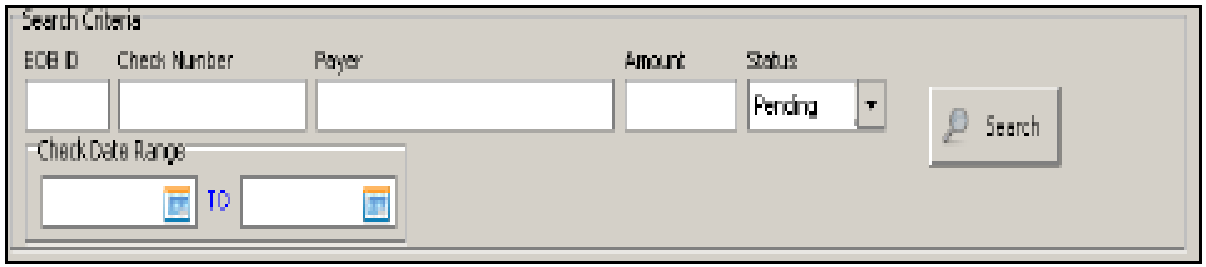
"July 24, 2015, Follow-up Audit: DoD Military Treatment Facilities Continue to Miss Opportunities to Collect on Third Party Outpatient Claims"

Explanation of Benefits (EOB)

- Definition and Purpose:
  - An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied
  - The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full

- Electronic EOBs can be viewed and printed from the 835 Viewer
  - Ledger Posting > EOB/ERA Maintenance





Sample EOB

EXPLANATION OF BENEFITS

This is **NOT** a bill.

Group Number: 1234567
Member: IMA MEMBER
Member's ID: 123456789-01
Claim Number: 8000000001
12 Provider: SMITH, ROBERT
Payment Reference ID: 20041220112345678

September 6, 2011

1 Service/ product description	2 Dates you received service/product (m/d/y to m/d/y)	3 Charges billed by provider	4 Provider's fee adjustment (*)	5 Your copay (C), deductible (D) or amount not covered (**)		6 Total amount eligible for benefits	7 %	8 Your coinsurance amount	9 Adjustment	10 Total benefits from your plan	11 Amount you're responsible for
OFFICE VISIT	06/01/11 06/01/11	75.00	12.00 PDC	15.00	C	48.00	100%			48.00	**15.00**
LAB	06/01/11 06/01/11	89.12	15.36 PDC	50.00	D	23.76	100%			23.76	**50.00**
X-RAY	06/01/11 06/01/11	100.00	20.00 PDC			80.00	80%	16.00		64.00	**16.00**
SURGERY	06/01/11 06/01/11	50.00		50.00	575	0	0%			0.00	**50.00**
Totals		$314.12	$47.36	$115.00		$151.76		$16.00		$135.76	**$131.00**

Your 2010/Plan Year Medical Deductible satisfied so far: $100.00
Your 2010/Plan Year Family Medical deductible satisfied so far: $300.00
Amount you're responsible for: $131.00

FUNDING ACCOUNT SUMMARY

Amount paid on this claim: $ 0.00
Your remaining family balance: $ 0.00

For more information relating to your funding account, please see your benefit booklet or visit us on the web at: www.premera.com

13 **Message Codes:**
PDC AGREEMENT DISCOUNT
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

Benefit Booklet Information:
575 Your plan does not cover any services or supplies furnished in connection with the following conditions, services or supplies: Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.

Other plan provisions may apply. Please consult your benefit booklet for full plan information.

If you have any questions about your EOB call Customer Service at 800-722-1471, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Pacific Time.
Para obtener ayuda en español, llámenos al número de teléfono que se indica arriba. Sa pagtamo ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.
如果想用中文獲取幫助，請撥打上面的電話號碼聯繫我們. Diné k'ehji yálti'igíí shika'adoolwoł nínízingo díí béésh bee hane'é bich'į' hodiilnih.
Our TDD/TTY number for the hearing-impaired is 800-842-5357.

LIFEWISE | HEALTH PLAN OF OREGON

1) **Service/product description** – services the patient received from the provider
2) **Dates of service** – when the patient received services
3) **Charges** – amount billed to the patient and healthcare plan
4) **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment
5) **Copay** – the amount the patient pays the provider for a visit/service

   Deductible – the amount the patient pays toward covered services each year before the third party payer starts paying for services

   Amount not covered – the amount of services/products not covered by the plan

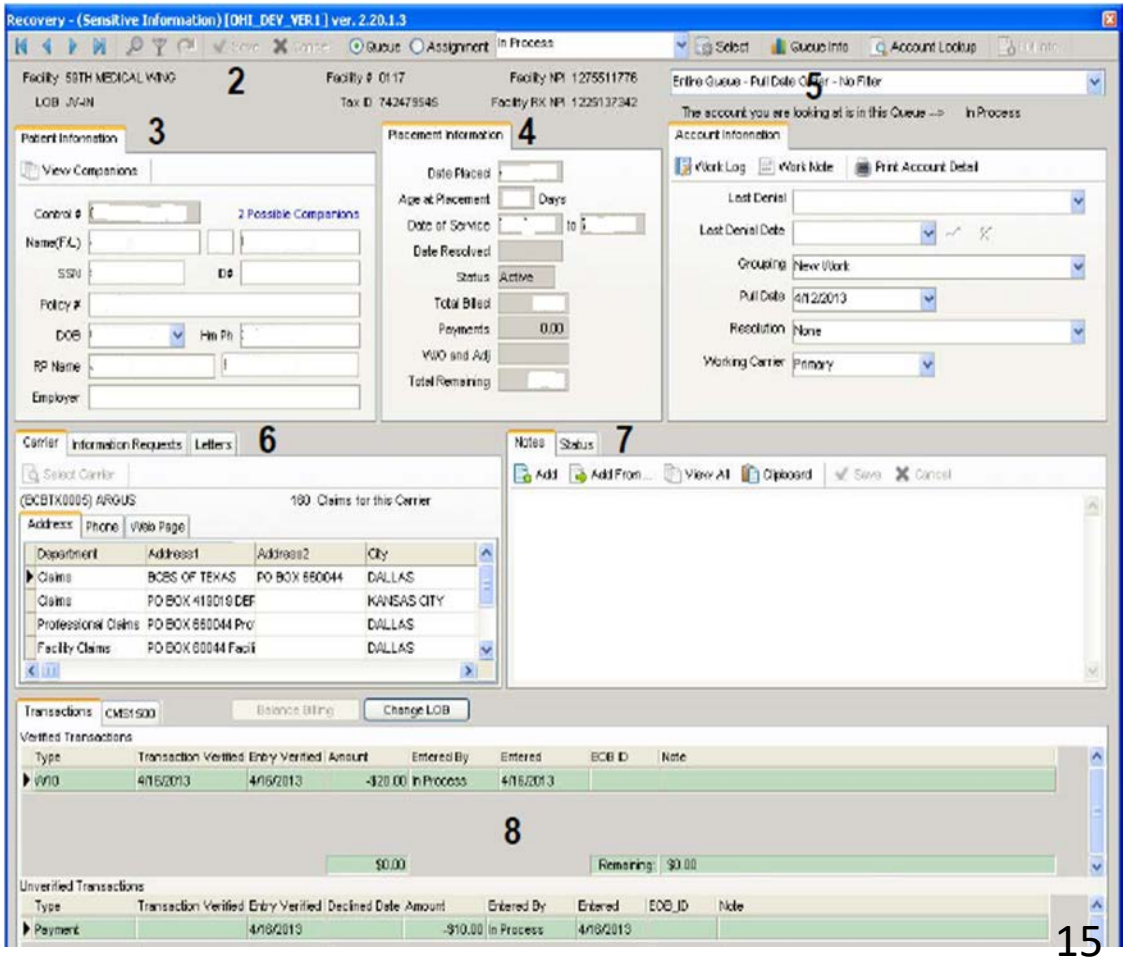
6) **Total amount eligible for benefits** – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered
7) **%** – percentage level of benefits for covered services/products
8) **Coinsurance** – what the patient must pay the health plan after the health plan pays the covered percentage
9) **Adjustment** – A change that relates to how a claim is paid differently from the original billing
10) **Total paid by health plan** – total amount eligible for benefits minus coinsurance amount
11) **Patient responsibility** – what the patient must pay of the billed charges after the plan benefits have paid

12) **General Information** – patient and provider information including group #, member name, member ID, claim #, provider name, and payment reference ID

13) **Message Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full

ABACUS Denials Management Features

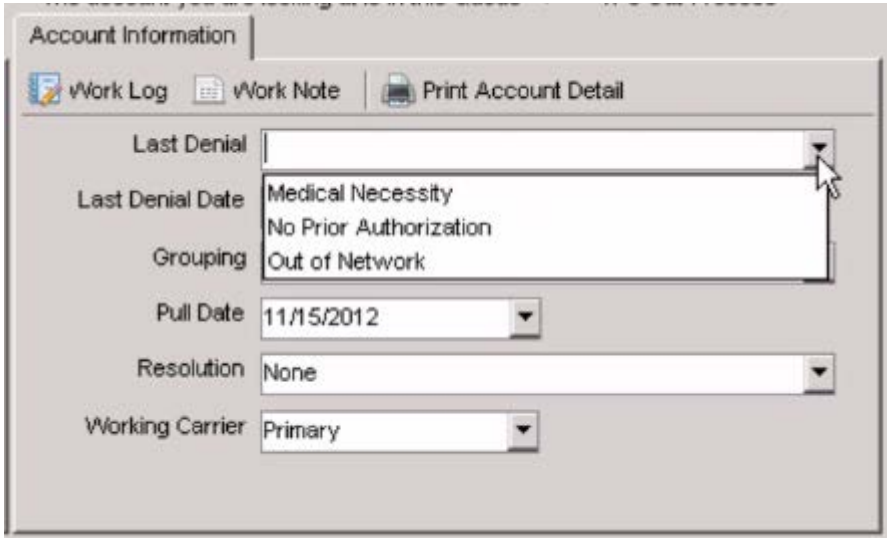
- Accounts Management > Recovery Management
- Recovery tool used to track and reconcile accounts
- Allows users to access information, in one location, which is used in denials management
  - Account information
  - Working Notes
  - Carrier information
  - Transaction notes

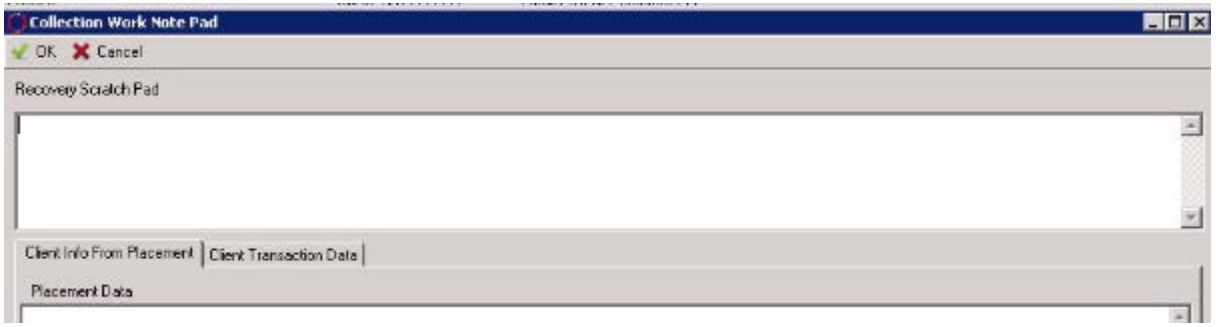


Common Reasons for Claim Denials

- Non-participating provider
- Medicare EOB required
- Incorrect dates of service
- Termination of coverage
- Failure to obtain pre-authorization
- Non-covered benefit
- Untimely filing
- Out-of-network provider utilized
- Procedure or service not medically necessary
- Additional Information Needed
- Coding Errors
- Incorrect Demographic information

- Account Management > Recovery > Account Information tab
  - Groups denials into specific categories





Actionable Denials

- Amount of Coverage
- Registration Inaccuracies
- MTF Did Not Comply with UR Procedures
- Other

Un-actionable Denials

- Patient Not Covered, Care Provided Not Covered, or Policy Expired
- TRICARE and/or Income Supplemental Plans
- Medicare Supplemental Plans
- HMO/PPO
- Patient Copays and Deductibles

Clinical Denials

- Medical Necessity
- Delay in Discharge/Procedure
- Alternate Setting
- LOS exceeds Authorization

Administrative Denials

- Failure to pre-certify
- Lack of clinical information
- Lack of Benefit
- Exclusion Denials

Understanding Denial Reason Codes

- Challenges in understanding denials:
  - Variance in denial reason codes by payer
  - Denial reason does not necessarily identify the real issue
  - Inconsistently applied codes even with same payer
  - Missing denial codes
  - Denial codes that don’t fit the reason the claim was denied

- Always best to call the payer for explanation. Some payers offer live online assistance through chat windows on their website.

Denials - Best Practices

- Early Intervention
  - Respond to denials immediately
  - Establish a timeline for working denials
  - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
  - Monitor and act upon unresolved denials
  - Follow-up on all levels of appeals process
  - Measure denials and appeal results
  - Trend issues by payer and reason
- Impact of Best Practices
  - Improved cash flow due to an increase in clean claims and a reduction in denials

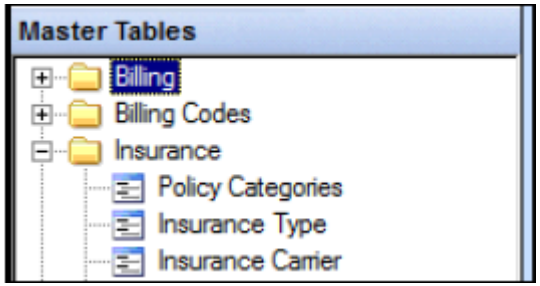
How to Establish a Best Practice

- Streamline billing responsibilities
  - Dedicate team specifically to manage denials
  - Standardize appeal templates by payer
- Show impact on revenue
  - Total amount denied by type
  - Denied amount as a percentage of revenue
  - Total write-off amount by transaction code
  - Write-off amount as a percentage of revenue
  - How much has been collected
- Establish goals
  - What is an acceptable percentage to write-off due to denials (point of reference - industry goal is 3%)
- Communicate results to leadership

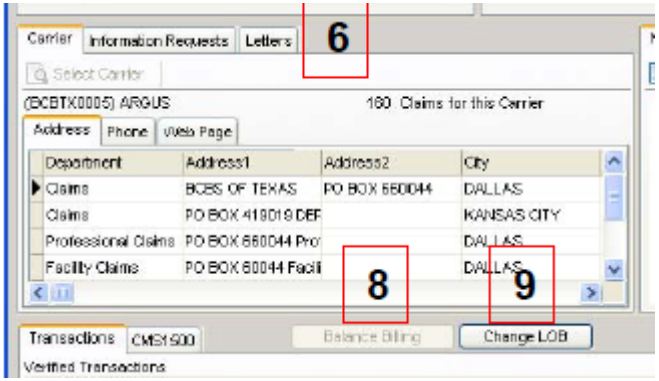
- Effective and continual communication with payers is essential
  - Develop standards for what information is required
  - Read the EOB carefully
  - Understand payer specific guidelines
  - Call the payer if a denial reason needs clarification
  - Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences
  - Develop process for receiving policy updates
  - Establish procedures for documenting communications

- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long you have to resubmit the claim?
  - Does the payer needs any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a claim when it is re-sent to indicate that it is a corrected claim?
  - Where does the information need to be sent?
  - Is there a reference number for this phone call?
  - If payer representative is not helpful, ask to speak with a supervisor

- Master Tables > Insurance > Insurance Carrier



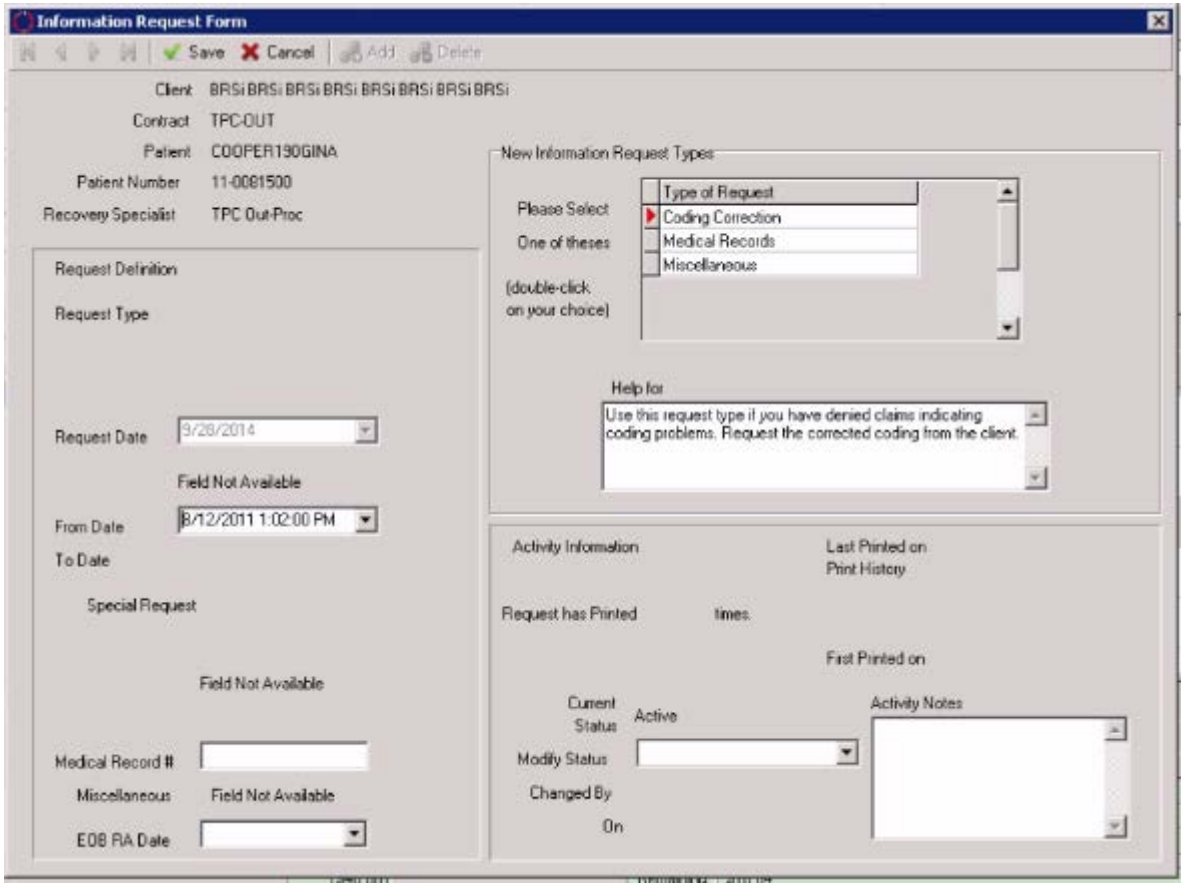
- Account Management > Recovery > Carrier Tab



Communication Between Billers and MTF Staff

- Coding
  - Accurate coding is necessary for receiving payment
  - Build relationships with coders so clean claims can be produced
- Patient Administration Directorate (PAD)
  - Registration
  - Other Health Insurance (OHI) collection
- Clinical Staff
  - Complete and accurate medical record documentation
  - Timely closing of encounters to avoid coding backlogs

- ABACUS feature used to request information internally
  - E.g., Coding correction or medical records
  - Account Management > Recovery > Information Request tab



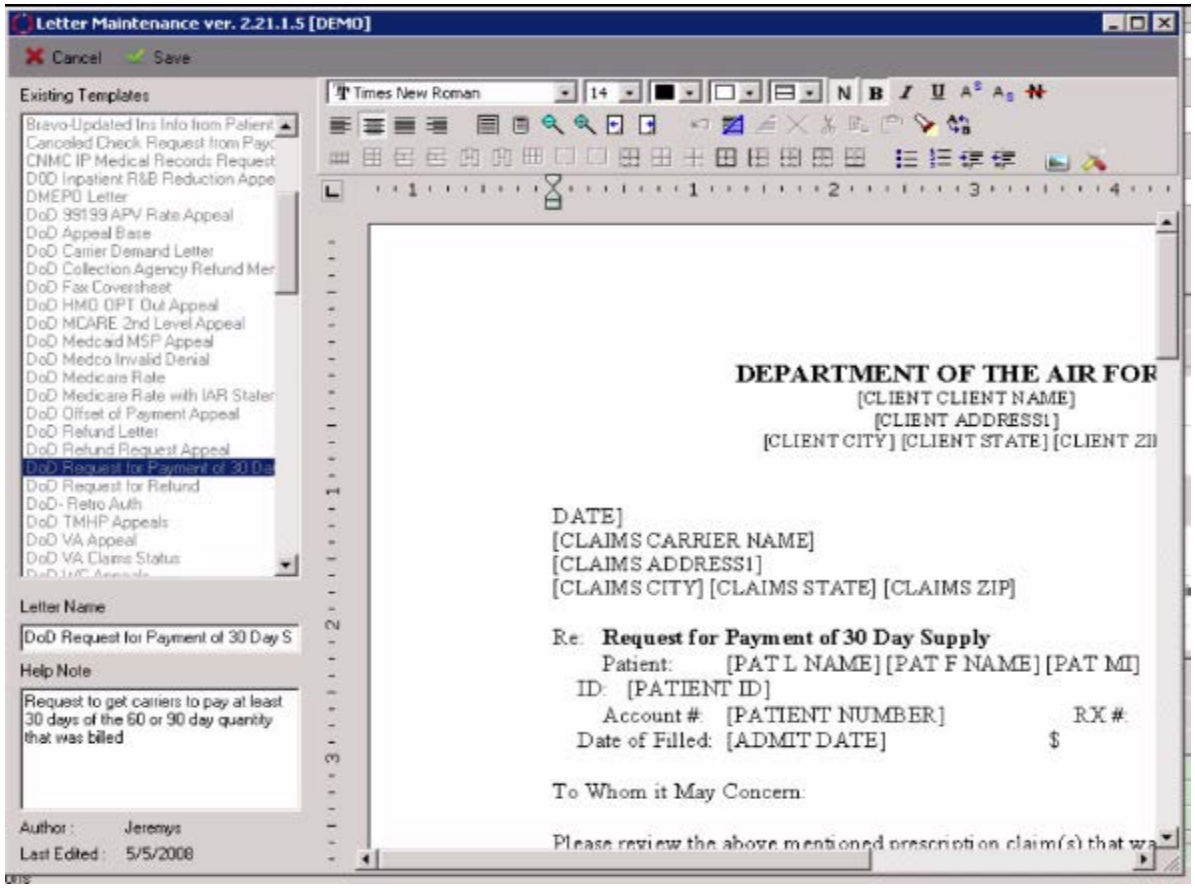
Process For Handling Claim Denials

- Interpret the EOB to ensure that a valid denial reason has been received
- Determine if it needs to be written off or billed to the patient
- Determine if denial can be corrected and resubmitted or if the claim requires an appeal
- Develop a communication plan
- Engage appropriate departments
- Establish goals for follow-up
- Develop your case based on the payer's guidelines
- Monitor corrected or appealed claims

Appealing Denials

- Denied claims should be pursued aggressively
  - Denied claims should be prioritized based on date and dollar amount
  - Aggressive does not mean calling every day
  - Scrutinize all denied claims for incorrect information
  - Disputed claims should be communicated to the payer in writing
  - Aggressively appealing denials has been shown to reduce denial rates

- Allows users to generate letters for specific accounts
  - E.g., coversheet, appeals, patient info request, etc.
  - Account Management > Recovery > Letters Tab > Letter Editor

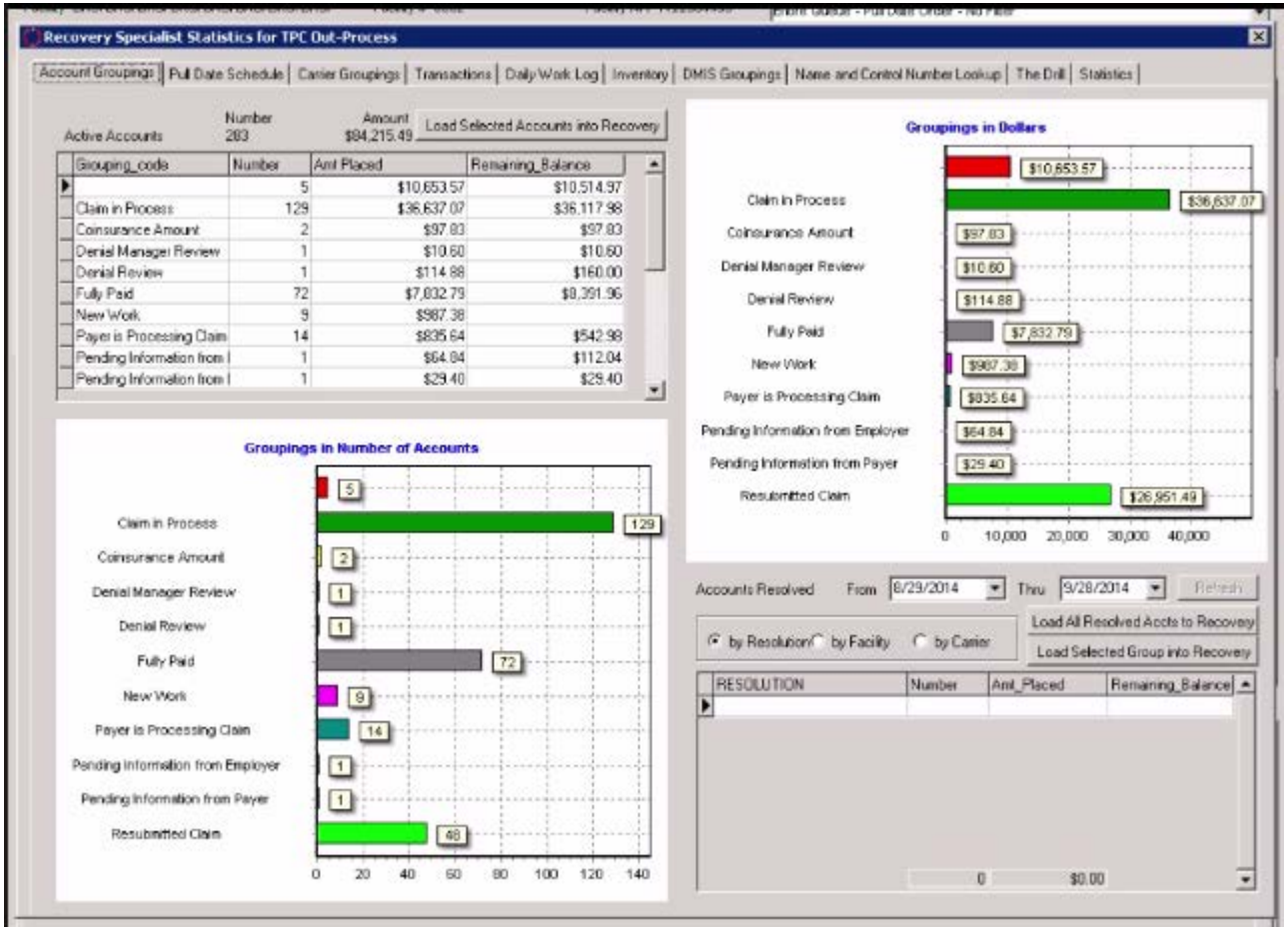


Follow-up on Appeals

- Insurance companies frequently do not pay what they approve
  - They have no incentive to ensure that everything is paid appropriately
  - Track payments for approvals or overturns
    - When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial
  - Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute
- What About Upheld Denials?
  - Request the payer send supporting documentation
  - For incorrect payments, request a copy of the fee schedule
    - A list of CPT codes and dollar amounts a payer will allow for a particular medical service

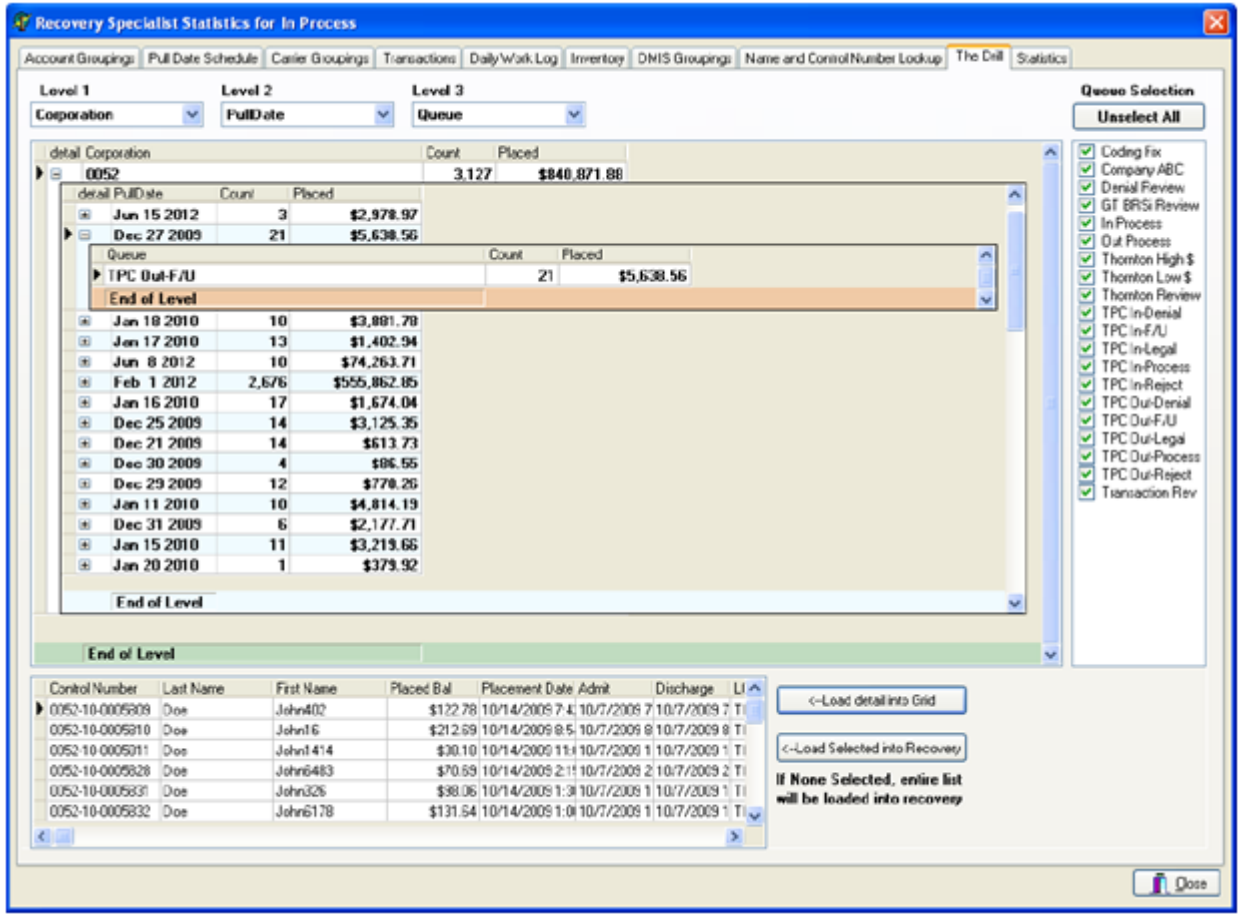
- Why track denials?
  - Defines where breakdowns are in the process to identify opportunities for performance improvement
  - Identifies unreasonable payer practices
  - Collaborative effort appeals are easier to handle in the future
  - Identifies areas where denial management efforts have been successful
  - Allows UBO to develop future goals and opportunities for preventing future denials

- "Queue info" allows user to access more detailed information



Tips for Tracking Denials, cont.

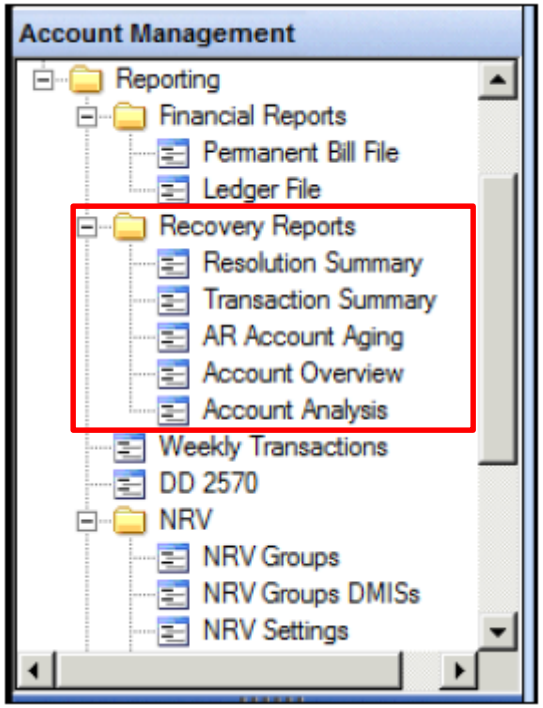
- "The Drill" tab allows users to search all queues using multiple levels



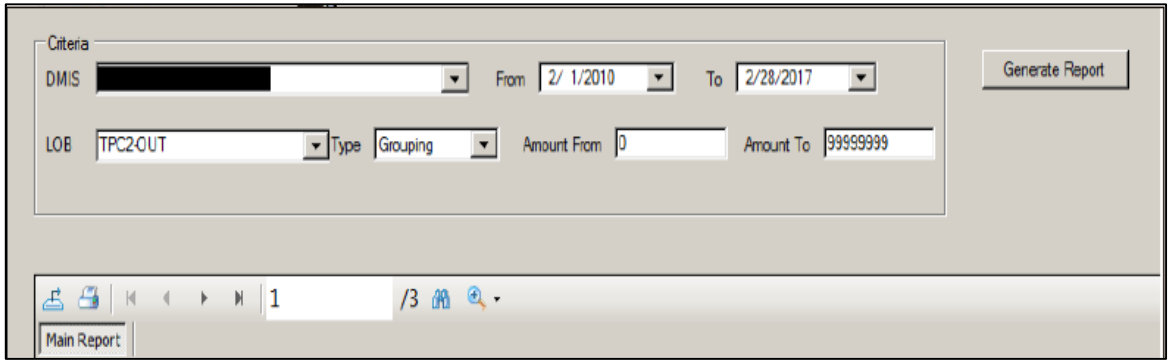
Tips for Tracking Denials, cont.

- Grouping claim denials
  - Payer and type
  - Reason
  - Develop denial categories
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Show impact on revenue
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
  - Communicate to leadership

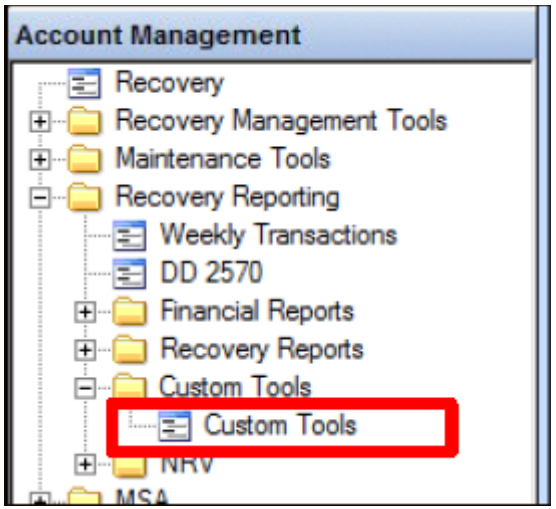
- Account Management Reports allows users to enter parameters for generating specific reports



- Resolution Summary
- Transaction Summary
- A/R Account Aging
- Account Overview
- Account Analysis



- Custom Tools has custom reports created upon the request of the Services and NCR MD.



- Accounts in a Negative Balance
- Un-Verified Transaction Report (Accounts that need double-verification to close out)
- A/R Clean-up Aging Report
- Trend Analysis – ETU Errors 5 Week Period
- Trend Analysis – Claim Build Errors 5 Week Trend
- Trend Analysis – Recovery 5 Week Trend

Tips For Submitting Clean Claims

- If paper claims must be filed:
  - Use only original claim forms
  - Make sure claims are printed clearly
  - Avoid folding claims, if possible
  - Avoid using terms such as “re-filed claim” or “second request”
  - Avoid handwritten claims
  - Don’t use all UPPERCASE letters
  - Don’t use punctuation or decimals on claims
  - Don’t send unnecessary attachments
  - Don’t use staples, paperclips or post-it notes
  - Don’t mark up the claim with highlighters
  - Don’t use circles or additional markings
  - Don’t attach labels or stickers
  - Don’t add notes or instructional assistance
  - Make a copy

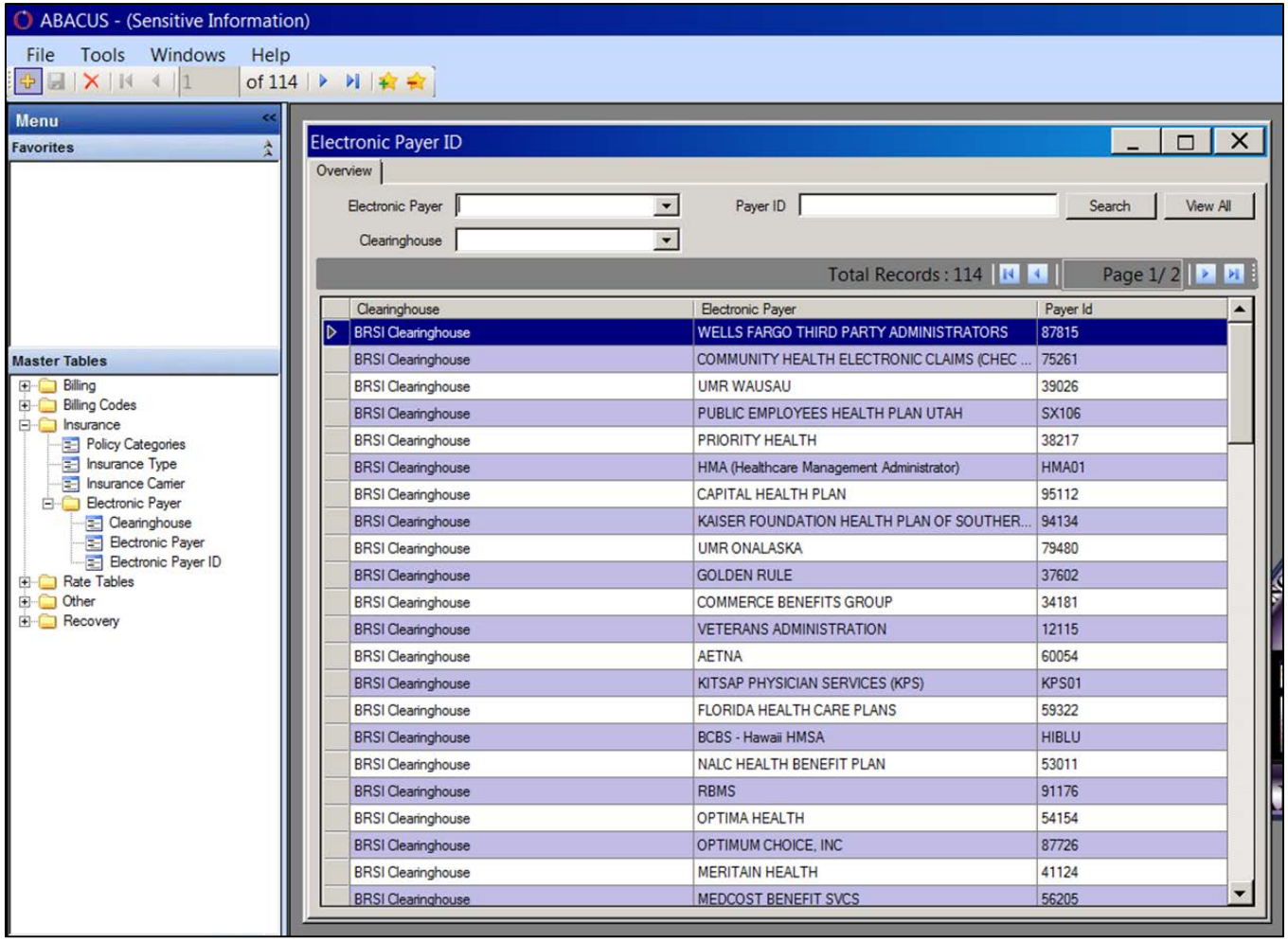
- If electronic institutional and professional (837I/837P) claims are sent:
  - Identify the correct payer ID for electronic transactions
  - Consult 837I/837P EDI companion guide found on payer website
  - Use the UBO User Guide* and online Data and Billing in Sync** training modules to identify information that is required for 837I/837P transactions
  - Be familiar with claim adjustment reason codes (CARC)***

*https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Policy-and-Guidance

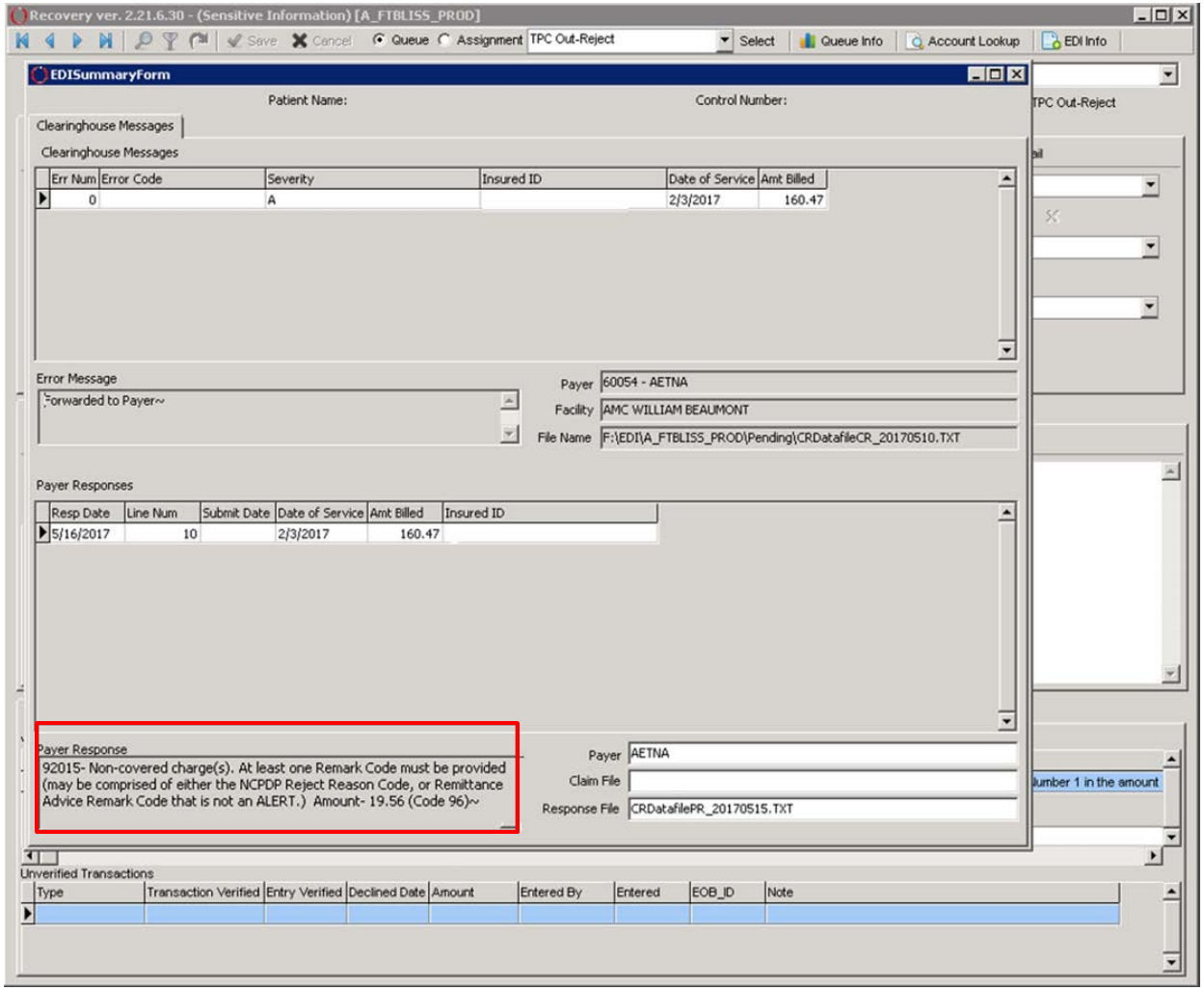
**https://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center/Online-Training-Courses

***http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes

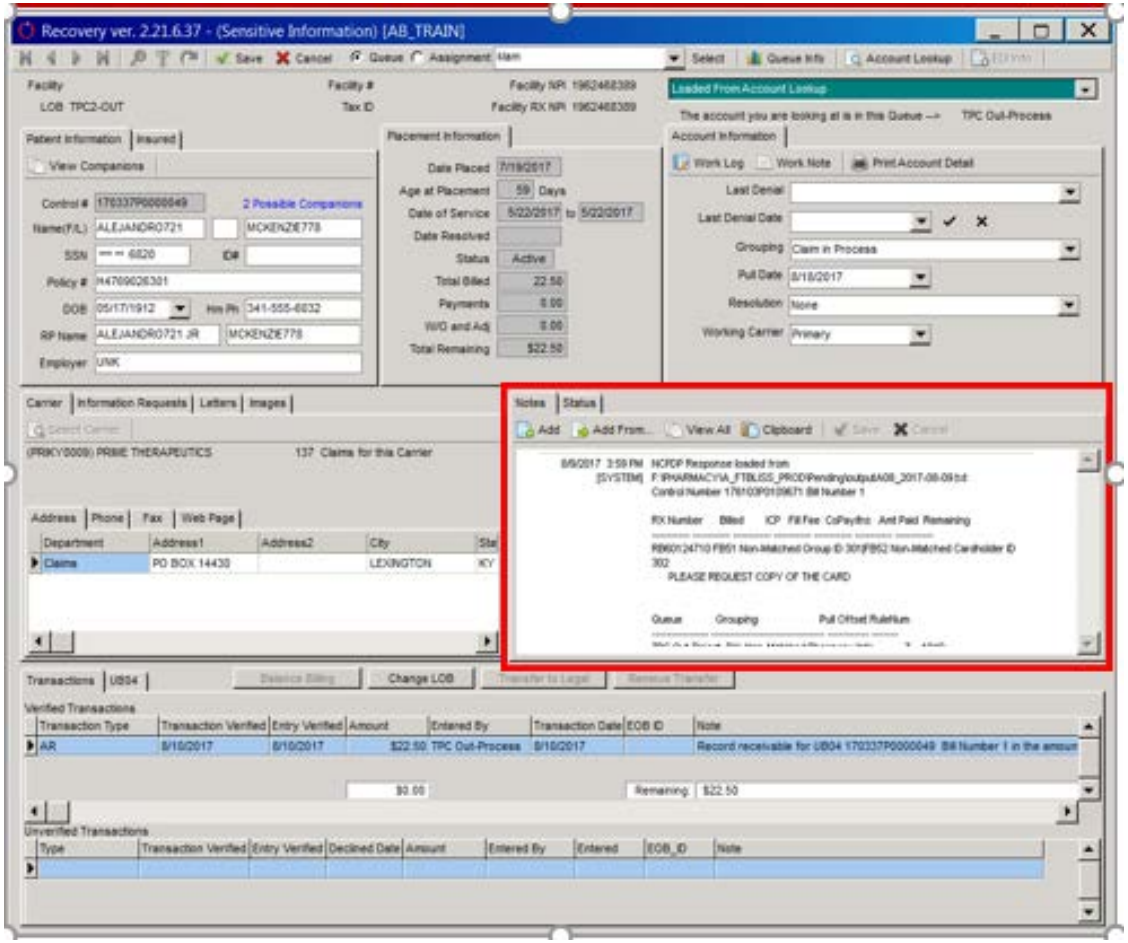
- Master Tables > Insurance > Electronic Payer



Submitting 837I/837P Claims, cont.



Submitting 837I/837P Claims, cont.



Summary

- Be sure to understand the denial codes on the EOB
- Focus on effective communication with payers
- Develop a strategic plan for managing individual claim denials
- Develop a method for tracking claim denials and appeals
- Make sure claims are “clean” before they are sent
- Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance

Questions?

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