Denial Management: Using Analytics to Address Their Root Causes

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JPS Health Network
Today’s Speaker

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Director, Patient Financial Services

Rhonda has been with JPS since March 2014. She has been in healthcare financial management for more than 25 years and has overseen patient access, billing, collections, A/R reconciliation, denial management, financial counseling, customer service, managed care contracting, and chargemaster management, among other revenue cycle functions, while working for both for-profit and non-profit providers. Rhonda is a mother of four daughters and is the proud grandmother of two. She has resided in Texas her whole life and enjoys spending time with her family and friends.
 Agenda and Learning Objectives

- This presentation will highlight the denial prevention task force formed by staff from throughout the revenue cycle and clinical areas at Texas-based JPS Health Network. With a customized dashboard, members of the task force are able to filter denial data to identify trends specific to a facility or service line, often revealing process gaps and inefficiencies that can be resolved to improve the organization’s financial health. Among other initiatives, JPS has improved pre-authorization compliance in radiology and oncology to ensure frontline staff follow best practices for obtaining payer approvals when scheduling and registering patients. These efforts have yielded millions in reimbursement that could otherwise have been lost.

Learning Objectives

- Gain strategies for identifying payer performance trends for erroneous denials and for leveraging that data in payer discussions to reduce unavoidable denials.
- Learn how to expand denial competency throughout the revenue cycle and clinical areas to develop an organizational perspective for denial prevention and management.
- Recognize how payers’ inconsistent use of reason-specific denial adjustment codes could be hindering denial management and explore possible initiatives to mitigate these circumstances.
Organizational Spotlight – JPS Health Network

• Based in Fort Worth, Texas, JPS Health Network was founded in 1877. The network includes a system of 42 clinics and an acute care hospital that also offers an outpatient surgery center and a psychiatric treatment facility. JPS provides a variety of specialty services, including urgent dental care, robotic-assisted surgery, and HIV/AIDS care in a dedicated outpatient center, among other offerings.

Key Stats

- Hospitals: 1
- Staffed Beds: 573
- Net Patient Revenue: $337.4M
- Employed Practitioners: 247
- Employees: 5,000+
Improving Denial Analysis

Previous Communication Barriers

Building the Task Force

Launching the Dashboard

Involving Frontline and Clinical Staff
Previous Communication Barriers

• In 2014, communication was a major barrier to denial management and prevention at JPS.
  – The director of patient financial services was unsure of the total volume and financial impact of denied accounts.
  – This prevented leaders from setting a denial baseline, making it difficult to craft effective performance improvements or to gain staff buy-in for any denial prevention or management initiatives.

Discussion among departments, including clinical functions, was sporadic, so it was difficult for staff to understand how all areas of the revenue cycle contributed to denials.
Building the Task Force

The organization developed a denial prevention and mitigation task force in April 2015, which included representatives from clinical departments and the revenue cycle.

- The task force meets monthly to discuss denials, review case studies, and to brainstorm process improvements.

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<th>Original Membership</th>
<th>Additional Members</th>
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<td>✓ Managed Care Contracting ✓ Surgery/Periop ✓ Clinical Quality ✓ Physician Advisor (representing Medical Executive Committee)</td>
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Denial Task Force
Launching the Dashboard

- The task force evaluates denial data from a customized dashboard, which helps staff analyze accounts from throughout the system and makes it easy for them to identify trends.
Launching the Dashboard (Cont.)

Let’s take a look!
Involving Frontline and Clinical Staff

- JPS leaders must grant access to the dashboard, but the tool’s use is not limited to directors or managers.
  - Frontline staff use the dashboard to identify denials related to their functions.
  - The dashboard display ensures information is accessible to all users, even those without extensive technology skills.

A case manager can use the dashboard to identify denials stemming from inpatient notification issues.

The intent was to develop a tool that was not intimidating to the users who would most benefit from the data.

Absent this type of access, clinical areas had little to no knowledge of the impact their daily activities had on reimbursement or denials.
Involving Frontline and Clinical Staff (Cont.)

• Broad access to the dashboard helps ensure that the staff members most familiar with process gaps and inefficiencies have the data necessary to help design meaningful and effective improvements.
  – Many task force meetings include staff-led case studies on past denials, and the group discusses strategies to prevent similar denials from occurring.

Sample Case Study

The task force reviewed pre-authorization denials from radiology

Analysis revealed two major root causes

Staff misunderstanding the extent of an authorization

Radiologists modifying procedures from the referring provider’s order
Changing Staff Actions to Prevent Denials

Resolving Radiology Missteps

Preventing Overuse of STAT Orders

Replicating Success in Oncology

Improving Timely Notification

Enhancing EHR Processes

Discussing Case Studies
Resolving Radiology Missteps

• Deeper analysis of the radiology example revealed the staff missteps that were resulting in denials, creating an opportunity to revise processes and improve training.

Clinically Appropriate Action:
• Radiologist performs add-on procedures
• Radiologist performs medically necessary test that does not match pre-authorization

Revenue Cycle Misstep:
• Radiologist does not alert revenue cycle staff that authorized CPT code will not match CPT code on claim

Solution:
• Retrained radiology staff on revenue cycle topics
• Created revenue cycle process for calling in same-day, nonurgent services
• Created revenue cycle process for when different services are performed
• Radiology staff reconcile services provided with pre-authorizations on file, creating opportunity to request amended authorizations before billing
Preventing Overuse of STAT Orders

• The task force also helped identify unnecessary use of STAT orders in radiology, where many patients required pre-authorizations but were being treated too soon to obtain them.

New STAT Order Review Process

A radiologist reviews the STAT order.

If the patient could wait to be scheduled, the radiologist tells the physician the service will be scheduled within the week.

Revenue cycle staff obtain pre-authorization before service is provided.
Replicating Success in Oncology

• Lessons learned and benefits seen from the radiology improvements carried over to oncology, where services were often being scheduled without a pre-authorization on file.

An electronic health record system **hard stop** prevents staff from scheduling an infusion without entering pre-authorization data.

Oncology Infusions

- **19%** of infusion referrals had pre-authorizations before implementing the hard stop.
- **51%** now have pre-authorizations.
- Patient access–related denials in the oncology infusion clinic decreased by **47%**.
- Reimbursement lost due to these denials decreased **53%**.

The task force is helping to implement a hard stop for chemotherapy injections (staff often miss pre-authorizations for the drug itself, which can cost more than $12,000, and since these services are repetitive, the potential loss is phenomenal).
Improving Timely Notification

• The task force also has helped improve inpatient notification processes for Amerigroup, a major Medicaid managed care payer.
• One high-cost example was a $126,000 denial in 2016.
  – Patient access staff notify payers of admissions, and utilization management staff would place a note on the account that they were waiting on the payer to request clinical information (no verbal or escalated contact) and the delay resulted in denials.

Previous Inpatient Notification Process at JPS

But with the task force’s help…
Improving Timely Notification (Cont.)

- The task force showed front-end staff how their reactive approach was affecting reimbursement and helped them recognize the benefits of a proactive approach.

- The task force helped develop new processes.

- Staff have a centralized fax number for sending clinical information to Amerigroup, so they do not have to wait for a request.

- The task force also is collaborating with IT to develop an electronic process to export patient census data to Amerigroup as a batch notification.

Additional Improvements

Registration and utilization management staff are developing a phone list for high-volume payers that will include details of where to send clinical information after admission.
Enhancing EHR Processes

• The task force also has helped mitigate frequent EHR user errors that were causing denials.

If a patient received an authorized, STAT service, billing staff were entering “STAT” in the EHR field for the pre-authorization number.

The pre-authorization number was stored in the EHR, but “STAT” is what was sent to the payer on the claim as proof of authorization. (This is obviously a tactical denial, when the payer should have the authorization in its own system)

The service was denied for lack of authorization.

The task force explained this to radiology registration and authorization staff, preventing tactical/technical denials.
Enhancing EHR Processes (Cont.)

• The task force also has helped identify how the errors of individual staff members contribute to denials, prompting further improvements.

A patient access team member changed an EHR setting to say a pre-authorization was not required.

The task force developed criteria for this change to be made in the future.

The claim was denied.

All staff must clearly document the source of reference for when an authorization is or is not required (e.g., website, phone call with notes about whom they spoke with and a reference number, etc.).
Conclusion

Results

Lessons Learned

Future Plans
Results

• Attention to denials has increased, yielding significant financial benefits and improvements.
  – Modified processes for updating authorizations when clinical plans change after securing the authorization.
  – An increased emphasis on resolving accounts in pre-billing work queues to reduce timely filing denials (e.g., through DNFB checks and claim edits).
  – Executive-level discussion for a confirmed organizational process for redirecting out-of-network patients once they are stabilized.
• Staff understand how they affect the organization’s financial health.

As one example, the revised oncology infusion workflow and the EHR hard stop increased reimbursement by more than $5 million within a few months.
Lessons Learned

• Because the task force relies so heavily on the dashboard, JPS realized it was necessary to share data with as many stakeholders as possible.
  – The dashboard tool, being so user-friendly, makes the use of the tool less daunting than other graphical and numerical data-driven reports.
  – Clinical staff who are not used to looking at financial reports typically shied away from viewing reports that they did not understand.

The dashboard helps physicians connect clinical care to coding and documentation issues.

This provides the perspective needed to link how clinical areas affect the revenue cycle.
Future Plans

• The task force’s successes have encouraged foundational change, such as a recent cleanup of reason-specific denial adjustment codes.
  – This cleanup eliminated unused codes and helped standardize interpretation of payer responses, which can vary greatly.
• The director of patient financial services intends to use this data to better understand denial root causes, after collecting a sufficient pool of information.

The new codes “tell the story” (i.e., cause of the denial).
Questions?

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