ADVENT | HEALTH PARTNERS

Case Study

Metropolitan Hospital in the Northeast

• 600+ Beds • Not-for-Profit

When the new operations executive arrived at her new post at a large northeast hospital, she immediately identified her first challenge: their rate of denials was too high. Moreover, this metropolitan hospital lacked the resources and skill sets to most effectively challenge medical necessity denials.

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>
> **- Hospital Operations Executive**

Problem

After a little investigation, she discovered a few hurdles to addressing the hospital's fiscal problems. Like many providers, their utilization review, case management and patient financial services departments operated independently without efficient communcation. Their staff members possessed the requisite clinical knowledge but not the business acumen, subject matter expertise and experience with payers and providers. And, when it came to admitting patients, they erred on the side of keeping patients in the hospital – both out of a fear of clinical liability and to accommodate patient preferences.

She knew the hospital needed to prevent denials, improve day-to-day documentation supporting the bill, and reduce time to revenue. It was clear better processes needed to be implemented. But first, they needed to get in better shape fiscally.

Solution

The provider knew Advent's reputation with payers for submitting quality medical necessity appeals and requested a proposal for first-pass denial services. If the provider's initial efforts met with denial, Advent would pick up the ball and do whatever it took. But Advent's processes take this service to the next level.

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After a few short months of reviewing and appealing claims, Advent was able to pinpoint the provider's root problems:

- Inconsistent documentation was leading to subsequent denials
- Inpatient claims were not being billed correctly due to documentation
- Claims were not meeting payer-driven industry criteria
- Information was not being provided to the payer in a timely manner

Based on this root cause identification, Advent recommended the review of inpatient claims prior to being billed to the insurance company (pre-bill/DNFB). On a per case basis, Advent clinical staff began to review specific claims prior to being billed to ensure documentation supported the bill, the length of stay met inpatient industry criteria, and made recommendations based on review of billing status changes.

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Results

Advent recovered over $20 million for the provider in the first 18 months while also reviewing an average of 300 pre-bill claims per month, with an eye toward preventing subsequent denials. Very quickly, Advent reduced inpatient denials considerably, and as a result, the provider's monthly gross recoveries significantly increased.

In addition, the education and best practices that Advent communicated with the provider fostered collaboration between key departments: case management, utilization review and patient financial services. Advent was so successful in this initiative that they no longer perform pre-bill services for the provider as this function now is performed internally.

"We brought proof to the provider," says Advent's Vice President of Operations. "We won the respect and recognition of those we worked with day-to-day in addition to the C-suite. We were happy to work ourselves out of that job; it shows we've been truly successful."

Today, Advent still offers consulting services to the provider and continues to recover significant dollars per month. The closed feedback loop is of particular interest to the provider as it allows their managed care team to share this information to their advantage in negotiating managed care contracts with payers.