Provider Reports Summary

Monthly Status Report

Details the status of the entire claim inventory Advent has received. Provides a claim rollup of the activity taken on the claims, where they currently reside in the process, and the final claim resolution.

Executive Summary

Provided by Advent Operations, this is an overview of metrics for the designated period (e.g., monthly, quarterly). This snapshot is intended for senior management and may show trends not easily seen within the project—and helps escalate any issues or opportunities for both Advent and our client.

On-Trend Report

Advent performs a case-by-case review to determine appeal opportunities, and, through our proprietary analytics, this process simultaneously identifies payer and client trends. The On-Trend Report aggregates and outlines the story of your denials placed with Advent, and our recommendations regarding how to address the root causes. These recommendations are based on a goal of a 30 - 45 day maximum for time-to-revenue, and each trend category is detailed with additional education, best practice, and implementation opportunities.

Upon implementation of these recommendations, our clients most often receive reimbursements at the time of claim submissions, which results in narrowed time-to-revenue. These process improvements also eliminate the need for additional documentation reviews (or worse, appeals that are not understood and, therefore, denied by payers). Therefore, as root causes are addressed and denial rates subsequently improve, we urge our clients to move toward pre-bill reviews and clinical education designed to improve initial documentation.

Strategic Monthly Reviews

During the monthly reviews, your Advent Team Lead will review the Monthly Status Report and On-Trend Report, along with providing root cause analysis and recommendations.

Strategic Quarterly Reviews

In addition to Monthly Reviews, Advent will provide Quarterly Strategic Business Reviews. The Advent team will meet with client leadership to provide in-depth analysis based on real-time insight obtained in Advent Optics Business Intelligence Reporting.

- Real time analytics
- Normalized EDI X12 and/or appealed claims data

835/837 & DENIAL MANAGEMENT REAL-TIME ANALYTICS	Quarterly Strategic Reports
OPTICS	• A/R aging with detailed specifics • Outstanding appeals (#, $ days) and success rate of same • RARC/CARC breakdown with line-item breakdown and detail • DRG downgrades • Root cause analysis and trending • 3 Additional Customized Reports determined by Client

Monthly Status Report

US Health System | August 20XX

Activity	Volume	Total Denied	Total Appealed	Total Recovered
Total Placed	12,157	$120,694,793	$33,570,114	$18,511,867
Open/Appeal	1,338	$16,650,509	$2,381,771	$80,600
Appeal in Processing	620	$9,988,374	$2,334,218	$80,600
In Review	712	$6,551,226	$0	$0
Rebill Request	6	$110,909	$47,553	$0
Closed	10,819	$104,044,284	$31,188,343	$18,431,267
Overturned	2,817	$45,992,690	$19,748,295	$18,431,267
Written Off - Unfavorable Appeal	2,670	$25,013,373	$11,440,048	$0
Written Off - Not Worked	5,332	$33,038,221	$0	$0

Resolution	Count of Denied Amount	Sum of Denied Amount	Sum of Appealed Amount	Sum of Recovery Amount
Appeal	**620**	**$9,988,373**	**$2,334,218**	**$80,600**
Partial Payment	41	$489,590	$59,496	$80,600
Appeal in Process	579	$9,498,783	$2,274,721	$0
Recovered/Overturned	**2,817**	**$45,992,690**	**$19,748,295**	**$18,431,267**
Recovered	2,817	$45,992,690	$19,748,295	$18,431,267
Written Off - Not Worked	**5,329**	**$33,027,129**	**$0**	**$0**
Appeals Exhausted	13	$338,593	$0	$0
Balance Below Threshold	1,338	$3,796,483	$0	$0
Benefit Limitation	21	$98,745	$0	$0
Client Advised Advent Not to Pursue	76	$775,537	$0	$0
Correctly Paid Prior to Placement	518	$4,504,265	$0	$0
Documentation Does Not Support Service	1,325	$7,336,837	$0	$0
Inappropriate Setting	1	$6,360	$0	$0

Resolution	Count of Denied Amount	Sum of Denied Amount	Sum of Appealed Amount	Sum of Recovery Amount
No Retro Authorization	775	$7,127,281	$0	$0
Past Timely Filing	1,198	$8,591,340	$0	$0
Patient Had No Insurance	5	$39,042	$0	$0
No Retro Authorization	775	$7,127,281	$0	$0
Past Timely Filing	1,198	$8,591,340	$0	$0
Patient Had No Insurance	5	$39,042	$0	$0
Payer Guidelines Not Met	59	$412,642	$0	$0
Written Off - Unfavorable Appeal	**2,660**	**$24,976,206**	**$11,419,747**	**$0**
Appeals Exhausted	29	$250,847	$125,926	$0
Balance Below Threshold	42	$278,291	$211,914	$0
Benefit Limitation	25	$128,156	$38,959	$0
Client Advised Advent Not to Pursue	24	$449,590	$192,034	$0
Coding Edit	14	$131,070	$105,696	$0
Correctly Paid Prior to Placement	174	$1,166,649	$646,233	$0
Documentation Does Not Support Service	625	$5,794,126	$2,648,187	$0
Inappropriate Setting	2	$24,198	$7,106	$0
No Retro Authorization	1,404	$13,591,953	$5,858,806	$0
Past Timely Filing	276	$2,414,426	$1,388,151	$0
Patient Had No Insurance	8	$96,753	$27,069	$0
Payer Guidelines Not Met	37	$650,142	$169,660	$0
In Review	**712**	**$6,551,225**	**$0**	**$0**
Nurse Review	106	$1,164,454	$0	$0
Requested Additional Records	6	$37,354	$0	$0
Document Review	329	$3,461,206	$0	$0
Analyst Assigned	271	$1,888,210	$0	$0
Rebill	**6**	**$110,909**	**$0**	**$0**
Rebill	6	$110,909	$0	$0
TOTALS	**12,144**	**$120,646,534**	**$33,502,261**	**$18,511,867**

Executive Summary

US Health System | August 20XX

Partnership Since 01.XX

Recovery To-Date $26,548,725

PURPOSE

Ensure all opportunities are shared in the spirit of our partnership while driving maximum financial returns and improving efficiencies.

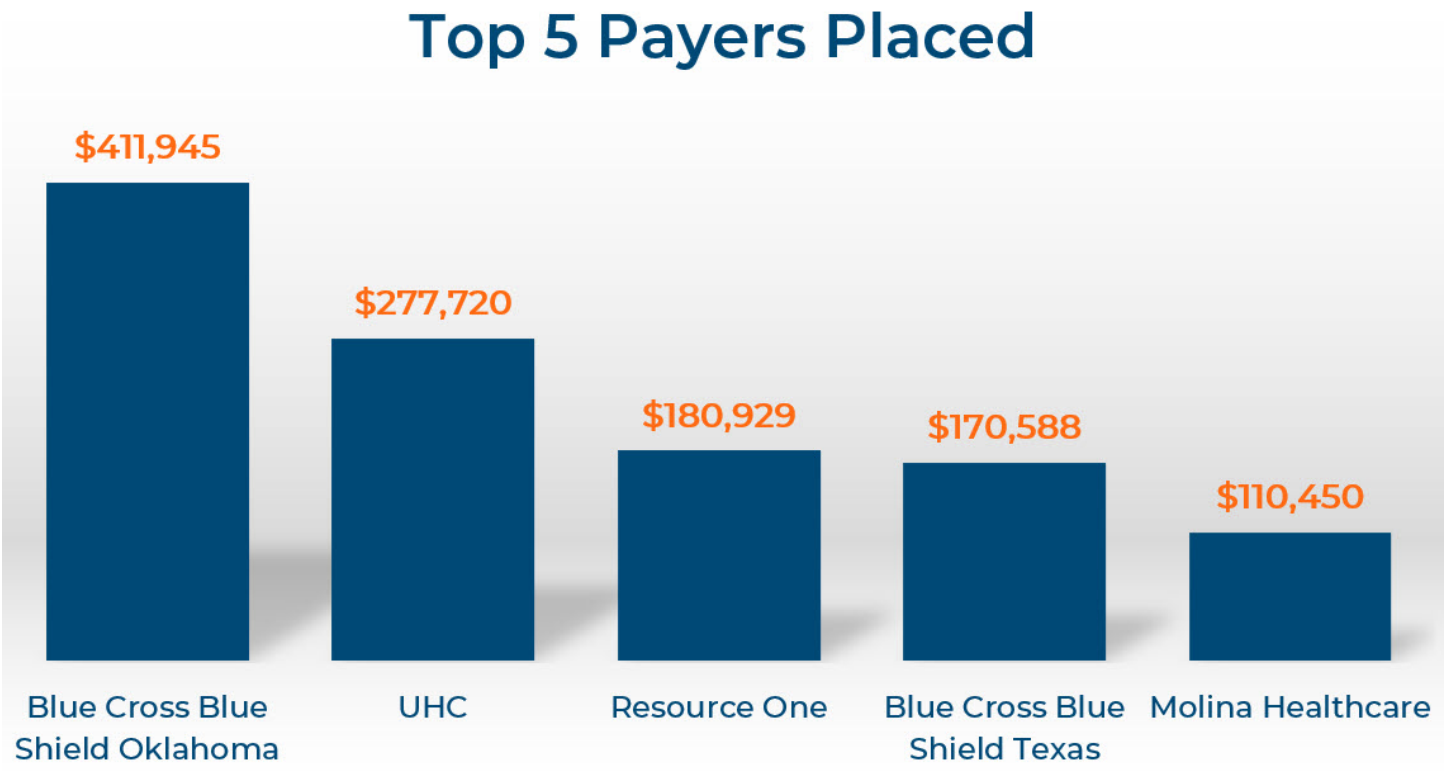
PLACEMENTS January - August

REVIEWED	APPEALED	CLOSED
253 accounts	**141** appeals written	**112** accounts closed
$3,176,328 in reviewed charges	**$2,154,742** in appealed dollars	**$1,021,586** in denied charges

Q2 RECOVERY

April 20XX	$205,859
May 20XX	$264,648
June 20XX	$349,261
Total	**$819,768**

FINANCIAL HIGHLIGHTS



ROOT CAUSE

SUCCESSES

- DRG downgrades are starting to pay.
- Received a batch of recoveries via state appeals.

OPPORTUNITIES

- Insufficient Documentation
- Two Midnight Rule
- Authorizations

LOOKING AHEAD

CAVO® Connect

On-Trend Report

US Health System | August 20XX

FACILITY NAME	SURFACED TREND	TREND DESCRIPTION	ADVENT RECOMMENDATIONS
123 Medical Center	Insufficient documentation	Protocols used for abdominal pain, chest pain, and drug overdose are resulting in patient dx POS resolving in <24 hours	Reconsider current protocols to ensure well-documented reasons for admissions relative to interventions.
456 Medical Center	Two-midnight rule	Admitting of Medicare ER patients with known co-morbidities to follow two-midnight protocol	Reconsider admissions once results are known from lab and imaging studies. Also, reconsider admissions after any consulting physicians have provided their recommendations.
ABC Hospital	Authorization	Authorizations differ from billed service	Two recommendations: 1. Obtain authorization at the time of referral and further verify patient benefits. 2. Log each procedure in OR and daily staff review to gain further authorization as needed. Establish and manage effectiveness of change to implemented workflow.

FACILITY NAME	SURFACED TREND	TREND DESCRIPTION	ADVENT RECOMMENDATIONS
ABC Hospital	OP procedures	OP procedures are being performed IP	At time of referral to hospital, ensure service is IP appropriate for payment. If emergent, question the need for admission since claim will not be paid unless an extenuating circumstance presents itself and can be proven on appeal.
123 Medical Center	OBS service, not IP service billed	IP industry criteria and payer policy not met	Educate clinicians regarding IP appropriateness to ensure proper payment at the time of claim submission.
EFG Medical Center	Contract modeling	DRG contracts which have outliers for $100K to be paid at percentage of charges	Line item charges were removed from claims and denied for being disallowed/unbundled, resulting in the claim being paid at DRG other than percentage of charges billed. Line items must be further reviewed, compared to payer policy, and appealed for appropriate reimbursement.