ADVENT
HEALTH PARTNERS

EBOOK

Hospital Claim Denial Prevention

Solving Six Common Denial Root Causes

Introduction

According to the HFMA, preventing denials can yield upwards of $5 million in additional revenue for a typical hospital. With ninety percent of denials preventable and two-thirds appealable, a strong denial prevention program can help your organization recover more of that additional revenue faster.

Advent Health Partners was founded in 2010 to help health systems and hospitals handle their denials. In the decade since then, our team has sifted through hundreds of thousands of claims and helped many organizations reduce their denials and recover revenue that would have been lost to them otherwise.

This eBook utilizes our denial management and denial prevention experience to help your organization resolve the six most common denial root causes. Through the discussion of preventative steps and a holistic view of the benefits that come with addressing them, we hope that your organization can identify possible areas of process improvement and find valuable solutions to develop a prevention-first mindset.

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1. Registration/Eligibility

Various industry analyses estimate that registration/eligibility issues cause roughly 25% of all claim denials. The good news is that denial prevention processes are straightforward to implement in this area.

Appointment scheduling or registration gives healthcare providers a unique opportunity to obtain patient demographic information along with standard insurance information. Statistically, patients are more likely to share this information at the time of registration.

In eligibility situations, the facility and patient are best served knowing the financial outcome prior to rendering services. As a first step, a provider-insurance company discussion easily confirms available benefits and coverage for upcoming services. Sharing this information during verification prior to the appointment results in a patient well-informed of benefit coverage, cost of service, and expected service payment—a 'win' for everyone involved. Providers can then capitalize on the opportunity to describe patient accountability and request payment for their portion of services; as needed, providers can proactively discuss alternatives, such as payment plans. The bottom line is open communication between the payer, provider, and patient typically translates into a successful financial outcome for all parties.

Benefits

- **Improve Patient Satisfaction**
  Improved communication and transparency with patients, key factors correlating with overall patient satisfaction, allow for discussion of treatment and payment alternatives.

- **Increase Pre-Payments**
  Pre-service payment discussions increase patient willingness to pay prior to rendering services by at least 20%.

- **Mitigate Denials**
  Aligning treatment needs with the patient and financial information in hand prior to treatment is a winning situation and sets the stage for accurate payment.

Typical Denial Causes	Recommended Prevention Steps
Coordination of Benefits	• Determine primacy through calls with insurance companies and employers as applicable. • Confirm plan benefits for upcoming patient services. • Collect amounts due from patients applicable to liability for services.
Benefit Maximum	• Before or at the time of service, collaborate with the health insurer to determine patient benefit plan for services. • Verify any alternatives available for coverage.
Plan Coverage	• At the time of or before the service, determine the coverage type the patient has in place. • Hold patients accountable for payment by confirming coverage with the insurance company and sharing this information with the patient to enable an informed decision. A payment plan can be established with the patient in advance, as needed. • If your facility has already received a denial citing plan coverage, the remaining payment option is typically a contract loophole not initially seen by the insurer. Otherwise, payment will not be issued since the patient did not have the required coverage type. For example, maternity may not be a covered benefit under the patient's policy.

Next Steps

- Verify and update registration processes to ensure your team completes all patient demographic information prior to services.
- Verify and update eligibility processes your hospital provides patients with, their insurance plan benefits, and collect monies prior to rendering services.

It's too late to learn that a service is not included in the patient's benefits after it's rendered and the claim is submitted. Instead, proactively avoid this situation:

- Review data and reports to identify specific areas for registration improvement opportunities.
- Verify and update registration and eligibility processes to solidify correlating process improvements.
- Conduct staff training.
- Continually monitor to ensure improvements and re-train or update processes further, as needed.

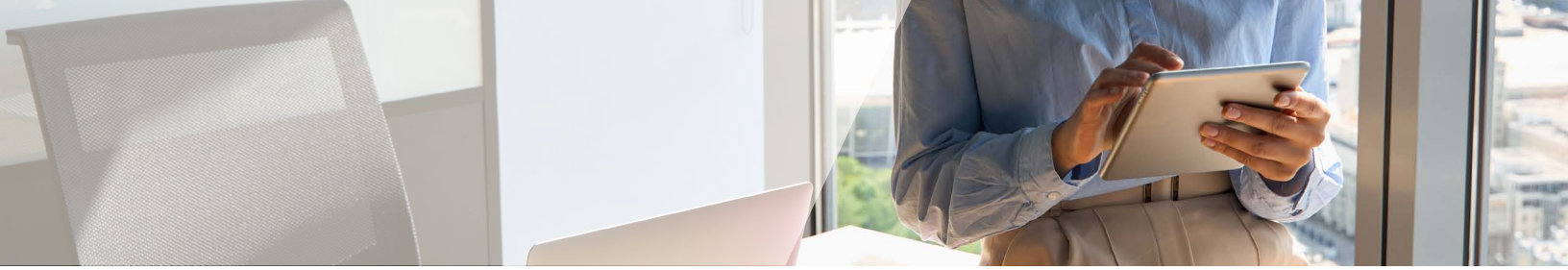
How Advent Can Help

Concurrent Reviews

Advent Health Partners can augment your organization's concurrent review process, leading to decreased time-to-revenue and a strong foundation for denial prevention.

Revenue Integrity Consulting

We develop best practices for hospitals and health systems to ensure that registration and eligibility processes reduce the number of denials on the front end.



2. Authorization

Authorizations can be time-consuming, and yet even the best efforts for obtaining authorizations cannot guarantee reimbursement. Issues commonly arise when approved services do not match rendered services. For example, a provider may call a health plan before the service and be told an authorization is not needed for the requested service. However, the claim may be denied on submission because the plan states that the billed CPT code differs from what was approved. Upon further review by the provider, the problem is evident given the surgeon chose a different approach during surgery, i.e., an abdominal approach was necessary rather than a laparoscopic service. In this case, a retro-authorization should have been obtained within 24 hours of the surgery.

How could we have prevented this denial? **Keep an OR log in the operating room that indicates any change in services provided and the reason why.** A phone call can be immediately made for authorization (within 24-48 hours) and the correct authorization indicated on the claim, preventing a denial.

Benefits

- **Narrow time-to-revenue**
  Proactively securing authorizations prior to services rendered improves clean claim rates.

Typical Denial Causes	Prevention Best Practices
Invalid Authorization	• Determine if a retro-authorization can be secured, identifying any extenuating circumstances that occurred. • Make a phone call to the payer to explain further the need for a resubmitted claim and retro-authorization. The payer may not do so and instead require writing an appeal to overturn the denial and secure payment.

Authorization Denied
or
Services Exceed Authorization
	• Determine if the denial is valid.
	  • If so, a phone call to the insurance plan is in order.
	  • If not, review documentation and provide the necessary details and documentation to support an appeal.
	
	Note: Often, if the plan originally stated no authorization was required, then there are relevant extenuating circumstances.

- Adopt an OR log process that documents any changes in surgery from services authorized. Then secure a retro-autorization the same or next day to append to those claims and avoid denial.
- Determine which payers do not often allow retro authorizations, regardless of circumstances. Create internal, payer-specific policies as needed.
- Pinpoint specific circumstances for services in which authorizations are not appended to the claim.
  - **Authorization denial example**: A planned outpatient procedure was performed inpatient. While an authorization is not required when performing the outpatient service, it is required when inpatient.
  - **Services exceed authorization example**: For instance, the surgeon located other areas requiring clinical/medical attention and resolved while the patient was in the OR. For instance, an additional mass removal required insertion of the scope into a different orifice (and, therefore, another CPT code is warranted and billed).
- Document and train staff regarding appropriate protocols, such as a phone call to the health plan, Availity submission, or third-party call (e.g., AIM, Evicore).

How Advent Can Help

Concurrent Reviews

Advent Health Partners can augment your organization's concurrent review process—including obtaining authorizations—leading to decreased time-to-revenue and a strong foundation for denial prevention.

Revenue Integrity Consulting

We develop best practices for hospitals and health systems to ensure that registration and eligibility processes reduce the number of denials on the front end.

Apello

Efficiently share documentation for authorization-related denials with the applicable health plan via API.

3. Missing or Invalid Claim Data

Missing or invalid claim data can most frequently be traced back to accidentally omitted or incorrect information, such as a missing or inaccurate MPI number; however, it must be corrected to avoid denials.

Billing issues are most often:

- an omission,
- careless mistake,
- incorrectly coded line item, or
- a "fired" edit.

Most missing claim data denials are caused by a needed charge master correction, such as:

- NPI change,
- diagnosis-to-procedure correlation, or
- taking time to review the explanation of payment/RAs.

Claim data denials are typically immediately recognizable and correctable—or, at a minimum, present opportunities for training or process improvements. Review your explanations and then evaluate payer behavior and collaborate with the payer to understand the errors. This allows you to correct for this specific claim and learn from mistakes to prevent recurrences. **Being accountable for payments by asking questions and understanding the methods for which you're paid (or not)—adds value to your facility, its patients, and the financial health of both.**

Benefits

- **Improve time-to-revenue**
  Clean claims equal timely receipt of reimbursements.

- **Increase efficiencies**
  "Clean up" your chargemaster and reduce redundant employee tasks. As a bonus, set the stage for employees to be thought leaders.

- **Ensure receipt of reimbursements**
  Incorrectly denied claims often continue until providers, utilizing trended data and compelling appeals, challenge—and change—health plan behavior. To do so, providers must examine EOBs and ensure proper payment; otherwise, there is the potential for monetary loss due to ignoring lack of payment, improper payment, or wrongfully denied claims.

Typical Denial Causes	Prevention Best Practices

Unspecified Billing Issue	• Confirm comprehensiveness before submitting claims, including:
	  • all NPIs are valid and consistent with the provider billed,
	  • billed CPT codes are valid and correlate diagnosis and procedure, and
	  • insurance company name and group number are correct.

Missing or Invalid EOB	• Verify that required EOBs are present and accurate. Determine if each EOB offers an explanation of payment for each billed line item. Specifically, is:
	  • each revenue code acknowledged?
	  • a valid reason code given that explains if a service is unpaid?
	• Determine next resolution steps and proactive steps to prevent future occurrences.

Next Steps

- Ensure an accurate chargemaster with continuous updating following a documented process.

How Advent Can Help

Analytics & Reporting

Optics visualizes 835/837 data to identify denial trends and present training or process improvement opportunities.

Revenue Integrity Consulting

We develop best practices for hospitals and health systems to ensure that missing or invalid claim data doesn't occur by helping to review their chargemaster on the front end.

Apello Predict

NLP models flag claims with the opportunity to gain payment and correct a claim. *(In development)*

4. Services Not Covered

This definition may seem self-explanatory, but that's not always the case. Consider beginning with learning what is not covered to determine whether there is a mistake in understanding the billing reason for the service. Following this process may uncover a payment opportunity. For example, maternity as a not covered benefit under the patient's policy is a valid reason for non-payment. However, a medically necessary, non-cosmetic blepharoplasty is likely a payable service if there is a clinical reason. When performed by an ophthalmologist with documented medical necessity of the service, the claim will typically result in payment. Of course, learning after the service is rendered and the claim is submitted that a service is not covered may be too late to receive reimbursement.

Many health plans apply their rules instead of Medicare or Medicaid. At times, this can work to the provider's advantage, since depending on the contract and the health plan's written policies, many health plans apply. Medicaid beneficiaries are often enrolled in a Medicaid-managed care plan and continually switch plans. Providers should take care to verify coverage prior to each date of service to ensure coverage changes have not impacted benefits or eligibility.

Specific hospital days are not paid for a variety of reasons, both valid and invalid. Common reasons include:

- ICU billed, medical surgery paid, given documentation did not support ICU care. The explanation must include the reason for monitoring in ICU vs med/surgery.
- The final days a patient spends in the hospital are while they're awaiting placement in skilled or rehabilitation. However, health plans are unwilling to pay for patients to stay in the hospital without monitoring or treatment.
- Inpatient billed and observation paid. Explain the necessity of inpatient care and define criteria/facts for the same.

Benefits

- **Capture less obvious reimbursements**
  Denials citing "service not covered" may be attributable to better documentation and explanation of the correlation between diagnoses and rendered services.
- **Decrease Medicaid denials**
  Prevent denials for Medicaid patients who may have changed plans—and, therefore, coverage—since prior service(s).

Typical Denial Causes	Prevention Best Practices
Service Not Covered	• "Service not covered" may be a literal interpretation if coverage was not verified before rendering services. In these cases, review and establish the likelihood for payment. Consider any contract loopholes not initially seen by the health plan, LCD/NCD, or an appeal opportunity based on written exception criteria that is relevant. • If one of these options is not applicable, payment will not be issued since the patient did not have the referenced coverage type. • "Service not covered" may indicate a lack of correlation between the diagnosis and service rendered. For these instances, verify (and provide, if applicable) documentation is present to communicate the correlation between diagnosis and rendered services. For example, the operative report is clear as to the service rendered and supports supplied LCD/NCD.
Unspecified Billing Issue	• Prevent future occurrences by resolving any chargemaster fallacies and educating staff.
Managed Care	• Re-verify coverage with each encounter for patients to ensure accurate billing to the correct MCO. When providers do not re-verify, denials statistically increase due to patient propensity to continually change MCOs, specifically. • Challenge services that do not follow health plan and Medicare or Medicaid rules with a compelling appeal, when applicable, explaining CMS guidelines and how the MA or MCO did not appropriately follow guidelines and issue payment. Examining EOBs and ensuring proper payment is the provider's responsibility.
Non-Covered Days	• Perform pre-bill reviews to ensure supporting documentation is evident in the medical record. • These denials are continual occurrences and warrant clinical review and challenge. An appeal is warranted when documentation supports the necessity for each billed hospital day. • For identified common denial scenarios, document protocols—and train staff accordingly—for proactively submitting medical records at the time of billing and writing a synopsis to submit as a 275 transaction. The synopsis should describe the necessity of admission and defend the number of hospitalized days—specifically if you have not been asked/secured additional days in the authorization.

Next Steps

Billing issues can often be identified and corrected before the payer receives the claim, either with pre-bill reviews or through clearinghouse edits.

- Identify the specific areas or payers for your facility's most common denials and determine root causes.
- Evaluate (or implement) pre-bill review processes and criteria to ensure supporting documentation to prevent these specific denial types.
  - For denials citing non-covered days, proactively submit medical records at the time of billing and include a written explanation for days.
- Continually monitor data and reports to ensure improvements and identify and address any lingering issues.
- Resolve any chargemaster fallacies and educate staff. Ensure a continual, ongoing process for both.

How Advent Can Help

Revenue Integrity Consulting

Advent Health Partners offers clinical expertise in providing compelling appeals that highlight supporting documentation in a 275 transaction, leading to service being covered.

Apello Predict

Algorithms customized to your hospital or health system flag claims with potential Services Not Covered issues. *(In development)*

5. Medical Coding

AHIMA and AAPC coders are well-versed in medical documentation requirements and understand coding principles/guidelines to validate DRGs. Advent also supports the review of documentation by a registered nurse to further explain the reason for billing a specific DRG due to the progression or deterioration within the admission, procedure, service, or encounter billed. Doing so allows the payer to see your facility takes appropriate steps to ensure proper documentation and that all coding guidelines are followed and met throughout the patient's hospital stay.

Typical Denial Causes	Typical Root Cause	Denial Management Steps	Denial Prevention Best Practices

Bundling	• Services are incorrectly bundled with other services/procedures.	• Verify the services are bundled with other services/procedures as identified by the payer.
		  • If so, correct the chargemaster to ensure there are no future occurrences of the same procedures bundled.
		  • If the services are not bundled, and documentation supports billing a separate code, then "bypass" that edit of overlapping services. An appeal explaining how you derived the means to code the claim using the services billed and not overlapping will be necessary through an appeal and working with that payer's provider representative to better explain the extenuating circumstances with supporting documentation and coding guidelines.
			• Follow CCI edits
			• Leveraging your provider representative to override the edit for bundling, which are not CCI edits, as this would be in inaccurate denials.

Typical Denial Causes	Typical Root Cause	Denial Management Steps	Denial Prevention Best Practices
Procedure/ Diagnosis Correlation	• A provider-submitted diagnosis does not correlate with the service provided at times, and a denial is experienced. For example, a chest x-ray is billed with a diagnosis of diabetes. While the patient has diabetes, this diagnosis is not a clinical reason to perform a chest x-ray; therefore, the claim is denied.	• Supporting documentation indicates the physician's reason to order a chest x-ray.	• Put in place a means to flag any line item which does not correlate with LCD/NCDs, i.e., correlation of service rendered and diagnosis billed.
DRG Validation	• DRG downgrade.	• Review supporting documentation to validate the sequencing of diagnosis billed to the DRG submitted on the claim and the applicable grouper.	• Review supporting documentation (QA) prior to submitting the claim.

How Advent Can Help

Advent can help with medical coding in many ways, dependent on the needs of the health system or hospital, whether from a technology or clinical expertise perspective.

Provider Services

Advent's clinical expertise can help identify the reasons behind DRG downgrades.

Apello

Store related documentation in Apello's central, searchable cloud-based repository.

Apello Predict

Reviews are automated to ensure appropriateness of charges based on a series of industry guidelines, payer policies, and standard protocols. *(In development)*

Revenue Integrity Consulting

Advent's Revenue Integrity Consulting team can analyze your claims data and processes, recommend solutions, and provide optional implementation assistance.

Analytics & Reporting

Combine real-time 835/837 and appeal/denial data from all of your data sources.

6. Medical Necessity

Documentation tells the story of the patient's encounter, and a well-written story with observable facts garners an audience's attention. The necessity of the admission should capture the reviewer's attention in the initial paragraph, which explains the continuum of care, progression of the admission, and discharge readiness (or explanation of reasons for the patient's inability to advance in care). Educated physicians are well-prepared to appropriately document the patient's development or deterioration, offering a detailed explanation of the continuum of care and any associated comorbidities treated.

Level of care denials are significant in volume for many providers and labor-intensive to resolve. Supporting documentation along with industry criteria and extenuating circumstances with factual lab, imaging, and vital signs showing progression and determination is paramount in getting the claim paid at the correct level of care.

Benefits

- **Increase clean claims**
  Improves operational practices, and monies are paid within 15 business days.

Typical Denial Causes	Prevention Best Practices

Medical Necessity	• Determine which portion of the claim was not paid based on a medical necessity denial. Questions to ask:
	  • Were medical records provided to the payer? If so, review the documents to pinpoint any omissions; if not, appeal and explain the necessity of the inpatient admission.
	  • Which payer policy is applicable? Explain how it was followed.
	  • Was there a lab progression (or lack of)? Verify imaging study results also and treatment recommendations.
	  • Are there physician orders, progress notes, or other physician documentation that tell the story necessitating an inpatient stay?
	• If paid per diem, explain within the appeal each daily activity and progression.

Level of Care	• Were the criteria evaluated? Were they inclusive?
	  • If not, argue on appeal.
	  • For instance, if Level III NICU is billed with a ventilation charge, the correct coding is Level IV NICU, which includes the ventilation. Payers may require a corrected claim, while others will accept it as an appeal. Know your payer requirements!
	• When appealing claims, showing criteria followed, especially industry criteria, such as Interqual or MCG, is good practice and reflects that documentation supports an inpatient stay. In contrast, arguing an appeal for physician order without supporting documentation or industry criteria will likely not result in reimbursement.

Next Steps

Supporting documentation is central to appropriate, timely reimbursement—and is typically at the root of most medical necessity and level of care claim denials.

- Evaluate (or implement) pre-bill review processes and criteria to ensure supporting documentation to prevent these specific denial types.
- Identify any specific areas, codes, or payers with higher denial rates and determine root causes quickly for resolution.
- Strategically prioritize improvement opportunities based on the highest potential ROI, available resources, and implementation timeline resulting in timely reimbursement and improved processes going forward.
- Educate staff regarding new or updated protocols.
- Monitor data to ensure improvements and identify additional opportunities for reimbursement.

How Advent Can Help

CAVO Connect

Efficiently share clinical documentation with health plans via API.

Analytics & Reporting

Customized dashboard visualizations allow for data to be drilled down to identify trends. Combine 835/837 claims data with denial and appeal data to generate reports to ensure improvements and identify additional opportunities for reimbursement.

Revenue Integrity Consulting

Our revenue integrity solutions team identifies root cause trends for your organization's denials and delivers actionable recommendations and solutions with the highest potential reimbursements and quickest timelines.

Apello

Easily aggregate decision data to expedite claims and create, assemble, and send compelling appeals, all within the same platform.

About Advent Health Partners

Advent Health Partners was founded as an outsourced review vendor in 2010 in Nashville, Tennessee. As our business grew, the Advent healthcare claims review solutions team of registered nurses, credentialed coders, and business analysts spent the majority of their time sifting through medical record documentation, trying to find decision data–instead of making decisions. Our team then began building solutions to increase review efficiencies and pinpoint process improvement opportunities for health systems and hospitals.

Today, we share our clinical expertise, technology, and best practices with providers to accelerate appropriate financial recoveries and operational insights, and increase review team productivity.

How Advent Can Help Your Hospital or Health System

Typical Denial Causes	Provider Services	Revenue Integrity Analytics	Revenue Integrity Consulting	Apello	Apello Predict
Registration/ Eligibility	Yes		Yes	Yes	
Authorization	Yes		Yes	Yes	
Missing or Invalid Claim Data		Yes	Yes		Yes
Services Not Covered	Yes	Yes	Yes	Yes	Yes
Medical Coding	Yes	Yes	Yes	Yes	Yes
Medical Necessity	Yes	Yes	Yes	Yes	Yes

To discuss how Advent Health Partners can assist your hospital or health system, get in touch at providerdemo@AdventHP.com.

adventhp.com