GETTING THE JOB DONE

A toolkit for denial prevention in a new age of COVID-19

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INTRODUCTION

To get the job done, you need tools

Not just any tools—the right tools. In healthcare, 'getting the job done,' refers to surviving and thriving in an environment filled with audits and compliance risks that emerge regularly. Against this dynamic backdrop is the COVID-19 pandemic that is also ripe with opportunities for payers and auditors to reduce or deny payments. It's an ever-changing landscape that forces healthcare organizations to innovate and improve denial-related strategies. Staying one step ahead of payers is paramount.

The wrong tools are those that no longer serve the greater purpose of enhancing revenue integrity. This might include antiquated workflows or a 'wait and see' approach to denial management. It might also include manual processes or ill-equipped staff who aren't able to tackle denials and appeals with the level of detail necessary to ensure capture all of the revenue to which the organization is entitled.

The right tools are a combination of people, data, and technology that enable denial prevention and support value-based patient care. Some organizations may have some of these tools in place already while others may find themselves starting from the ground up. Either way, what truly matters is ensuring that your toolbox is there when you need it. This requires some proactive planning and patience. After all, Rome wasn't built in a day.

FACT:

Denials have existed for a long time, but the landscape related to denials continues to change, and organizations must shift from retrospective processing to ongoing prevention throughout the organization.

CHAPTER 1

YOUR NEW DIY PROJECT: DATA-DRIVEN DENIAL PREVENTION

The Right Tools

When healthcare organizations have the right tools, they don't rely on temporary fixes or patches that give the illusion of compliance. That's because they're equipped to identify and address the root causes of denials. They're able to go to the source of problems and remedy them directly.

The right tools also enable organizations to push proactive denial prevention upstream so that errors are resolved as early in the revenue cycle process as possible—and long before payers have an opportunity to deny payment. It's about anticipating the repairs and fixing them as quickly as possible before additional damage occurs. By 'damage,' we're talking about costly and time-consuming appeals and claim resubmissions, patient dissatisfaction, compromises in quality of care, poor data quality, and more. Today's already cash-strapped hospitals can't afford unnecessary revenue loss and leakage. It's time for a new approach.

Not sure where to start when thinking about a denial prevention toolbox? You've come to the right place. This e-book describes how to assemble your toolbox and put the tools to work—all with the goal of creating a larger blueprint for financial success during COVID-19 and beyond.

FACT:

Total hospital revenues in 2021 could be down between $53 billion and $122 billion. All the more reason why proactive denial prevention is paramount.

Source: https://www.aha.org/system/files/media/file/2021/02/KH-2021-COVID-Impact-Report_FINAL.pdf

CHAPTER 2

ASSEMBLING YOUR TOOLBOX

Denial Prevention Toolbox

Every denial prevention toolbox needs the following three tools.

1. People

When we say 'people,' we mean everyone—not just coders and billers. Ideally, denials would be prevented long before a record reaches anyone in the revenue cycle department. For example, denial prevention includes:

- Registration staff who input patient demographic and financial data.
- Clinical documentation improvement (CDI) staff and nurses who query physicians and perform utilization review.
- Physicians who document in each patient's medical record.
- Health information technology team responsible for electronic health record updates and templates.

Proactive denial management essentially involves anyone who provides directs patient care or who inputs or validates information in the patient's medical record in any way. It's a novel integrated approach that we like to call a clinically-integrated revenue cycle (CIRC).

DENIAL STRATEGIES: OUT WITH THE OLD, IN WITH THE NEW

Say goodbye to a siloed approach to denial management. It's time for proactive denial prevention using a Clinically Integrated Revenue Cycle (CIRC).

A CIRC is not a single person, process, or technology, it is a cumulation of many different people, processes, and technologies that bring varying skill sets to the table to ingest information and make informed decisions based on data. It includes representation from multiple departments across the healthcare system, including nursing, care management, quality, ancillary departments, and others. It cannot be a back-end or business office-driven team.

2. Data

Data should drive every healthcare organization's proactive denial management strategy. Consider these questions:

- What types of denials does your organization see most frequently?
- What is your history of denials by payer?
- What is your volume and type of query to each provider? What about COVID-related queries specifically?
- What was your query volume over the last two or three months? Response rate? Impact on the case-mix index?

3. Technology

Long gone are the days when organizations can use Excel spreadsheets to manage their denials. In this age of big data, technology and analytics are paramount. This includes analytics to draw actionable insights from the data your organization ingests and creates as well as dashboards that provide real-time performance monitoring.

The technology must also be intuitive to the end-user. It must complement daily operations and provide real-time analytics driven by accurate data. The goal is to focus on prevention and slowing the incoming denials and audits while ensuring the current inventory is accurately addressed to recoup as many dollars as possible. Lost revenue is not an option.

Three hidden data gems that can support denial prevention

Have your tools handy to uncover these three 'data gems' that can help strengthen your denial prevention strategy.

835 file *This file, which is the payer's response to the electronic submission of a healthcare claim, includes remittance information, including charges that were paid, reduced, or denied; deductible, coinsurance, and copayment amounts; and details about bundling and splitting of claims. Monitoring this file allows revenue cycle staff to address problems immediately—not weeks or months after claim submission.*

277 file *This file includes information about claim status, including whether claims must be recoded and resubmitted. More specifically, it can help immediately pinpoint compliance vulnerabilities and opportunities for physician and/or coder education.*

Release of Information (ROI) data *In the past, ROI data was either inaccessible or organizations couldn't mine it for quality and trends. However, that has changed. Today, ROI includes several key data elements that help organizations identify leading and lagging that can directly support denial prevention programs. This includes the following: Top requestors, top payers requesting information, and top types of requests coming into the organization (e.g., audit, denials, Recovery Audit Contractors). It also includes timeliness of fulfillment of requests that directly identify barriers and opportunities related to timely filing.*

CHAPTER 3

PUTTING THE TOOLS TO WORK

Now that you've got the right tools, let's put them to good use. The following are several best practices for proactive denial management.

People

1. **Be clear about roles and responsibilities.** For example, are there certain aspects of denial prevention for which nurses vs. coders are responsible? What role does each individual play and at what point in the process? Clearly delineate this information as part of your written denial prevention strategy.

2. **Provide ongoing denial prevention training.** For example, coders may need a higher skill set to address complex coding denials. Nurses or CDI staff may need additional training on how to address clinical validation denials, ensure medical necessity throughout the continuum of care, write effective appeals, and engage in active clinical discussions. This is not a poor reflection on staff abilities—it simply represents an acknowledgement that compliance is a dynamic target. Remember: Training isn't a 'one and done' event.

3. **Augment staff, when necessary.** Mistakes happen when staff are overwhelmed or burned out. Knowing how many staff are necessary for effective denial prevention—and flexing up or down, when needed—is critical. Many appeals take at least an hour to complete depending on the size of the record, denial requirements, and any necessary research. Look at your volume of denials, and plan accordingly.

4. **Promote denial prevention from the top down.** Hospital leaders must be committed to making denial prevention a priority and put it on equal footing with the discharge-not-final-billed rate. Leaders must acknowledge that although it may take time and resources, their organization—and their patients—are worth the effort. Accurate documentation and coding are important not only for financial reasons but also for patient outcomes, continuity of care, quality profiles, and more.

5. **Encourage knowledge sharing.** For example, encourage coders to share their coding knowledge with CDI, and vice versa. Encourage them to talk about how their work has positively impacted one another using specific examples. How did a CDI specialist's query, for example, help a coder assign a more specific code? How did a coder's explanation of a coding guideline help prepare a CDI specialist to provide physician education? The key is to foster a sense of appreciation and teamwork.

Data

1. **Establish a source of truth.** Many organizations continue to struggle with obtaining clear and concise denials data that supports a denials program and provides end-users with an easy to use tool to address denials daily. However, some organizations have made the transition from manual data collection and manipulation to the utilization of the 835, 837, and 277 files specifically (instead of combining data from multiple systems). These files allow organizations to perform analytical analyses and identify trends in data. Remember, manual processes that involve multiple applications can lead to errors.

2. **Leverage ROI data.** Demand that any ROI partners provide key data elements from the ROI data repository to complement your strategic work approach.

3. **Share the wealth.** Remember that coders aren't the only ones who need to see this data. CDI specialists, physician advisors, and front-desk staff need to see it as well. CDI specialists can help appeal denials due to lack of clinical validation. Physician advisors can identify educational opportunities for physicians. Front-desk staff can ensure accurate capture of demographic and insurance data. It truly does take a village to address denials. To distribute information, consider quick email blasts or banners on your organization's Intranet pages. You can also distribute information at team meetings and even turn learning into a game with prizes.

4. **Remember: Garbage in, garbage out.** The data doesn't lie. If documentation is poor, then coded data quality will be poor as well. Reiterate this messaging so everyone understands that they won't be able to rely on the data unless everyone plays a role to ensure documentation and coding integrity.

5. **Let data guide your decisions.** Data—not assumptions—should drive both retrospective and pre-bill audits. Data-driven decisions can help maximize efficiency and return on investment during a time when resources are limited.

FACT:

Payers will use an organization's own data to deny claims—and to set policy and future payment rates. Organizations must ensure their data accurately reflects the care provided.

Technology

1. **Focus on usability.** Denials applications must compliment current daily operation processes and not add extra steps to staff. Remember: Denials translate to rework and lost revenue.

2. **Provide sufficient user training.** Training end-users on denials is not always as straight forward as other types of system/application training. Users may have many questions as they use the technology to work a denial. Plan to provide initial and follow up trainings, as needed.

3. **Know how to vet denial management vendors.** Consider these questions when evaluating a denials partner:

- Does the vendor focus on retrospective denials, concurrent denials, or both?
- Does the vendor have a prevention strategy in place that can be deployed to slow/stop the flow of current denials coming into the organization?
- Does the vendor have the ability to handle pre-certifications/pre-authorizations as part of a denials program?
- Does the vendor offer education for staff in all areas of the organization?
- Does the vendor offer software/analytics that will enhance the organization's efforts and provide meaningful data without increasing operational burden?
- Does the vendor offer the ability to submit industry questions, billing questions, etc. for research and response?

Quick Reference Guide to Denials in an Era of COVID-19

Type of Denial	Tips to Avoid the Denial	Why Ciox: Solutions We Provide
1. Lack of positive COVID-19 test for COVID-19 admission	Obtain a copy of the test immediately upon admission for patients who say they tested positive elsewhere or repeat a COVID-19 test for all symptomatic patients on admission. Send all cases with a U07.1 code into a queue so a coding auditor can perform a pre-bill second level review to confirm that the positive test is present in the record prior to claim submission.	ACO/MSSP reviews Appeal letters Billing/payer research CDM reviews Concurrent medical necessity reviews Consulting services Denials education for all staff Fee schedules Payer defense audits Pre-authorizations Pre-bill audits Pre-certifications Revenue integrity Workflow redesign
2. Insufficient documentation to support outpatient office-based E/M codes using new 2021 guidelines	Perform pre-bill audits to ensure physician's documentation supports time-based billing or billing based on medical-decision making. Documentation should also clearly reflect a relevant and medically necessary history and exam.	CDI education Coder education Denials education Physician education Physician staff education Pre-bill audits
3. Lack of medical necessity	Organization teams must collaborate to address medical necessity. Medical necessity is a patient-centric problem, and the entire revenue cycle plays a role. Multiple departments (e.g., registration, coding, physicians) play key roles in reducing this item early in the patient care process.	Validate health coverage Validate demographic information Review LCDs and NCDs Complete, concise, documentation Patient engagement

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FACT:

Medicare payments for inpatient discharges of beneficiaries diagnosed with COVID-19 is on the OIG's Work Plan. How will your organization ensure proactive compliance?

Source: https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000515.asp

Quick Reference Guide to Denials in an Era of COVID-19

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Type of Denial	*Tips to Avoid the Denial*	*Why Ciox: Solutions We Provide*
4. Demographic-related denials	Move denial prevention upstream, and provide registration staff with tools and education to prevent these errors from occurring.	Duplicate account education Duplicate medical record education MPI cleanup Patient information education
5. Telehealth	Conduct pre-bill audits to ensure compliance with payer-specific telehealth policies.	Ancillary education CDI education Coder education Denials education Physician education Pre-bill audits Registration education
6. Lack of clinical validity for CCs, MCCs, and HCCs	Use pre-bill coding audits to ensure the presence of clinical indicators that support code assignment for all diagnoses.	CDI education CDI reviews (inpatient and outpatient) CDI staffing augmentation Clinically-targeted focus reviews Denials education
7. Incorrect ICD-10-CM codes for COVID-19 admission	Perform pre-bill audits to ensure compliance. Prior to April 1, 2020, organizations reported ICD-10-CM code B97.29. After April 1, 2020, that code changed to ICD-10-CM code U07.1.	Coder education and training Coding quality reviews Denials education

FACT:

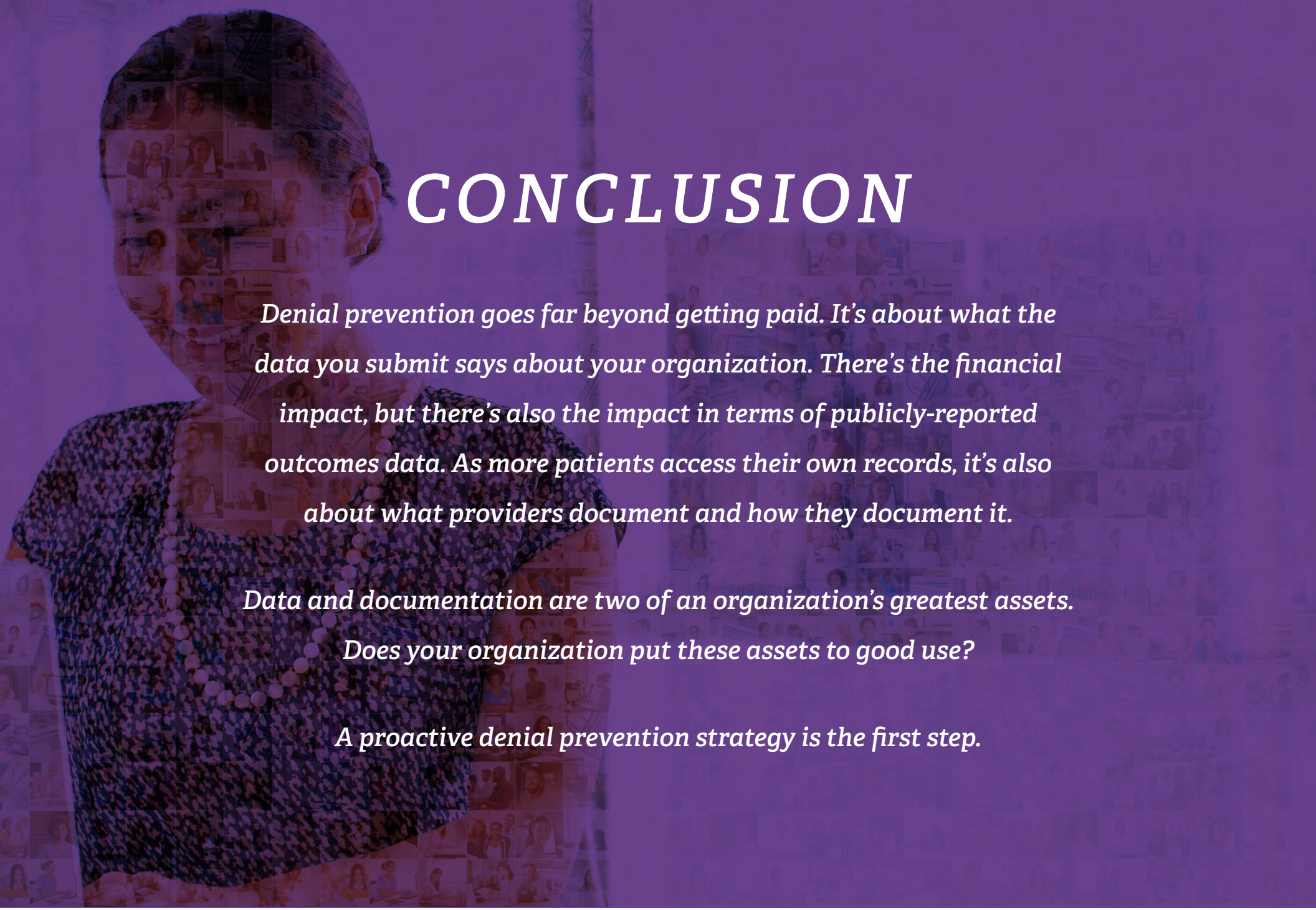
Medicare telehealth services during the COVID-19 pandemic are on the OIG's Work List. How will your organization ensure proactive compliance?

Source: https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000491.asp

FACT:

More than half of the inpatient stays billed at the highest severity level in FY 2019 (54 percent) reached that level because of just one diagnosis. Was that diagnosis justified? The OIG is asking this question, and so should your organization.

Source: https://oig.hhs.gov/oei/reports/OEI-02-18-00380.pdf



CONCLUSION

Denial prevention goes far beyond getting paid. It's about what the data you submit says about your organization. There's the financial impact, but there's also the impact in terms of publicly-reported outcomes data. As more patients access their own records, it's also about what providers document and how they document it.

Data and documentation are two of an organization's greatest assets. Does your organization put these assets to good use?

A proactive denial prevention strategy is the first step.

ABOUT CIOX HEALTH

For 40 years, Ciox has advanced the healthcare industry through better health information management and exchange of health information. Our broad reach in medical records extends across industries, allowing us to modernize workflows, facilitate access to clinical data, and improve the accuracy and flow of health information.

We help our clients manage, protect, and leverage health information to achieve operational improvements, optimized revenue, and better patient outcomes.

To learn more, please visit cioxhealth.com
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