CASE STUDY

How Baptist Health achieved a 0.65% denial write-off rate

Article by Revenue Cycle Advancement Center

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Overview

The challenge

Despite their best efforts, many hospitals have observed an increase in the amount of denials being written off as uncollectable. Industry data confirms this trend—Advisory Board's *2019 Hospital Revenue Cycle Benchmarking* indicated the median percentile denial write-off rate for hospitals is 1.4%, a 80% increase from 2011.

The organization

Baptist Health is a 8-owned-hospital health system in Louisvillle, KY with $2.9 billion in revenue. The not-for-profit system spans across two states.

The approach

Over the past two years, Baptist Health has significantly lowered their denial write-off rate. The system contributes their success to the combination of four cultural and technical tactics developed by their revenue cycle department.

The results

While the industry remains frustrated over denied claims, Baptist Health's 2019 denial write-off rate was 0.65%, the lowest rate in the organization's history.

0.65%

Baptist Health's denial write-off rate

1. Electronic Health Record

Source: Revenue Cycle Advancement Center interviews and analysis.

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Approach

How Baptist Health achieved a 0.65% denial write-off rate

Baptist Health's denial write-off rate ranks well above the 95th percentile in Advisory Board's 2019 denial benchmarking. The remainder of this publication details their approach to mitigating denials across the organization.

The four initiatives to lower denial write-offs

01 Bringing clinical stakeholders into denials mitigation.

02 Designing custom authorization EHR[1] work queues.

03 Implementing pre-service review for clinically complex services.

04 Establishing appeal escalation tiers.

1. Electronic Health Record

Source: Revenue Cycle Advancement Center interviews and analysis.

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01 Bringing clinical stakeholders into denials mitigation.

While some systems focus on engaging revenue cycle staff in denials mitigation efforts, Baptist Health takes the effort one step further: building denials mitigation collaboration across revenue cycle *and* clinical stakeholders. In the last two years, Baptist has built a culture of denials collaboration across revenue cycle, case management, service lines, and managed care.

United they stand

All stakeholders work towards a denials-free future

Monthly meetings between revenue cycle and case management

Revenue integrity identifies opportunities for clinician training

Weekly meetings between the Director of Revenue Integrity and managed care

Baptist Health staff share a common goal: a **denials-free future**. This ambitious vision unites clinical and financial stakeholders, prompting each group to acknowledge their shared responsibility in denials mitigation.

To encourage collaboration, Baptist has implemented three channels of partnership. First, revenue cycle and case management meet monthly to discuss specific inpatient denials and brainstorm workflow changes to avoid future mistakes. Second, Baptist's revenue integrity program works closely with service line leaders to identify clinician training opportunities. Finally, Baptist's revenue integrity program meets weekly with managed care to identify contract non-compliance issues.

Source: Revenue Cycle Advancement Center interviews and analysis.

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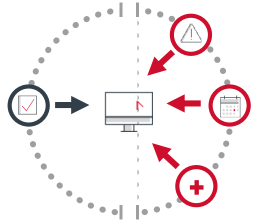
FOUR INITIATIVES TO LOWER DENIALS WRITE-OFFS

02 Designing custom EHR work queues.

Baptist Health designed several authorization check points through a series of custom EHR work queues. Completed either by the system's centralized financial clearance center or the revenue integrity department, these work queues ensure prior authorization is supported both pre- and mid-care.

Baptist Health's authorization check points



Pre-care check point

- Known order work queue

Mid-care check point

- Work queue for service changes
- Surgery and cath lab schedule review
- Add-on work queue

Upon scheduling, Baptist Health's EHR automatically creates a "known order" work queue for services requiring prior authorization. The system's clearance center secures authorization for these accounts, prioritizing the work by date of scheduled service and by payer. Notably, several high-dollar services do not follow this workflow, instead undergoing "pre-service review" as described on the next page.

Regardless, to address authorization issues that occur mid-care, Baptist designed three check points. First, the clearance center manages a work queue for service changes, which flags when services are changed after scheduling and require payer follow-up. For example, this work queue would flag if a radiologist determines that a different type of scan is needed from the one initially scheduled. Second, the revenue integrity team reviews the next day's surgery and cath lab schedule to compare the procedure codes to the corresponding authorization. Finally, the clearance center manages a retrospective work queue for any add-on procedures that took place without authorization. If needed, the center contacts the payer to secure authorization within the same day the service took place.

Source: Revenue Cycle Advancement Center interviews and analysis.

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03 Implementing pre-service review.

The third initiative in Baptist's denials mitigation strategy is their pre-service review. While most scheduled services receive financial clearance through the workflow described on the previous page, clinically complex high-dollar services are sent to the revenue integrity team after scheduling for prioritized attention from staff with a clinical background.

Baptist Health currently requires scheduled high-dollar cardiac services and outpatient infusion services to undergo pre-service review.

Which services qualify for pre-service review?

High-dollar cardiac services (such as pacemakers or invasive cardiac procedures)

Outpatient infusion services

When a scheduled service qualifies for pre-service review, the account bypasses the financial clearance center and is instead assigned to a clinical nurse or field specialist in the revenue integrity department. First, the staff member secures the appropriate prior authorization. Second, they examine the associated documentation to ensure the information proves the service is medically necessary. If the clinical documentation does not meet medical necessity, the revenue integrity department requests further documentation from the physician. Once the nurse or specialist finishes their two-step review, the account is cleared for service.

Source: Revenue Cycle Advancement Center interviews and analysis.

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APPROACH – INITIATIVE 3

Baptist Health's pre-service review

Patient scheduled

Non-qualified service

Prior authorization obtained by centralized financial clearance center

Service qualifies for **pre-service review**

Account sent to revenue integrity department

Clinical nurse or field specialist reviews the scheduled service

Two aspects of review

- Obtain prior authorization
- Examine accompanying documentation for medical necessity of scheduled service

If no issue, account cleared for service

If documentation does not support medical necessity, further documentation requested from physician

Source: Revenue Cycle Advancement Center interviews and analysis.

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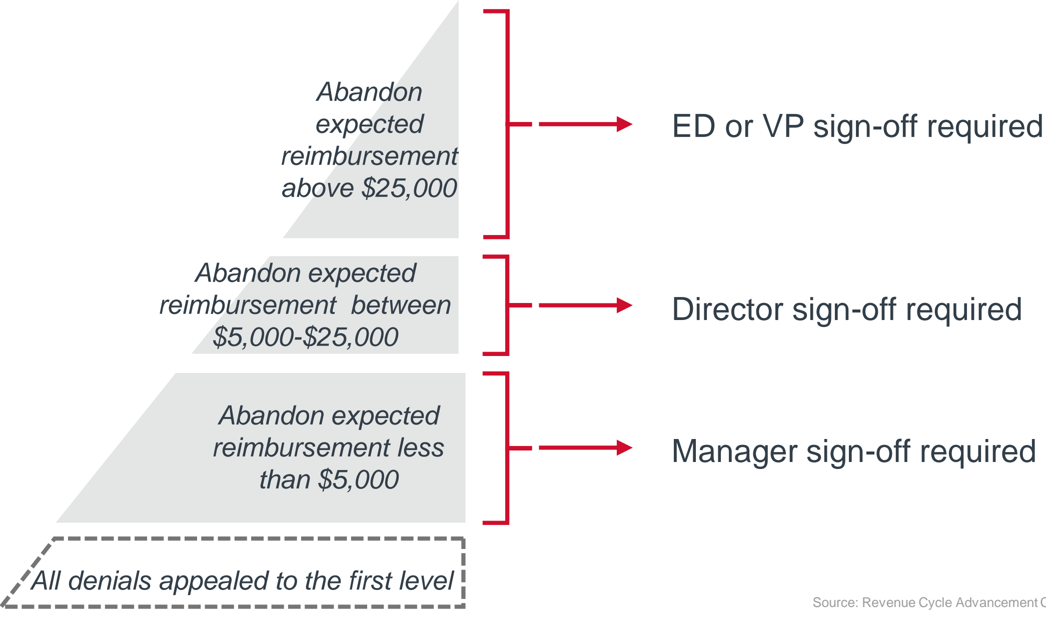
04 Establishing appeal escalation tiers.

The final initiative in Baptist's denials mitigation strategy establishes appeal escalation tiers. These tiers implement a uniform appeal strategy across all denials, discouraging employees from prematurely writing off denials that could be overturned with leadership involvement or a change in appeal strategy.

Appeal escalation tiers

Baptist appeals all denials to the first level. If the appeal is not overturned after the first pass and the staff believe the appeal should not be reworked and sent again, the decision must receive leadership sign-off.

If the expected reimbursement value is $5,000 or less, any decision to not appeal past the initial attempt requires manager sign-off. Any expected reimbursement valued between $5,000-$25,000 requires director sign-off. Anything above $25,000 requires approval at the Executive Director of VP level.



Source: Revenue Cycle Advancement Center interviews and analysis.

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Results

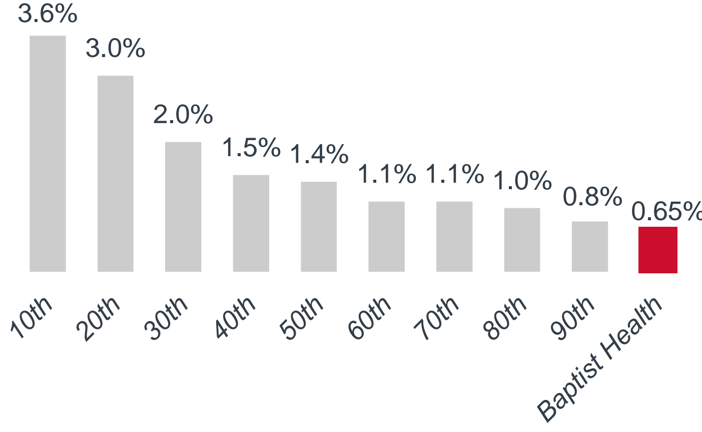
Recording-breaking lows in denial write-offs

Since implementing these four initiatives, Baptist Health has seen a significant decrease in their denial write-off rate. Today, the organization reports a denial write-off rate of 0.65%, ranking them well above their peer organizations.

0.65%

Baptist Health's denial write-off rate

2019 denial write-offs percentile breakdown
Percentage of net patient revenue
n=90



As clinical denials continue to challenge hospitals and health systems, a successfully denials mitigation strategy is critical for margin performance. Baptist Health's initiatives serve as a notable profile in excellence, suggesting most organizations can learn from their efforts.

Source: 2019 Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center interviews and analysis.

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The Hospital Revenue Cycle Benchmark Generator

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