Advisory Board | Revenue Cycle Advancement Center

The State of Denials

The most important trends impacting denials strategy today

Executive summary

Denials, and denials write-offs are up for providers nationwide, from both commercial and public payers and for many different types of procedures. While tactics for mitigating denials are well-known, certain forces, including changing patient demographics, evolving payer standards, and increasing compliance risk require an updated approach.

Keep reading to get an overview of key denials trends and denials performance data from the Revenue Cycle Advancement Center.

Common complaint heard round the country

Denials top-of-mind issue for providers

"There's a big increase in overall denials"

"It's like playing whack-a-mole"

"[The payer] takes the most stringent government policies, overlays their own criteria, and then adds more criteria to have more reasons to deny the claim"

"We're undoubtedly seeing a huge uptick in denials, and they're getting harder to overturn"

"It's time, it's energy, it's effort. It's relentless"

"I've needed a way tougher approach to appeals"

"Just when you thought you have it all figured out, things change"

Source: Revenue Cycle Advancement Center interviews and analysis.

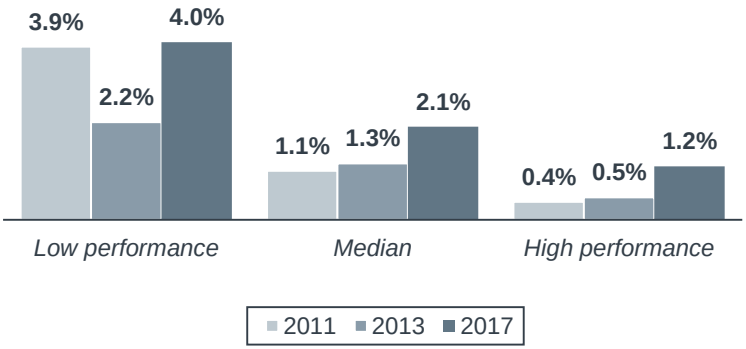
Data supports our pain: denials on the uptick

A slippage in performance, or something else?

Denial write-offs[1,2]

Percentage of net patient revenue

n=72 (2011); n=33 (2013); n=56 (2017)



Significant increase in write-offs for the median 350 bed hospital[3]

$3.9M	Dollars written off in 2011 (1.1% NPR)
$7.4M	Dollars written off in 2017 (2.1% NPR)
90%	Increase in write-offs from 2011 to 2017

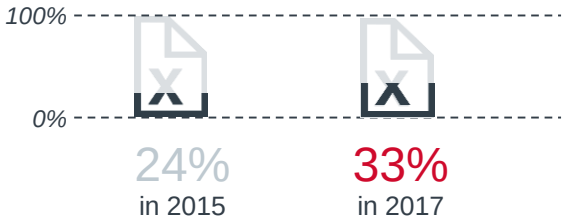
1) Survey data only.
2) Low, median, and high performance categories correspond to 75th, 50th, and 25th percentiles.
3) Assumes 350-bed hospital with $350 million in revenue and median performance in 2011 and in 2017.

Source: 2011-2017 Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center interviews and analysis.

Medicare no longer the “safe” harbor

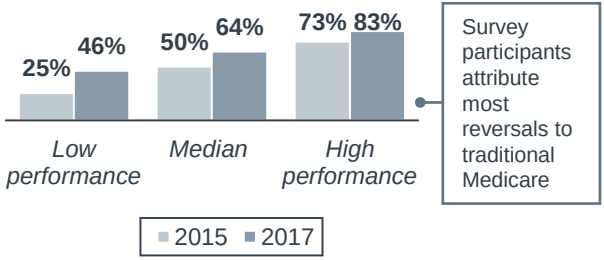
Medicare (and MA) increasing scrutiny on claims

Initial denials, by payer (Medicare/MA)



Appeal success for Medicare/MA denials[1]

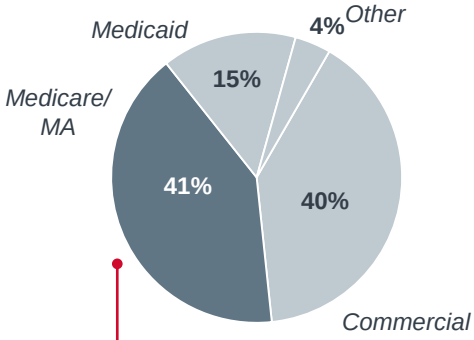
2017



Survey participants attribute most reversals to traditional Medicare

Denial write-offs, by payer

2017



Survey respondent follow up indicates M.A. denials a significant challenge

1) Low, median, and high performance categories correspond to 25th, 50th, and 75th percentiles.

Source: 2015-2017 Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center interviews and analysis.

Denying themselves into a corner

OIG investigates inappropriate denials of MA services and payment

Announcement of OIG work plan

Inappropriate Denial of Services and Payment in Medicare Advantage

Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services in an attempt to increase profits for managed care plans. We will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, we will determine the reasons for any inappropriate denials and the types of services involved.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
June 2018	Centers for Medicare & Medicaid Services	Inappropriate Denial of Services and Payment in Medicare Advantage	Office of Evaluation and Inspections	OEI-09-18-00260	2020

CMS has admitted inefficiency in the past

2016 hospital appeals settlement

612
Hospitals agreed to back-pay at discounted rate for outstanding claims

72,000
Total number of claims settled

2014 hospital appeals settlement

2,022
Hospitals agreed to back-pay at discounted rate for outstanding claims

346,000
Total number of claims settled

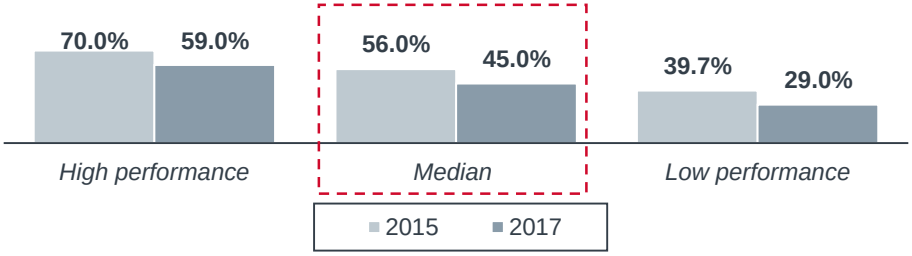
Source: CMS; Revenue Cycle Advancement Center interviews and analysis.

Commercial denials still demanding attention

Performance slipping on commercial and Medicaid appeals success

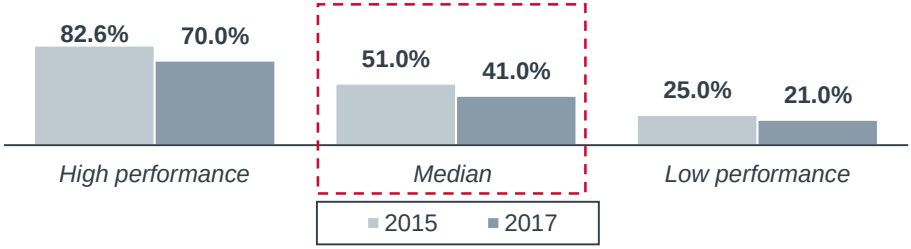
Commercial payer denials: appeal success rates

n=63 (2017)



Medicaid denials: appeal success rates

n=53 (2017)



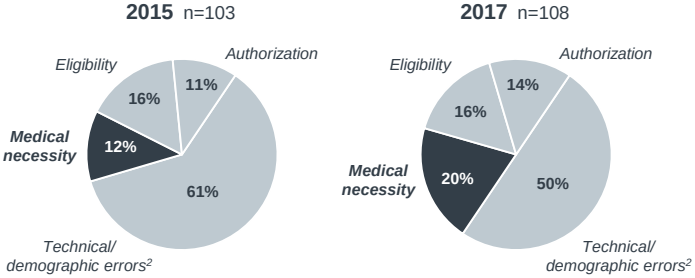
Source: Revenue Cycle Advancement Center interviews and analysis.

A growing concern: medical necessity

Eligibility and authorization denials not going away either

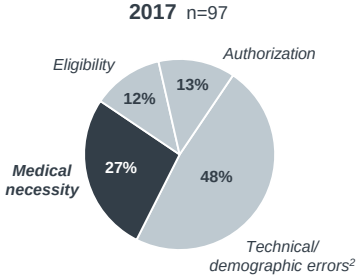
Medical necessity denials increasing…

Initial denials, by reason[1]



…And contribute significantly to write-offs

Denial write-offs, by reason[1]



Key Takeaways

1. Medical necessity denials are not being overturned
2. Eligibility and authorization denials remain constant, and have not been able to be driven down

Overheard during research

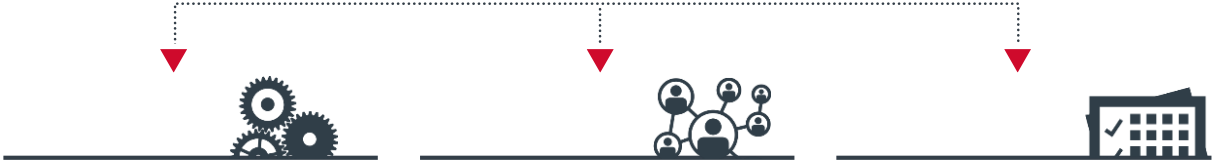
"The problem isn't only that medical necessity denials are increasing, but that there are just **more denials overall—the pie is getting bigger.**"

Source: Source: Revenue Cycle Advancement Center interviews and analysis.

Members reporting increased payer scrutiny

Why it feels like denials are coming through thick and fast

Three primary tools employed by payers



1 Overwhelming volume of automated reviews

Algorithms can pull out potential DRG downgrades, medical necessity issues, and quickly deny a higher volume of claims.

2 Increasingly complicated criteria

Members report payers using more complex criteria for claim submission and medical necessity requirements, often layering payer-specific requirements over CMS' suggested criteria.

3 Unique contract requirements

Each payer contract demands different things from providers, from medical necessity criteria to technical requirements. Contracts can differ in small but meaningful ways, making it difficult for providers to consistently comply.

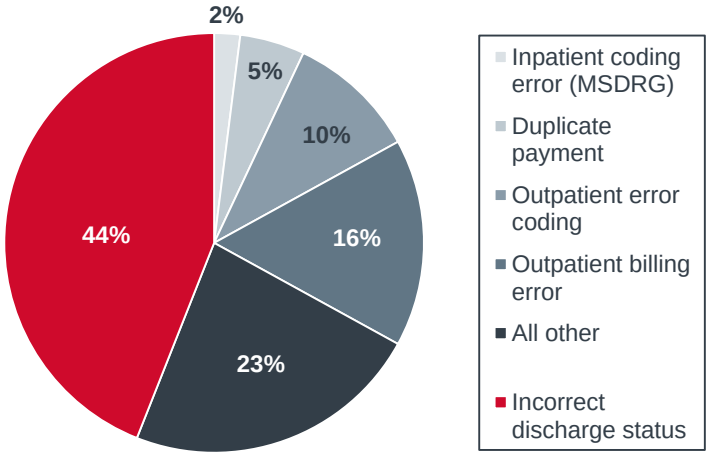
Source: Revenue Cycle Advancement Center interviews and analysis.

Technology-enabled payers can deny claims easily

Automated reviews place the burden on providers

Reasons for automated denials

Percent of participating hospitals by top reason[1] for automated denials by dollar amount for medical/surgical acute hospitals with RAC activity, 3rd/4th quarter 2016



Low dollar value, but strong appeal success rate makes RAC denials worth fighting

$721
Average dollar value of automated denials, 2016[2]

45%
RAC denials appealed by providers, 2016

62%
Claims that complete the appeals process are overturned in favor of the provider, 2016

1) Survey participants ranked denials by reason, according to dollar impact.
2) Average dollar value of complex denial is $5,574.

Source: American Hospital Association, "AHA RAC Trac Initiative", https://www.aha.org/2017-12-11-recovery-audit-contractor-rac-program-ractrac-initiative, 2016; Revenue Cycle Advancement Center interviews and analysis.

Providers must keep tabs on lists of lists

Payers leverage proprietary criteria, research, and policy bulletins

Aetna's criteria for coverage determination

Criteria used includes:

- Criteria used includes:
- Aetna Clinical Policy Bulletins (CPBs)
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual
- MCG™ guidelines
- American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition
- Level of Care Assessment Tool (LOCAT)
- Applied Behavior Analysis (ABA) Guidelines for the Treatment of Autism Spectrum Disorders
- State requirements, where applicable

1) As defined on Aetna's website, "coverage" includes "either the determination of (i) whether or not the particular service or treatment is a covered benefit pursuant to the terms of the particular member's benefits plan, or (ii) where a provider is contractually required to comply with Aetna's utilization management programs, whether or not the particular service or treatment is payable under the terms of the provider agreement."

Source: Aetna, available at: https://www.aetna.com/health-care-professionals/utilization-management.html; Revenue Cycle Advancement Center interviews and analysis.

Providers must juggle multiple criteria lists

Comparing medical necessity criteria by payer

Example of medical necessity criteria, by payer

Sample of criteria for total shoulder replacement (arthroplasty/arthrodesis), as of 7/13/18

Payer	Surgery Criteria
Aetna	*Discrete care guidelines listed[1]:* "Member has advanced joint disease […]; treatment of proximal humeral fracture, malunion, or nonunion…"
United Healthcare	*Published third-party care guidelines:* MCG™ Care Guidelines, 22nd edition, 2018: Shoulder Arthroplasty, S-634 (ISC). Shoulder Hemiarthroplasty, S-633 (ISC)
Anthem Blue Cross	*Customized third-party guidelines:* MCG™ Care Guidelines, 22nd edition, 2018: Shoulder Arthroplasty, S-634 (ISC) "For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program…"
BlueCross BlueShield of Texas	*No universal criteria:* "Carefully check state regulations and/or the member contract"

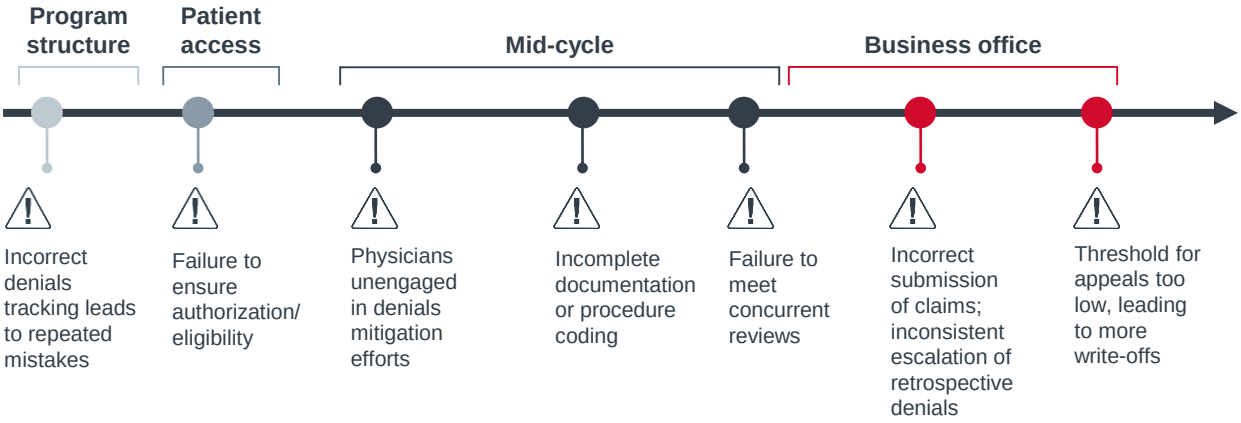
Source: Aetna, "SHOULDER ARTHROPLASTY AND ARTHRODESIS," http://www.aetna.com/cpb/medical/data/800_899/0837.html, accessed: July 13, 2018; United Healthcare, "SHOULDER REPLACEMENT SURGERY (ARTHROPLASTY)," https://www.uhcprovider.com/content/provider/en/viewer.html?file=%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fcomm-medical-drug%2Fshoulder-replacement-surgery-arthroplasty.pdf, accessed July 13, 2018; Anthem BlueCross, "CUSTOMIZATION TO MCG CARE GUIDELINES 22ND EDITION," https://www11.anthem.com/ca/provider/f1/s0/t0/pw_g337957.pdf?refer=culdesac&name=onlinepolicies, accessed July 13, 2018; BlueCross BlueShield of Texas, "SHOULDER RESURFACING," http://www.medicalpolicy.hcsc.net/medicalpolicy/activePolicyPage?lid=jbaq8n9g&corpEntCd=TX1, accessed July 13, 2018; Revenue Cycle Advancement Center interviews and analysis.

1) Aetna also reports using third-party guidelines. including MCG™ care guidelines, but did not specify their inclusion for this procedure.

Recipe for denials

Multiple vulnerabilities throughout a claim's lifespan

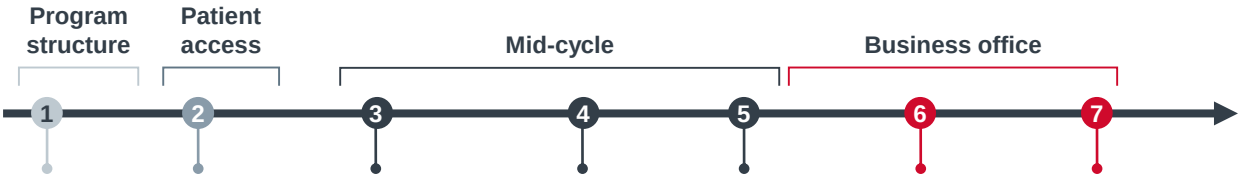
Revenue cycle pain points leading to denials



Source: Revenue Cycle Advancement Center interviews and analysis.

Mitigation strategies meet denials where they start

Finding windows of opportunity throughout revenue cycle



Define denials by their root-cause

- Standardize definitions
- Track root-cause of denials

Mitigate denials in the front-end

- Assess front-end denials source
- Assign authorization responsibilities
- Partner with case management

Bridge the gap between the clinical and financial worlds with Physician Advisors

- Define roles and responsibilities of Physician Advisor
- Select Physician Advising program model

Continue pushing towards best-practice CDI

- Redefine the importance of CDI
- Utilize Physician Advisor in CDI efforts

Meet concurrent review challenge

- Alleviate burden of peer-to-peer requests
- Restructure concurrent review process through payer contracting

Standardize denials escalation process for each appeal type

- Specialize denials staff
- Organize denials around appeal approach
- Craft impactful clinical appeal letters

Appeal everything, when you know you're right

- Set thresholds if appropriate

\+ **Payer contracting** 8

Hardwire solutions into payer contracts

- Review utilization review standards
- Find common pain points to negotiate

Source: Revenue Cycle Advancement Center interviews and analysis.

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