*HFMA*

*Northern California Spring Conference*

*March 25, 2010*

# BEST PRACTICES IN DENIAL MANAGEMENT

**Triage**. *Beyond Your Expectations*

# Agenda

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**Presenters:**

**Principal:**
Shawn Tienken

**Manager:**
Chris Clayton

Introduction & Overview

Defining Denials

Understanding Your Denials

Denial Prevention

Denial Resolution

Conclusion & Questions

# Denials Are Headline News

***HMO claims-rejection rates trigger state investigation***

*- L.A. Times*

September 4, 2009

- California health insurers reject 1 in 5 medical claims
- Six of the State's largest insurers rejected $45.7 million in claims for medical care between 2002 and June 2009
- Reported rejection rates:*
  - 40% PacifiCare
  - 33% CIGNA
  - 30% Health Net
  - 28% Anthem Blue Cross
  - 28% Kaiser
  - 7% Aetna

**Data is from the first half of 2009 and does not include Blue Shield of CA, which does not report claims-denial figures in their annual report to the DMHC*

# Denials Statistics

**Active Denials**

- Based on hospitals surveyed by Triage, managed care claims in a "denied state" range between 10-20% of open A/R
- At any given time, a hospital with $50 million monthly managed care net revenue will have $5-10 million in an open state of denial

**Overturn (Paid) Ratio**

- Hospitals reported 55-98% of denied claims are overturned and ultimately paid correctly

**Data Analysis**

- No smoking gun
- Situation at each hospital is unique - it depends highly on the individual revenue cycle processes and systems, clinical service offerings, payer mix and contract structure

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# Denials as Payment Discrepancies

## Denial

- A refusal to pay as a result of the provider not adhering to insurance company policies/procedures, or pending receipt of additional information

## Underpayment

- Incorrect payment resulting from pricing inaccuracies or differences in contract interpretation

## "Lost" Revenue

- Undetected Underpayments
- Incorrect payment due to incomplete or inaccurate billing.
- Charges or codes are missing from the bill and are thus never considered for payment

# Types of Denials

| Hard Denials (Appeal Required) | |
|---|---|
| | • Denied claim for elective service without pre-authorization<br>• Denied days, service, or level of care for no concurrent authorization<br>• Denied as not financially responsible<br>• Denied as not a covered service<br>• Denied charge/procedure as bundled<br>• Denied for untimely submission |

| Soft Denials (Additional Information Required) | |
|---|---|
| | • Denied ER claim pending receipt of medical records<br>• Denied claim due to missing/inaccurate information<br>• Denied claim due to charge/coding issues<br>• Denied charges pending receipt of itemized bill<br>• Denied drug/implant reimbursement pending receipt of invoice<br>• Denied secondary payment pending receipt of primary EOB |

# Tracking and Trending Denials

**Options**

- Automatically through ERAs
- Automatically or manually through hard copy EOBs

**Translating & Grouping (HIPAA 835 Codes)**

- Claim Adjustment Reason Codes
- Remittance Advice Response Codes

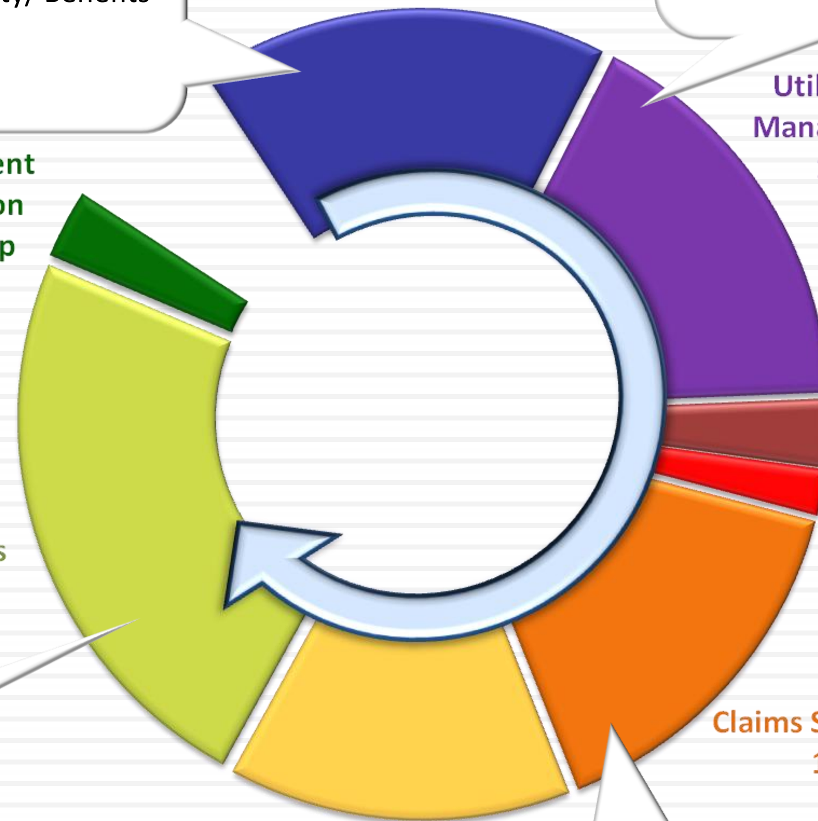
**Trending & Reporting**

- Identify key problem areas by payer and reason
- Track overturn ratios for cost-benefit assessment, potential false variances, and unreasonable payer practices

# Understanding Your Denials

**Patient Registration Issues**
- Incorrect Plan/ID
- No Verification of Eligibility/ Benefits
- No Pre-authorization
- No Notification

**UM Issues**
- Insufficient Authorization:
  - Length of Stay
  - Level of Care
  - Service



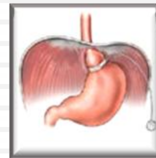

**Initial Claims Follow-Up Issues**
- Requested (Reasonably Necessary) Documents Not Submitted

**Claims Submission Issues**
- Insufficient Bill Edits
- Claim Sent to Wrong Address/ Unit
- Claim Not Submitted Timely

# Registration & UM - Process

## Registration

- **Accurate Mapping**
  - PPO Networks
  - Workers’ Comp
  - Sub-cap’d Services
  - Out-of-State
- **Patient ID Numbers**
  - Alpha Prefixes
- **COB Information**
- **Notifications**



## Authorization

- **Responsibility**
  - Plan v. Med Group
- **Services**
  - PPO Members
  - Emergency
  - Post-Stabilization
  - High-cost Elective
- **Documentation**
- **Concurrent & Retro-Auth**

## Other

- **Verifying Eligibility & Benefits**
  - State Law
- **Software Solutions**

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# Registration & UM – Managed Care

- **Claim Filing Limits (180 – 365 Days)**
- **Retrospective Authorization Processes**
- **Protection against unreasonable timely filing or no pre-authorization denials**

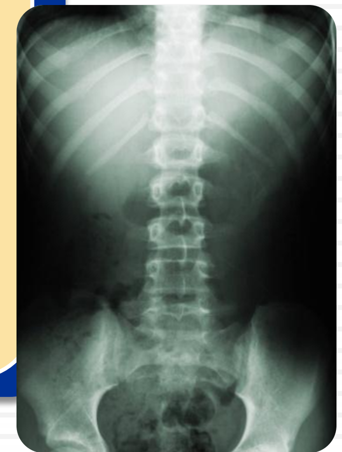
## Best Practice Contract Language

*In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility appeals and can show all of the following:*

*i.) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that patient was a Member,*

*ii.) that Facility took reasonable steps to learn that patient was a Member, and*

*iii.) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Member.*



# Claim Submission - Process

## Payer- Specific Bill Edits

- Software Solutions
- Manual Processes
- DOFRs

## Time Limits

- Initial Claim Submission
- Corrected Claim Submission
- COB Submission

## Special Billing Requirements

- Separate Stop Loss Submission Requirements
- Hard Copy v. Electronic Billing
- Attachments

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# Claim Submission – Managed Care

- Claim Filing Limits (180 – 365 Days)
- Obtain DOFRs
- State Law / Forwarding Requirements

## State Law [*CCR 1300.71(b)2*]

***Claim Billed to Plan, Responsibility of Capitated Provider:***

*   *ER:  Plan must forward to capitated provider*

*   *Non-ER – Hospital contracted with capitated provider:  Plan must forward or deny claim (with details)*

*   *Non-ER – Hospital <u>not</u> contracted with capitated provider:  Plan must forward claim*

***Claim Billed to Capitated Provider, Responsibility of Plan:***

*   *All services:  Capitated provider must forward to plan*

# Initial Claims Follow-Up – Requested Docs

## Process

- Consider bill edits to hold claim until documentation is attached

## Managed Care

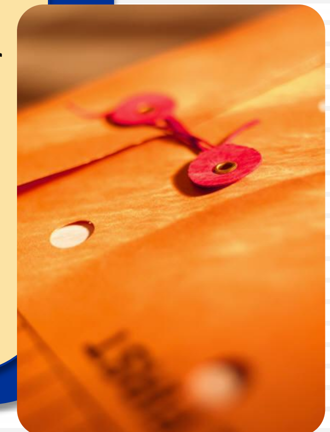
- Attempt to avoid provisions requiring 'additional information' to process claim for payment
- Use AB1455 definition of 'complete claim'

***Reasonably Relevant Information***

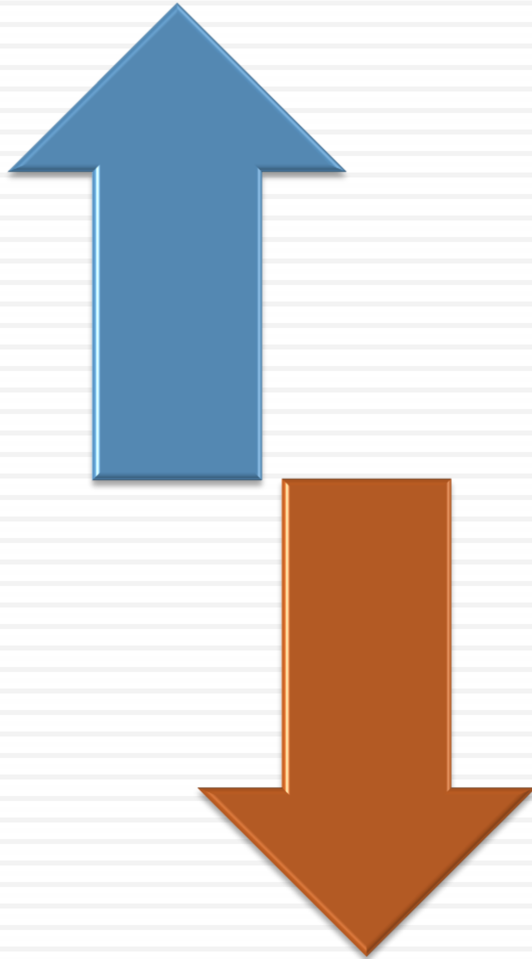
"… the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services…"

***Information Necessary to Determine Payer Liability***

"… the minimum amount of material information in the possession of third parties related to a provider's billed services …"



# Other Best Practices: Software Solutions



## Lots of Options

- Eligibility Systems
- Case Management Systems
- Order Entry Systems
- Claims Management Systems (Comprehensive Scrubber/Editor)
- Charge Capture Systems
- Contract Management Systems
- Patient Accounting / Host Systems
- Soft/Hard Remittance Posting Systems
- Denial Management Systems

## Implementation Drawbacks

- Cost
- Resources to integrate

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# Other Best Practices

## Multi-Disciplinary Teams

- All Revenue Cycle stakeholders involved
- Regularly-scheduled meetings
- Reporting on agreed-upon KPIs

## Training & Education

- Cross-train coders and billers
- In-service & external training
- IT training
- Reference materials/ resources

## Information Sharing

- Contracts accessible on shared drives/ intranet
- Shared underpayment/ denial trend reporting
- Shared network resources/ reference materials
- Share issues with payers

# Case Studies in Effective Negotiation

"The name of the game is this: Be as sweetly unreasonable as possible in a convincingly logical fashion without permitting your opponent to decide that it is impossible to deal with you!"

**Bruce D. Henderson**
"Brinkmanship in Business"
*Harvard Business Review*
March–April 1967

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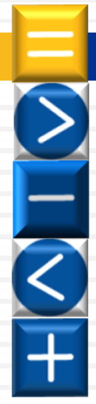
# Negotiation Tools



**Audience Effect**

- People behave differently when scrutinized
- Audience's relation to the party may influence outcomes

**Framing**

- "Frames are perceptions that the parties hold about what defines the conflict, who is involved, how issues are presented, what the expected outcomes might be, and how outcomes will be reached."

**Consistency Principle**

- "Social psychologists have discovered that people have a deep need to avoid the disjointed, erratic and uncomfortable psychological states that arise when our actions are manifestly inconsistent with widely shared standards and beliefs."

**Naïve Realism**

- I see the world correctly, as will other reasonable people, given enough info.
- Confirmation Bias
- Assimilation Bias

Audience Effect

Framing

Naïve Realism

Consistency Principle

Success!

**Desired Result**

# Case Study #1

## The Case of "Inpatient Ambulatory Surgery"

**OUTPATIENT RATES:**

| Service | Billing Codes | Rates |
|---|---|---|
| **Ambulatory Surgery:** Default Rate | All surgical procedures not otherwise identified | [redacted] |

d) Multiple Procedure Processing:

Ambulatory Surgery-Default: The primary surgical procedure will be identified as the highest applicable category. The primary procedure will be reimbursed at [redacted]% of the contracted rate. The secondary procedure will be reimbursed at [redacted]% of the contracted rate. Subsequent procedures will be reimbursed at [redacted]% of the contracted rate.

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# Opposing Viewpoints

## Their View of the World

"Our Director of Contracting says that the correct interpretation of the Multiple Procedures clause is that it applies only to Inpatient Surgery."

-Payor counsel

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# Opposing Viewpoints

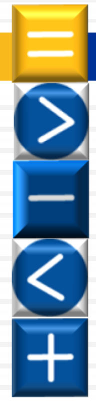
## Our View of the World

1) First, a textbook definition:

> **APG**—Ambulatory patient group. A reimbursement methodology developed by 3M Health Information Systems for the HCFA.
>
> APGs are to outpatient procedures what DRGs are to inpatient days. APGs provide for a fixed reimbursement to an institution for outpatient procedures or visits and incorporate data regarding the reason for the visit and patient data.

*The Managed Health Care Handbook*, 2nd Ed., by Peter Kongstvedt, MD, FACP (1993), p. 500 (**APGs provide for…outpatient procedures or visits.**")

# Opposing Viewpoints



## Our View of the World

2) From the Ambulatory Surgery Center Association:

**Q. What are Ambulatory Surgery Centers'**

A. ***Ambulatory Surgery Centers (ASCs) are facilities where surgeries that do not require hospital admission are performed***. They provide a cost-effective and convenient environment that may be less stressful than what many hospitals offer.

***Patients who elect to have surgery in an ASC arrive on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff, all without a hospital admission***.

http://ascassociation.org/faqs/faqaboutascs (emphasis added).

# Opposing Viewpoints

## Our View of the World

3) From *The Federal Register*:

> "**Ambulatory surgical center** or ASC would mean any distinct entity that operates exclusively for the purpose of providing **surgical services to patients not requiring an overnight stay following the surgical services**…"

Vol. 72 *Federal Register* 169; at p. 50471 (emphasis added).

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# Opposing Viewpoints

4) The text of the Code of Federal Regulations:

42 CFR Ch. IV (10–1–01 Edition)

PART 416—AMBULATORY SURGICAL SERVICES

Subpart A—General Provisions and Definitions

Sec.
416.1 Basis and scope.
416.2 Definitions.

**§ 416.2 Definitions.**

As used in this part:

*Ambulatory surgical center* or *ASC* means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part.

42 C.F.R. §416 ("Ambulatory Surgical Services…means…providing ***surgical services to patients not requiring hospitalization***.")

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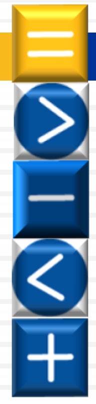
# Opposing Viewpoints



5) Next, this from the Joint Commission:

"**Eligibility for Ambulatory Care Accreditation**

In order for an organization to be accredited under our Ambulatory program, the following requirements determine eligibility. Any health care organization may request Joint Commission accreditation if the following eligibility requirements are met:

1. The Joint Commission has applicable standards for services provided by the organization;
2. The organization is freestanding – not hospital owned or operated; note, hospital-operated ambulatory centers can voluntarily choose Ambulatory Health Care Accreditation program as alternative to Hospital Accreditation covering ambulatory services.
3. ***Care is not provided on an inpatient basis – the length of care does not exceed 24 hours*** …"

http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/HTBA/ac_eligibility.htm (e.a).

# Using Negotiation Tools

**New Information:**

- Past Payment Practice
- If IP, then $4M underpayment risk

**New Frame:**

- Adopt Payer's point of view,
- Apply the "Consistency Principle"

# Consistency Principle, Part One

**1) [redacted]s Perfectly Consistent Prior Payments Prove the Correct Interpretation of the Multiple Procedures Ambulatory Surgery Clause:**

A review of claims between January 2006 and September 2007 shows:

- [redacted] paid _55_ separate multiple procedure claims using ***the correct, outpatient interpretation*** of the Multiple Procedures Clause in the Contract; Exhibit C.
- Conversely, [redacted] paid exactly ***-0-*** separate multiple procedure claims using [redacted]s newfound -- and demonstrably bad-faith -- ***inpatient*** interpretation of the Multiple Procedures Ambulatory Surgery Clause in the Contract.

[redacted] own actions create a course of dealing that is itself dispositive of any issue of interpretation; it proves that [redacted] agreed, on fifty-five separate occasions, that the correct interpretation of the Multiple Procedures Clause is for ***outpatient*** surgeries. If our analysis and conclusion on this point is incorrect, we welcome from [redacted] any additional or contrary information.

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# Consistency Principle, The Sequel

**2) [redacted] Elects to Stand on its "Ambulatory Inpatient" Interpretation, then [redacted] Owes [redacted] Hospital at Least $3,958,085.78:**

[redacted] disagrees with [redacted] extant "inpatient" interpretation of the Multiple Procedures Ambulatory Surgery Clause. But if [redacted] continues to assert that the subject text applies only to inpatient surgeries, then [redacted] must pay [redacted] consistent with that interpretation.

After [redacted] reiterated that its interpretation was indelibly correct, [redacted] reviewed all [redacted] claims between January 1, 2006 and September 30, 2007 and identified 99 inpatient claims with multiple surgical procedures which – per [redacted] interpretation – are underpaid by $3,958,085.78. If our analysis and conclusion on this point is incorrect, we welcome from [redacted] any additional or contrary information.

# Case #1, Re-framed

## Payer Counsel's Options:

Negotiate on absurd "ambulatory IP surgery" theory, knowing Hospital will escalate to carrier's corporate counsel

(personal risk)

Arbitrate on "ambulatory IP surgery" theory, knowing Hospital will claim $4M

(corporate risk)

Abandon "ambulatory IP surgery" theory, create new defense to defend pricing

(n/a, ethical risk)

Pay claim

(personally and corporately defensible)

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# Case Study #2

**The Case of**
**"The 'Non-Contracted' ERISA Plan and their Contractual Discount"**

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# Produce *Our* Confidential Contract, Or Else

*Certified Mail Return Receipt Requested & 1st Class Mail*

Attention:

Re: Water Ink Technologies, Inc. Employee Benefit Plan Restated May 2003
*Patient Name:*
Member ID:
Account Number:

Dear Mr. Dubyn:

We have received your correspondence dated August 25, 2008, regarding the above matter. In your letter, you refer to a contract between the network and You also state that CBSA/WIT has "accessed" that network. Please provide us with copies of any and all agreements that Water Ink Technologies, Inc. has signed or entered into that you contend give a right to payment upon terms other than as set forth in the Employee Benefit Plan referenced above.

I will look forward to your reply.

Very truly yours,

Stephen H. Morris

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# "You Lie"

Dear Mr. Johnson:

We represent Water Ink Technologies, Inc. ("WIT") and its above-referenced Employee Benefit Plan. We are writing to reply to your August 4, 2009 letter.

We understand that it is your contention that the WIT Plan "contracted" with [redacted] by "accessing" a provider contract between the hospital and the [redacted] Network. Despite numerous requests, we have never received a copy of this contract and do not believe that one exists. I also understand that it is your contention that your request for payment and any deadline for the claim to be made is governed by California law. We disagree.

Very truly yours,

Stephen H. Morris

# Add New Info & an Audience

October 23, 2009

Stephen H. Morris, Esq.
Essex Richards, P.A.
1701 South Boulevard
Charlotte, North Carolina 28203

Mr. Ken W. Harvey, CLU, ChFC
President, Corporate Benefit Services, Inc.
2127 Ayrsley Town Boulevard, Suite 200
Charlotte, North Carolina 28273

*via* Federal Express

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# Your Network & TPA Say You're Contracted

1) ███ ***Has Confirmed* that the Plan was a Participant in the ███ Network**:

For avoidance of doubt, however, we re-confirmed that the Water Ink Plan had in fact accessed the ███ network. On July 6, 2009, Mr. Jerry Robinson, a supervisor in the Customer Service department of ███,[2] verified that Water Ink had at all times material been a contracted participant in their network. Mr. Robinson then confirmed this fact in writing:

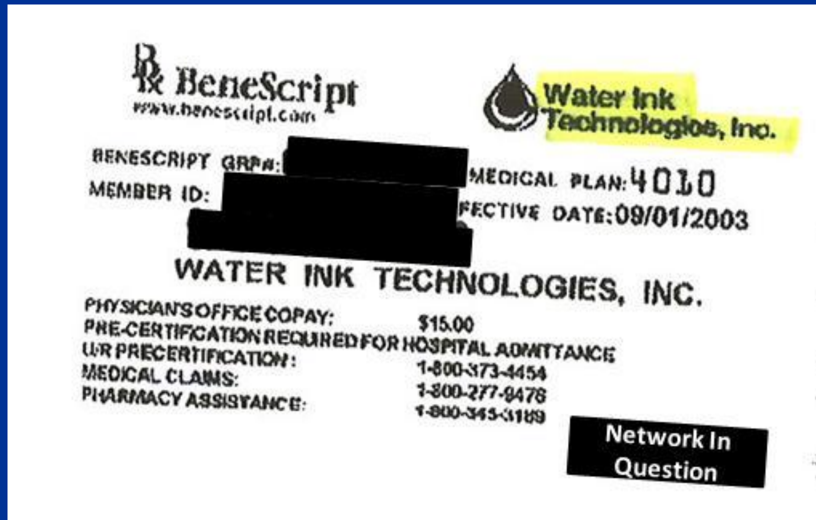
> *Water Ink Technologies, Inc with (Corporate Benefits Service Inc) was a participating client with the ███ network from 05/01/01-04/30/07.*

Memo, July 6, 2009, ███ Customer Service, Exhibit E.

2) ***CBSI Has Confirmed* that the Plan was a Participant in the ███ Network**:

On October 7, 2008, Ms. Tracy Fields of CBSI confirmed with our staff that the CBSI records documented that "***the*** ███ ***network was being accessed on this date of service***." (emphasis added). Exhibit E.[2]

# Your Name, the Network, and the TPA on the Card




**Verified Benefits & Authorized Care**

Your plan requires certification prior to ho… …tion for non-emergency admissions. If an emergency o… …go directly to the nearest hospital; certification must be mad… …thin 48 hours of emergency admission. You or a family … …mber must call 1-800-373-4454 for certification.

Please Mail Claims to:
Corporate Benefits Service, Inc.
P O Box 12953
Charlotte, NC 28220-2953

This card may be presented only at participating pharmacies for the purchase of drugs covered by your prescription drug program. This card is owned by BeneScript and is not transferable.

THE UNAUTHORIZED OR FRAUDULENT USE OF THIS CARD TO OBTAIN PRESCRIPTION DRUGS IS PUNISHABLE BY LAW.

# …And the Network Lawyer Says You Have the Contract

Unfortunately, due to confidentiality provisions in our payor contracts, we cannot forward copies of our payor contracts or other correlating documentation to third parties unless it is under subpoena/court order. As you know, however, Network provided WIT, the payor, with access to Network's national preferred provider (PPO) network (the "Network Network" formerly known as the [redacted] Network) via Network's contract with Corporate Benefit Services, Inc., (CBSI), the Third Party Administrator for WIT, at the time medical services were rendered by your client to the covered member. To that end, I have confirmed that CBSI has in its possession a copy of the Network Payor Base Agreement, dated December 16, 1996, as amended, between CBSI and Network (the "Network Agreement").

Please feel free to call me with any questions in this regard at (301) 581-5790.

Yours truly,

[redacted]

[redacted]
Corporate Counsel, Network, Inc.

cc: Stephen H. Morris, Esq., Essex Richards
Shannon Carney, Corporate Benefit Services, Inc.
Tammi Blount, Network National Account Service Representative

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# BTW, your Client has just been acquired

**ALTANA completes acquisition of Water Ink Technologies**

**Wesel, October 2, 2009.** The specialty chemicals group ALTANA AG has today concluded the purchase of the business of Water Ink Technologies, Inc. The

# Plan Counsel's Audience Now Includes:

| Audience | Notes |
| --- | --- |
| Altana AG | • Will be keenly interested in $0.5m liability, the Plan's bad-faith denial of this liability, and thus law firm's representations about all other pre-merger liabilities |
| TPA | • Surely excited about becoming a co-defendant in litigation alongside bad-faith denials |
| Network | • With bad-faith refusal to pay, now has far more interest in its network, itself, and the Hospital, than in your fate |
| CA Judge | • Applying CA Law per Contract<br>• Business & Prof Code §511.3<br>• Contract Awards Attorney's Fees |

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# Case #2, Re-framed

## Payer Counsel's Options:

**Negotiate from a "no-contract" theory, knowing that Hospital's next step is to escalate to Altana corporate counsel**

**(personal, professional and corporate risk)**

**Stand on "no contract" theory and defend, as a foreign corporate payer, a trial brought by a CA hospital, in a CA court, applying CA law, before a CA jury**

**("all-in")**

**Abandon "no contract" theory, assert your ERISA pre-emption argument, even though *Blue Cross v. Anesthesia Care* holds against you for contracted providers in the 9th Circuit**

**(corporate risk)**

**Pay claim**

**(defensible on these facts)**

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# Denial Resolution Takeaways

Recognize Naïve Realism, so you can

Reframe the Negotiation, with their lens and your New Information, so you can

Leverage the Consistency Principle, ideally before an Audience that helps

Limit any Options other than

Payment.

# Conclusion & Questions

## Contact Information:

**Triage *Consulting Group***

**221 Main Street**

**Suite 1100**

**San Francisco, CA 94105**

**415.512.9400**