Denial Management with Predictive Analytics and Preparing for ICD-10
Agenda

Commercial Claim Basics

ICD-10 Impact

Technology Needs for Disputed Claims

Questions?
Commercial Claim Revenue

Managing denials (and underpayments) critical, complex financial issue

- Highest margin revenue
- Significant portion typically questioned
  - Equal to overall profitability
- Constantly moving target
- Involves every plan and payor

![Metric 11 - Percentage of claim lines denied](chart.png)

Sources: AMA National Health Insurers Report Card; Connance

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# Denial and Underpayment Sources

Issues are created end-to-end in the business system

- Which means the solution will require end-to-end engagement

<table>
<thead>
<tr>
<th>Front</th>
<th>Middle</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max benefit hit</td>
<td>Additional clinical information required</td>
<td>Additional claim information required</td>
</tr>
<tr>
<td>Covered by another payor</td>
<td>Bundle</td>
<td>Duplicate claim</td>
</tr>
<tr>
<td>Member not eligible</td>
<td>Diagnosis / code mismatch</td>
<td>Incorrect contractual payment (short pay)</td>
</tr>
<tr>
<td>Member not found</td>
<td>Medically not necessary</td>
<td>Previously paid claim</td>
</tr>
<tr>
<td>Non-covered charges</td>
<td>Missing claim information</td>
<td></td>
</tr>
<tr>
<td>Precertification or Authorization required</td>
<td>Missing modifiers</td>
<td></td>
</tr>
<tr>
<td>Pre-existing condition</td>
<td>Non-covered service</td>
<td></td>
</tr>
<tr>
<td>Provider out of network</td>
<td>Wrong payor</td>
<td></td>
</tr>
<tr>
<td>Terminated coverage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Will ICD-10 be your Fiscal Cliff?
ICD-10 Potential Impact on Reimbursement

• Potential Denial Rate increase by 100% to 200% post-implementation
  – Incongruities between the two coding systems
  – Coding errors
  – Improper eligibility and authorizations
  – Insufficient documentation
  – Payers may be more inclined to assume miscoding

• Potentially cash flow will slow for 24+ months
  – Payers must be more diligent to validate appeals
  – Appeals become more complicated, requiring more clinical documentation

• Increase in AR Days by 20% to 40%
  – Payers delay in processing claims and appeals
  – Incorrect payments
  – Retroactive adjustments
  – Mapping issues at both payer and provider


Data as a Roadmap

Start with retrospective – know where we are and have been – and move to prospective – know how to optimize and where to go.

- Standardized data
- Standard reporting
- Trending/analysis
- Predictive analysis
- System optimization

- What has happened...
- What is changing...
- What would happen IF...
- What could be optimal...

Advantage

Data sophistication
Technology Need

Visibility – Reporting

• Aggregate denial data from multiple sources, which allows mapping hundreds of denial reasons into a smaller set of denial types for more efficient management
• Extensive denial reporting, helping pinpoint problem areas and causes, identifying solutions to reduce future denials
• Monitoring and tracking of revenue cycle denial-related productivity on a daily, weekly, or monthly basis
• Identify and measure process breakdowns and bottlenecks using objective metrics

Workflow – Process Control

• Integrated workflow tool that eliminates manual processes, driving denials to the proper area/department for resolution
• Business rules can be easily built and maintained, facilitating quick and effective resolutions
Opportunity Visibility

Impossible to fix anything until we have a clear view of the problem

• Capture information
  – Electronic or spreadsheet
  – Denied / underpaid / non-responded
• Standard organizing system
  – Single internal categorization
  – Your language that ties the various other languages together
  – Claim adjustment reason codes / remittance advice remark codes / claim adjustment groups
  – Within which payor, balance and other variables live
Metrics Reporting

- Key Performance Indicators
- Trending by:
  - Payer
  - Procedure
  - DRG
  - Diagnosis Code
  - Physician
- Coding Efficiency
- Productivity
- Payer Scorecards
Workflow

- Standard Work per Denial Type
- Claim Status Auto Generated
- Web- Botting
- Hyper Links
- Appeal Templates
  - Auto Populated
  - Specific to Denial Type
  - Attachments
  - Sent via email or fax
- Write off Authorization Streamlined and Automated
- Completion Codes
  - Specific to Denial Type
  - Standard Work built into technology
Expectations from Appeal Processes

- **What type of denials do you need to be prepared to appeal?**
  - Registration Errors due to incorrect authorization
  - Clinical Denials
  - Contract Term language

- **Clinical Documentation needs to be addressed**
  - Resistance to more detailed documentation may occur during initial phases
  - More physician queries will be needed
  - Terminology changes will affect coder interpretation and may be confusing to clinicians
Optimal Work Distribution

- Priority Work Flow set by management team
- Elimination of staff selection of accounts
- Sharing of Priority Accounts
- Tasking without impacting work flow
- Define work queue prioritization logic
  - Balance sorting
  - Reason codes
  - Analytics?
LEAN Workflow Test

*Is my system set up to be “LEAN?”*

- Are work efforts exception-based?
- Quality versus quantity work?
- Is there duplication of work?
- Is everything accounted for?
- Can staff select their own accounts?
- How do you communicate within the RC team and other departments?
Immediate Risk Mitigation

• Determine current baseline for denials
• Invest in robust denial technology
• Optimize cross department collaboration
• Identify denial prevention strategy
• Manage A/R assertively and minimize denied payments and write-offs
• Staffing Support to keep cash flowing
Denials and Underpayments Process

Remains a game of “hurry up and wait” and “hide and seek”
Operating Cost

Average is more than 9 touches per claim, representing direct cost of $30-$50, even the 90% without any significant cash value
- “Touch” SWB cost of $4-6, with overheads in addition
- Those without cash return tend to live the longest... consume the most investment

Sources: Connance Client Analysis
Operating Productivity

Waste: spending more in collection effort than you realize in cash

Percent of Cash Collected

- Low value / negative net cash efforts
- Avoid investment or reallocate

Percent of Accounts
Impact of System Disruption

Our routine systems are not set up to absorb spikes, leading to cash crunches and cost spikes
Data as a Roadmap

Predictive systems can avoid the painful swings from spikes and changes

Prospective

- System optimization
  - What could be optimal...
- Predictive analysis
  - What would happen IF...
- Trending / analysis
  - If the past continues...
  - What is changing...
- Standard reporting
  - What has happened...

Advantage

Retrospective

Standardized data

Data sophistication
Predictive Analytics

What if data could unlock patterns otherwise missed...

<table>
<thead>
<tr>
<th>If We Knew…</th>
<th>Then…</th>
</tr>
</thead>
<tbody>
<tr>
<td>This account would be worth a lot of cash if we worked it quickly…</td>
<td>We would make it a priority.</td>
</tr>
<tr>
<td>This account will be be paid in 10 days regardless of our effort…</td>
<td>We would wait 15 days before checking the status.</td>
</tr>
<tr>
<td>This account is worth very little cash regardless of our effort…</td>
<td>We would move to the next payor as soon as possible.</td>
</tr>
</tbody>
</table>
Predictive Analytics and Denials and Underpayments

Predictive models can identify the 20% of accounts where cost to follow-up exceeds cash recovery

- **Denied claims**: first 60% of accounts in subsequent effort = 98% of cash (shown)
- **Underpaid claims**: first 60% of accounts in subsequent effort = 97% of cash

![Diagram showing distribution of accounts by likelihood of subsequent payment and recovery amounts.](image)

**RECOVERY:**

- **First 60% of accounts** generate over 98% of subsequent $ collected
  - **RECOVERY:** $4,280/CLAIM
- **Last 20% of accounts** generate less than 0.3% of subsequent $ collected
  - **RECOVERY:** $11/CLAIM

Source: Connance
## Predictive Analytic Market Data

The concentration of low-value effort is common across the market

<table>
<thead>
<tr>
<th></th>
<th>Hi / Med</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of Claims</td>
<td>% of Collections</td>
</tr>
<tr>
<td>Provider A</td>
<td>74%</td>
<td>99%</td>
</tr>
<tr>
<td>Provider B</td>
<td>65%</td>
<td>96%</td>
</tr>
<tr>
<td>Provider C</td>
<td>63%</td>
<td>98%</td>
</tr>
<tr>
<td>Provider D</td>
<td>58%</td>
<td>99%</td>
</tr>
<tr>
<td>Provider E</td>
<td>48%</td>
<td>96%</td>
</tr>
<tr>
<td>Provider F</td>
<td>42%</td>
<td>99%</td>
</tr>
</tbody>
</table>
Deployment Strategies

Predictive modeling can make our existing processes smarter

- Status when it makes a difference
- Follow-up with the right priority and effort
- Leverage contingent vendors to retain focus but manage cost investment

<table>
<thead>
<tr>
<th>Claim</th>
<th>Status</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>X3476</td>
<td>HI</td>
<td>23</td>
</tr>
<tr>
<td>X8754</td>
<td>HI</td>
<td>29</td>
</tr>
<tr>
<td>Y3186</td>
<td>Low</td>
<td>40</td>
</tr>
</tbody>
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<tr>
<th>Claim</th>
<th>Priority</th>
<th>Duration</th>
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<tr>
<td>X3476</td>
<td>HI</td>
<td>120</td>
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<tr>
<td>X8754</td>
<td>HI</td>
<td>90</td>
</tr>
<tr>
<td>Y3186</td>
<td>Low</td>
<td>--</td>
</tr>
<tr>
<td>Y2190</td>
<td>Med</td>
<td>70</td>
</tr>
</tbody>
</table>

Payor

- High: highest priority and extended
- Med: priority
- Low: Outsource partners / Next Payor

Generate Claim → Submit Claim (837) → Claim Editor → Claim Response (835) → Denied → Follow-up analytic

Predictive modeling can make our existing processes smarter

- Status when it makes a difference
- Follow-up with the right priority and effort
- Leverage contingent vendors to retain focus but manage cost investment
Balance Sorting and Payor Strategies

Enhance balance sorting approaches and payor teams

Source: Connance
Reason Code Strategies

Enhance the focus of specialists working by reason code

Claims in By Reason Code, Hi/Med vs. Low Priority

- 45% all claims
- 3.4% of all cash recover
- $11/claim recovery

- 55% all claims
- 96.6% of all cash recovered
- $248/claim recovery

Source: Connance Client

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Feedback Systems

Predictive insights can inform process improvements to prevent the denial in the first place

<table>
<thead>
<tr>
<th>Outcome of Denial Efforts (Reason Code 95)</th>
<th>Eventually Paid</th>
<th>Never Paid</th>
<th>Claim Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$40,733</td>
<td>$49,812</td>
<td>Total Charges</td>
</tr>
<tr>
<td></td>
<td>36.42</td>
<td>38.81</td>
<td>Patient Age</td>
</tr>
<tr>
<td></td>
<td>23.67</td>
<td>6.67</td>
<td>Days Between Admission and Claim Filing</td>
</tr>
<tr>
<td></td>
<td>75%</td>
<td>81%</td>
<td>% with Prior Auth Flag</td>
</tr>
<tr>
<td></td>
<td>45%</td>
<td>5%</td>
<td>% Primary Diagnosis Chronic Active</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>46%</td>
<td>% Primary Diagnosis Chronic In-Active</td>
</tr>
</tbody>
</table>

Patients with a primary diagnosis that is an active chronic condition are much more likely to be denied in error.

Patients with a primary diagnosis that is an in-active chronic condition are much more likely to be denied correctly.
Predictive Analytics

Predictive analytics can lead to a system-wide enhancement

Changing Edits and Initial Billing Routines

Generate Claim

Submit Claim (837)

Claim Editor

Modify Bulk Settlement Strategies and Contract Negotiations

Regular Payor Management

Claim Response (835)

Denial / Underpayment Effort

Next Payor (Patient / 2nd Plan)

Accelerating Movement to Next-payor

Status analytic

Follow-up analytic

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Are You Ready for the ICD-10 and the Fiscal Cliff?

- Commercial denials and underpayments are critical sources of profitability
- Determine current baseline for denials
- Review existing process for opportunities to improve
  - Root cause analysis
  - Track activity
- Invest in robust denial technology
  - Maximize recovery efforts with existing staff
  - Consider outsourcing least likely to recover claims
- Predictive analytics can optimize the cost-value dynamic
  - Eliminate low value effort
  - Focus resources where there is return
  - Avoid being swamped when or if volume spikes
- End-to-end opportunity