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MANAGEMENT CONSULTING

Optimizing the business of healthcare

CHUG

Oct 2014 ~ Palm Desert
Centricity Healthcare User Group

6 Steps to Denial Management in CPS

PRESENTED BY
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Ambulatory Services Team
Hayes Management Consulting

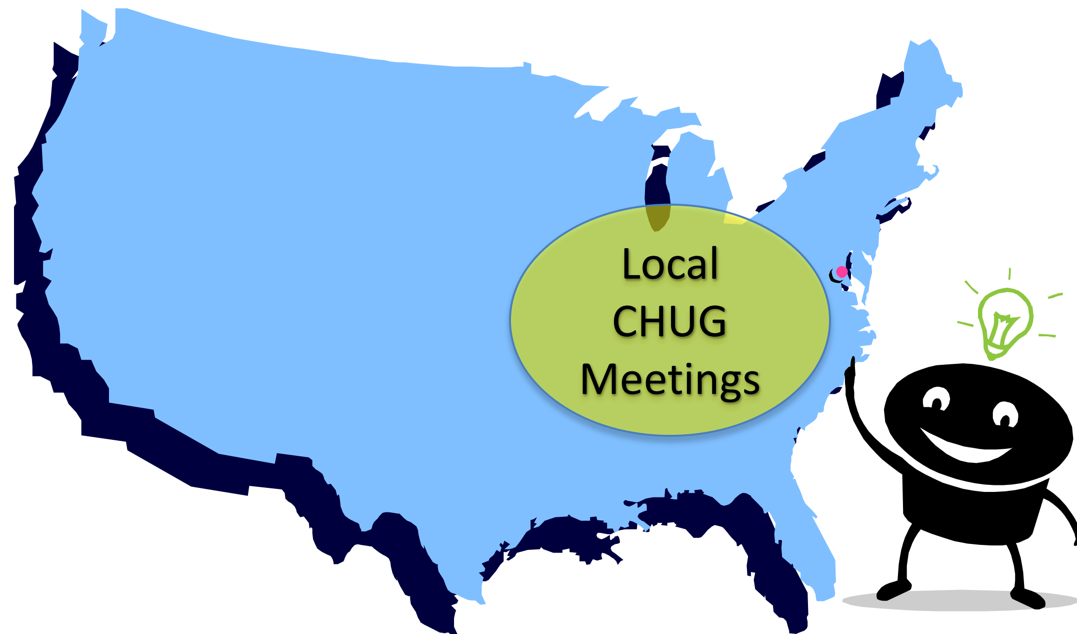
Meet Your Hayes Consultant

- Angela Hunsberger
  - Senior Healthcare Consultant
  - Ambulatory Services Team
- **YEARS OF EXPERIENCE**: Sixteen
- **SYSTEMS KNOWLEDGE**: GE Centricity Practice Management (Millbrook), EMR (Logician), Centricity Practice Solutions (CPS), Centricity Analytics, GE EDI, & McKesson Clearinghouse, Docutrak, Visual Form Editor, CCC forms, Kryptiq Secure Messaging, Patient Portal, and ePrescribe, HL7, LinkLogic, Microsoft Office, Microsoft CRM, Microsoft , SharePoint. Allscripts Enterprise EHR version 11.2
- **KEY RESPONSIBILITIES**: implementations, system build, project management, training, testing PM/EMR system and workflow optimizations, EMR VFE forms, training, billing, EDI clearinghouse, revenue cycle analysis

Fun personal fact: Angela lives in Indianapolis and got her start as an Optician for two providers for more than seven years!

Local CHUG User Groups

- Stop by and sign up for your local user group
- Hayes volunteered to host Indiana, Ohio, and Kentucky and will also be hosting virtual meetings for special topics/specialties. Stop by the booth to get on the contact list.



THANK YOU

A **BIG thank you** to the individuals who took time to interview and share their "best tips" and perspectives on denial management. My deepest apologies if I unintentionally left anyone out.

- Debi Mitchel, Children's Orthopaedic and Scoliosis Surgery Associates, LLP
- Paul Utterback and Allison Trout, Valley Professionals Community Health Center (Vermillion-Parke)
- Dulcye Field, Carlos Ruiz, Kimberly Yerbich, Columbia Basin
- Joann Morgantini, Theresa Snyder, Michele Davis and Denise Zapko, Commonwealth Health Physician Network
- Kevin Cronin, Hallmark Health Medical Associates
- Darlene Johnson, John Tidwell and the entire billing team at Affinity Health Group (Vantage Health Plan)
- Cindy Klain, GE Healthcare

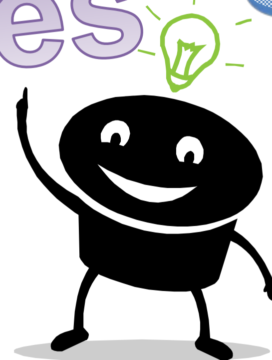
This sharing is the spirit of CHUG!

Agenda

- Introductions
- Understanding filed rejected vs. denials
- Denial management defined
- Six steps to denial management

TIPS Ideas Tricks

Best Practices



Introduction

- Gone are the days of paper claim submission and human review. As payors implement sophisticated computer systems, the volume of denied claims are on the rise. You may be getting "clean claims" out the door, but are claim denials leaving you in denial?

Filed Rejected vs. Denials

- Let's spend a moment discussing the difference between a rejection and a denial

Filed Rejected

vs.

DENIALS

Filed Rejected vs. Denials

» **Rejections** and denials are commonly thought of in the same "bucket" of A/R

- **Filed rejected** tickets **are not** the same thing as **DENIALS.**

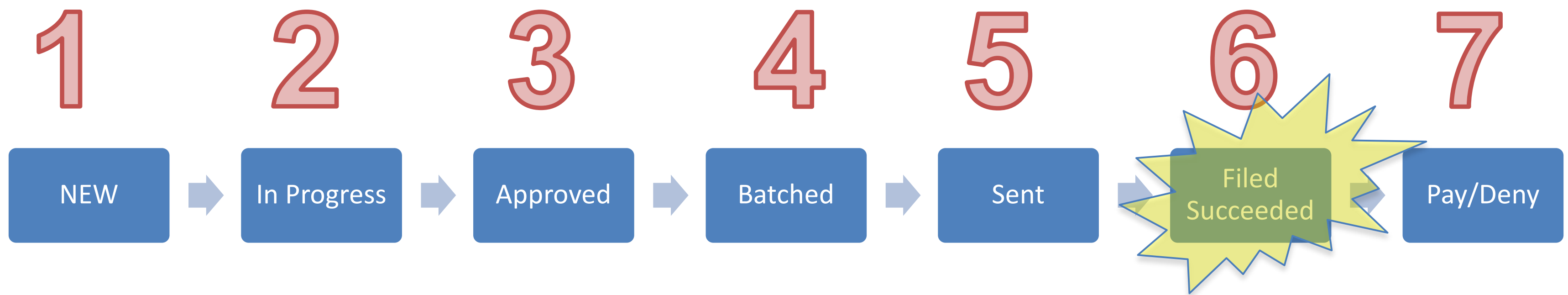
Filed Rejected	**Denial/Non Payments**
Ticket unable to be received and processed by payor	Claim is accepted and processed by the payor
Occurs during claim SUBMISSION	Occurs during adjudication process by the payor
Front end	Back end
ENTIRE ticket not accepted for processing	INDIVIDUAL line item(s) on claim are processed but NOT PAID
Visit status in CPS = **FILED REJECTED**	Visit status in CPS = **FILED SUCCEEDED**

Filed Rejected vs. Denials

- Filed rejected tickets are a major part of the revenue cycle and we will spend the next few minutes discussing rejections
  - TIP: If you have the CEDI Clearinghouse, check out the Rejection Reports on your website
- However, the majority of this session specifically focuses on tools, tips, and workflows for Denial Management in Centricity.

Filed Rejected vs. Denials

- A ticket typically goes through 7 steps before getting paid in Centricity



- Filed rejected can happen during the claim submission process. Claims do not move past step 6 if rejected.
- Once past step 6, payors accept the claim for processing and “deny” line item(s) on the claim for non payment

Filed Rejected Tickets

» How do tickets become “Filed Rejected”?

- Tickets go through several “scrubs” or “edits” during the claim lifecycle. Within Centricity, you have to “approve” the claim and “batch” the claim. Sometimes the claims fail these scrubs and you have to correct and repeat.
- Then, when you send the claim to the clearinghouse it can get “kicked out” by failing those edits too
- If your claim does get past the clearinghouse it still needs to pass the payor edits in order to be accepted for processing

Filed rejected - Primary
Filed rejected - Primary
Filed rejected - Primary
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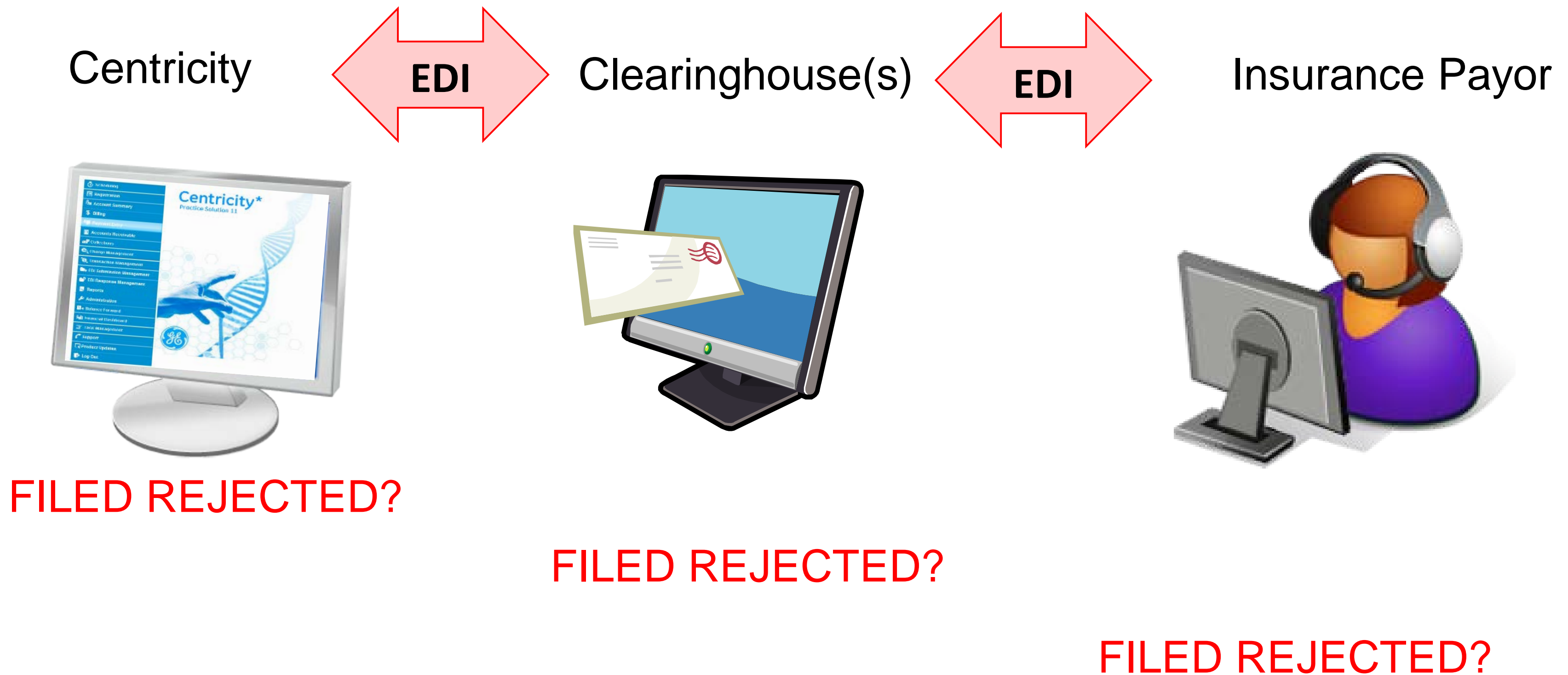
Electronic Claims Submission Process:



Understanding WHERE your claim failed will help you figure out how to fix it

Filed Rejected Tickets

» How do I fix "Filed Rejected"?

- Fixing the rejection depends upon the reason it was rejected and where in the claims process it was rejected
- Rejection reasons can be found on the notes tab (Centricity edit) or on the claims tab (clearinghouse or payor edit) within the visit
- Rejection reasons are sometimes hard to understand. Use your support department to help troubleshoot as needed.
- Typing the rejection in an internet search can also be helpful!

Filed Rejected Tickets

» Special note regarding rejections due to eligibility:

- Enroll and use electronic eligibility (RTE). While the data returned by the payor is limited, it does help reduce front-end rejections and promotes better patient/subscriber data entry.
- You will likely find and fix rejections due to: punctuation, wrong DOB, misspelled names, incorrectly keyed subscriber ID numbers, etc.

Filed Rejected Tickets

» The Do's and Don'ts of Filed Rejected Tickets:

DO	DON'T
Try to research and understand the point of rejection and rejection reason before resending the claim. Use the GE EDI Clearinghouse as a tool to help troubleshoot and report rejections	Do not keep resubmitting the claim hoping for a miracle. Do not play "hot potato" with claims to get them out the door and off of your desk.
Follow up with payors on "Filed Succeeded" tickets. Use Correspondence Notes on EVERY action you take for a rejected ticket.	Do not hesitate to find and show proof of filing for submitted claims. Do not put pop up notes any and everywhere you can find a spot.
Track rejection reasons so that you can fix the issue and send more 1st-time clean claims. Use the GE EDI website and the CPS Dashboard Reporting tools to identify trends.	Do not drop the claim to send on paper if you cannot figure out the reason. Do not be afraid to use your SUPPORT Department!!!

Managing Denials

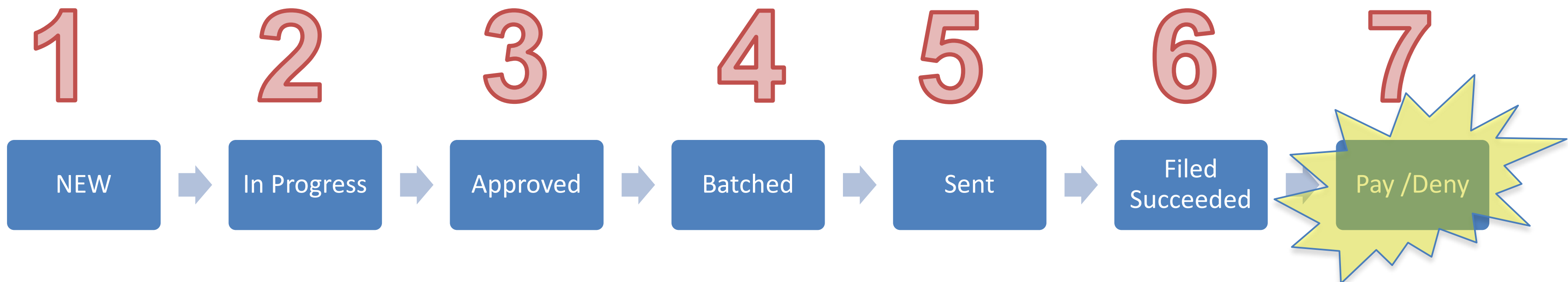
- What is a denial and at what point in the claim lifecycle does it occur?
- What makes denials difficult to manage?

Denial Management

Denial/Non Payment:

» Claim made it to the payor (Filed Succeeded) but procedures and services were not paid for various reasons

» You are made aware of the non-payments and reasons when you receive the EOB during the payment posting process



Denial Management

Technical Challenges to Denial Management:

- Lack of reporting in CPS to gather metrics to track and trend non-payment reason codes per payor (or provider)
- Some EOBs come electronically (835 remit file) for auto-posting and some come on paper for hand posting
- Old remittance settings put all non-payment codes into one big bucket (at best) unaware of CPS tools to help automate and track non-payments for follow up

Denial Management

Personal Challenges to Denial Management:

- No formal policy or expectations on non-payment follow up. No documented processes for follow up.
- Easier to "file it away" than to take action and follow up
- Easier to adjust off the balance and make the A/R look better than to hold on to the balance
- Lack of communication and collaboration with payment posters and other departments (different teams doing different tasks)

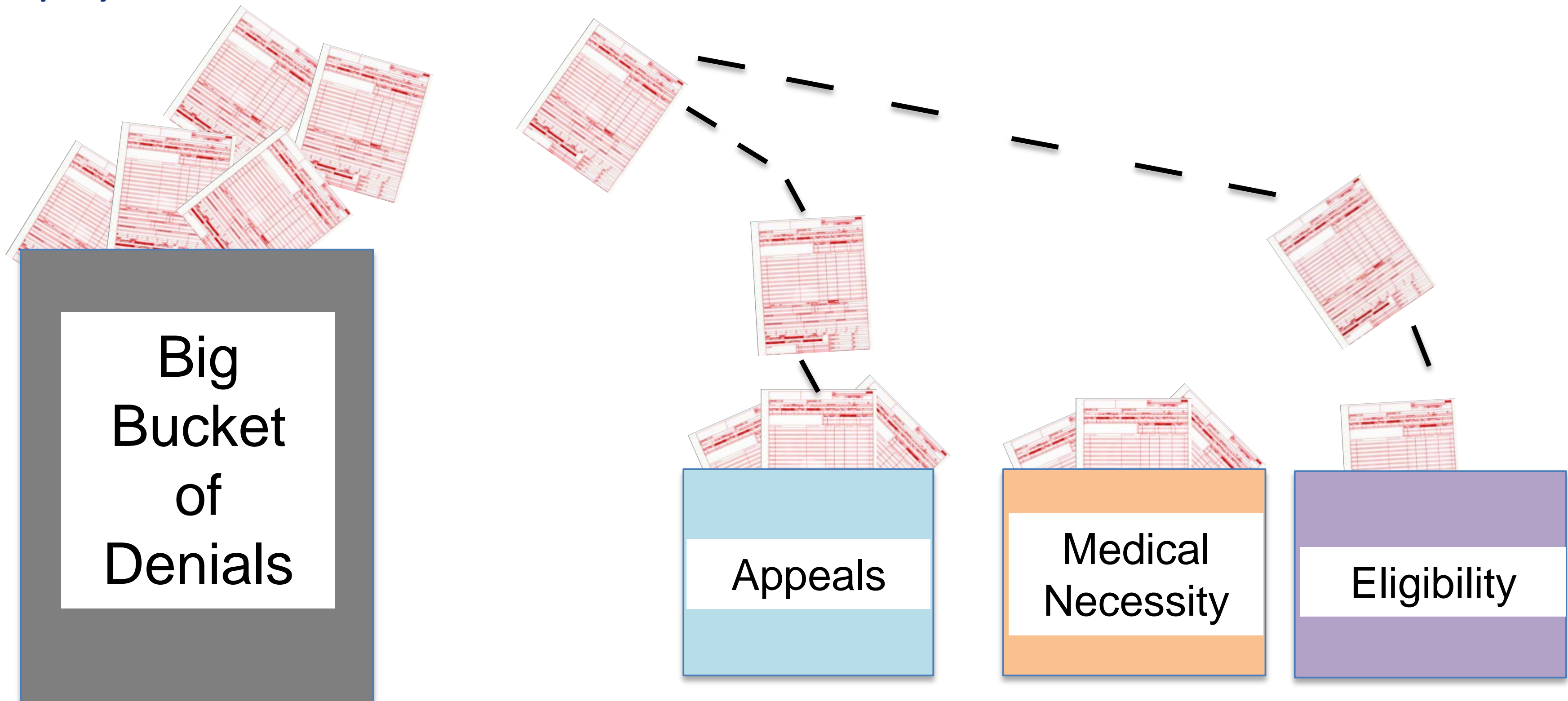
Denial Management

Bottom Line: Don't let denials leave you in denial!

- Unpaid services and procedures cost your organization lots of time and money
- Denials and lower reimbursements are on the rise (and will significantly increase with ICD-10) and payors have leveraged technology to implement sophisticated processes
- Insurance policies are designed to place more responsibility on the patient (higher deductibles/non-covered services) than ever before
- Denials/non-payments are $ in the payors pocket

Denial Management

GOAL: Prevent and decrease the quantity of denials and decrease % of denials/charges ratio by implementing a more automated, organized, and efficient process for tracking and working non payments

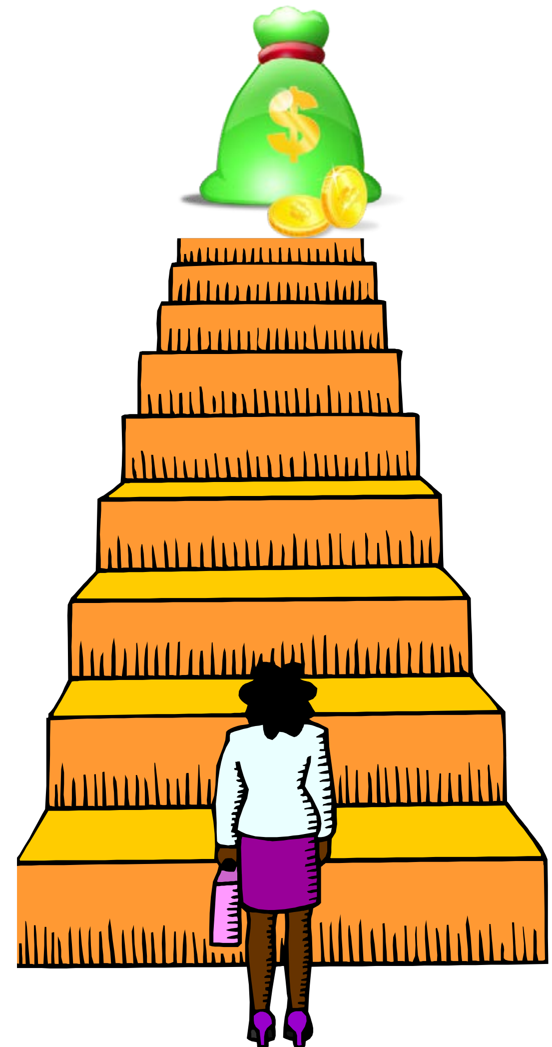


6 Steps to Denial Management

- 6 Steps to Denial Management
- The CPS tools shared today will help speed up your recognition of issues so you can react to them quickly and future denials

6 Steps to Denial Management

- Step 1. Define
- Step 2. Track
- Step 3. Analyze and improve
- Step 4. Measure and control
- Step 5. Just do it
- Step 6. Share and celebrate success!



6 Steps to Denial Management

- » **Step 1. Define**
- » Step 2. Track
- » Step 3. Analyze and Improve
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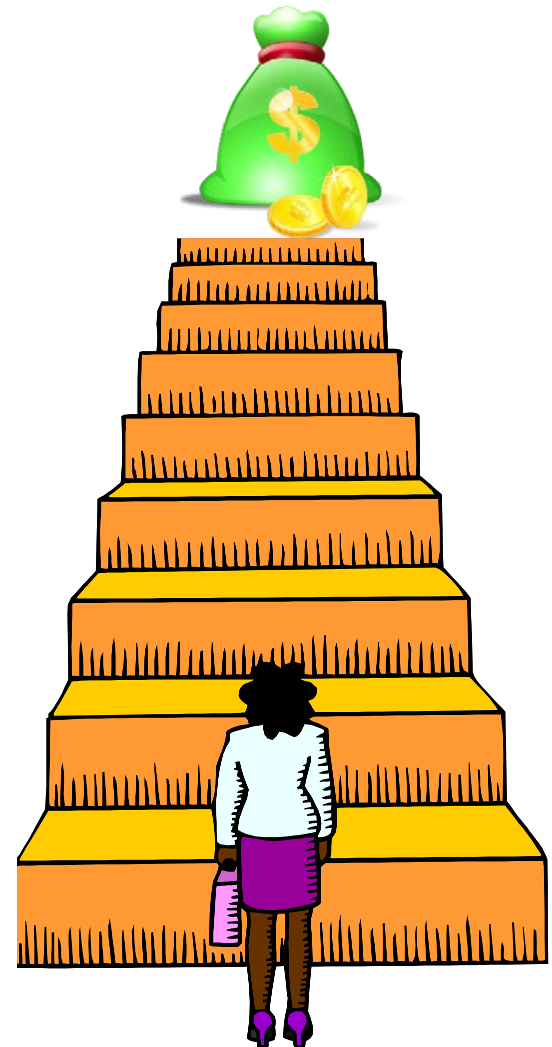
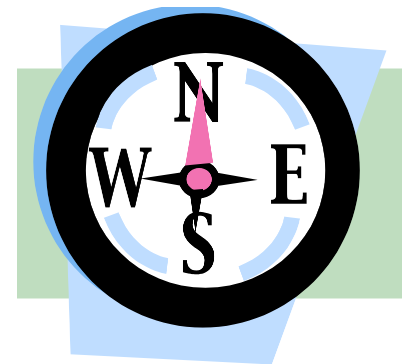


Step 1. Define

» Step 1. Define

- Investigate and identify your most common denial reasons
- Denial codes are your **call to action** on where improvements need made in your practice
- Denial code frequency and impact to your revenue cycle are your **compass** to process improvement



Step 1. Define

» Where to start:

- Denial codes are found on the EOB (paper and 835 electronic remittance files)

PROVIDER #: 540719796
PAGE #: 1 OF 1
DATE: 07/02/09
CHECK/EFT #: 884831264
STATEMENT #:

PERF PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT		RC-AMT	PROV PD
NAME		HIC 224545499T			ACNT 463078	ICN 0209169704230		ASG Y	MOA MA01 MA18	
	0612 061209	22	1	71010 26	36.00	8.77	.00	1.75 CO45 PR2	27.23	7.02
PT RESP 1.75				CLAIM TOTALS	36.00	8.77	.00	1.75	27.23	7.02
				INT PMTS .00		LATE FILING .00				

TOTAL:	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	1	36.00	8.77	.00	1.75	27.23	7.02
	INT PMTS .00		LATE FILING .00				

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes:

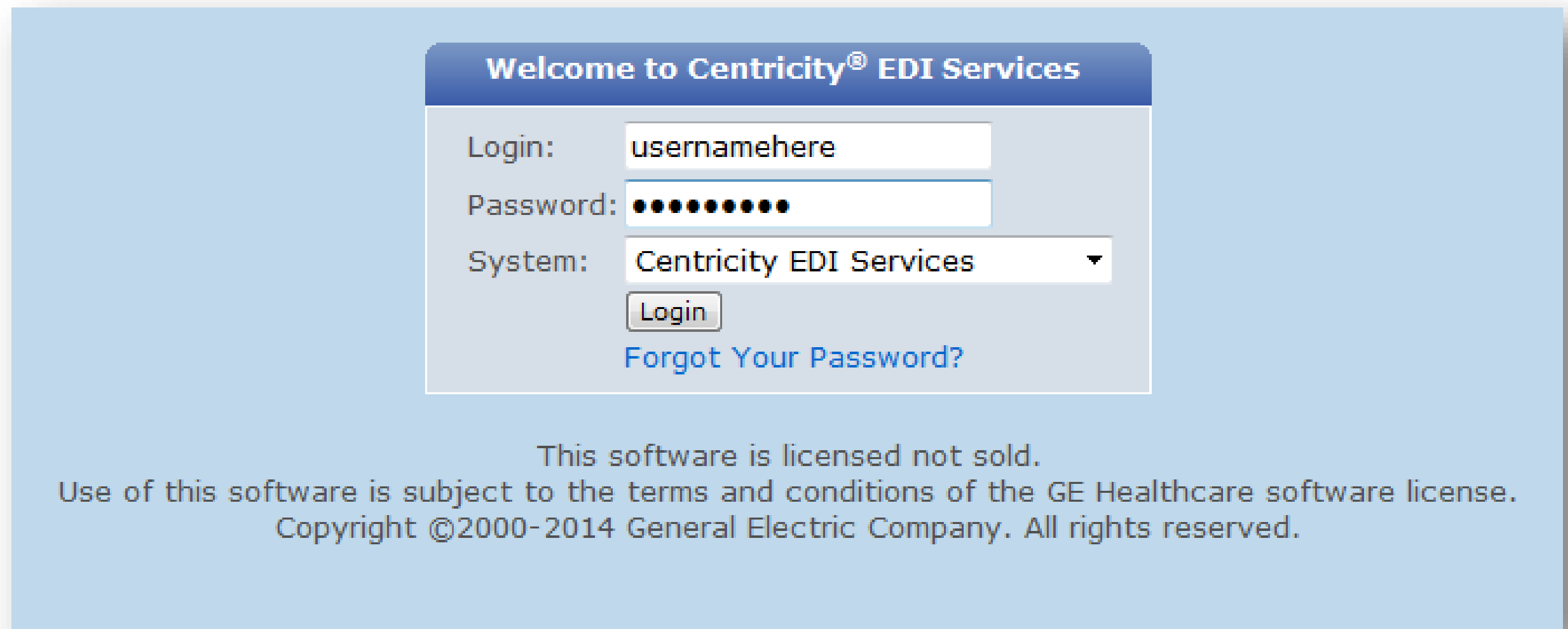
CO Contractual Obligations. Amounts for which provider is financially liable. Patient may not be billed for these amounts.
PR Patient Responsibility. Amount may be billed to beneficiary or another payer on beneficiarys behalf.
2 Coinsurance Amount
45 CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
MA01 ALERT: IF YOU DO NOT AGREE WITH WHAT WE APPROVED FOR THESE SERVICES, YOU MAY APPEAL OUR DECISION. TO MAKE SURE THAT WE ARE FAIR TO YOU, WE REQUIRE ANOTHER INDIVIDUAL THAT DID NOT PROCESS YOUR INITIAL CLAIM TO CONDUCT THE APPEAL. HOWEVER, IN ORDER TO BE
MA18 ALERT: THE CLAIM INFORMATION IS ALSO BEING FORWARDED TO THE PATIENT S SUPPLEMENTAL INSURER. SEND ANY QUESTIONS REGARDING SUPPLEMENTAL BENEFITS TO THEM.

- Start by listening to your payment posting, A/R or other billing staff about the denials that they encounter most often
- Chances are that they know where the pain points are, but just may not have the “data” to back it up

Step 1. Define

» CEDI Clearinghouse:

- If you have the GE Centricity EDI Clearinghouse, look at the remittance reports



CEDI Clearinghouse Tools

- Once logged in to your website, go to the ‘Reports’ tab and scroll down to the ‘Remit Summary Reports’
- Click on the standard/default report named ‘Remit Summary By Payor For Last Calendar Month’

Report	Type	
Remit Check Summary Reports (Create New)		
Remittance Check Summary	Standard	12
Remit Summary Reports (Create New)		
Remit Summary By Payor For Last Calendar Month	Standard	12
Remittance Trend For Last 12 Months	Standard	07

Step 1. Define

» Remit Summary By Payor:

Remit Summary By Payor For Last Calendar Month

Scenario ➔ Procedure ➔ Payor ➔ Group ➔ Category ➔ Modifiers ➔ Rendering Provider ➔ Billing Provider ➔ Place Of Service

Date Range: 07/01/2010 to 07/01/2014

Scenario	Count	Billed	Paid	Not Paid	Disallowed	Deductible	Coinsurance
PRB7						$0.00	$0.00
PR96						$0.00	$0.00
OA23,PR27						$0.00	$0.00
PR49						$0.00	$0.00
OA109						$0.00	$0.00
PR27						$0.00	$0.00
PR26						$0.00	$0.00
PR204						$0.00	$0.00
PR109						$0.00	$0.00
PR22	10	$1,285.00	$0.00	$1,285.00	$0.00	$0.00	$0.00
PR29	4	$1,136.00	$0.00	$1,136.00	$0.00	$0.00	$0.00
PR16	6	$1,052.00	$0.00	$1,052.00	$0.00	$0.00	$0.00
PR170	9	$694.00	$0.00	$694.00	$0.00	$0.00	$0.00
PR2	18	$2,589.93	$1,907.00	$682.93	$0.00	$0.00	$682.93
PR35	3	$479.00	$0.00	$479.00	$479.00	$0.00	$0.00
PR50	2	$412.00	$0.00	$412.00	$0.00	$0.00	$0.00
PI109	2	$396.00	$0.00	$396.00	$0.00	$0.00	$0.00
OA23,PR26	2	$275.00	$0.00	$275.00	$0.00	$0.00	$0.00
OA23	2	$213.00	$17.10	$195.90	$0.00	$0.00	$0.00
OA23,PR96,PR23	1	$180.00	$0.00	$180.00	$180.00	$0.00	$0.00
PR17	1	$168.00	$0.00	$168.00	$0.00	$0.00	$0.00

Reasons

PRB7 This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remarks

No Remarks

Billed Amount (07/01/2010 to 07/01/2014)

All Others $3,170 (3.6%)
OA109 $4,664 (5.3%)
PR49 $5,243 (5.9%)
OA23,PR27 $15,575 (17.7%)
PR96 $19,813 (22.5%)
PRB7 $39,702 (45%)

These nonpayment codes are your compass for process improvement!

CEDI Clearinghouse Tools

- This 'Remit Summary By Payor' report is useful for identifying the <u>most frequent</u> and <u>highest financial impact</u> of non-payment codes by payor using your 835 remit files
- The report is dynamic in that it provides high-level view with the option to filter and drill down to granular detail right down to the visit
- It is a great starting point to see where potential problems are by payor or by provider
- You can save various versions of this report. For example, you could save by payor by provider.

CEDI Clearinghouse Tools

» Click the 'Modify' button to see all the filtering options. It may take some "playing around" to become familiar and get the data to display what you want to see.

Page < 1 > of 4 — Remit Claim Detail List

Payor Name	Billed	Paid	Not Paid	Scenario	Procedure
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$909.00	$0.00	$909.00	OA23,PR27	71250
BLUE CROSS PPO	$168.00	$0.00	$168.00	OA23,PR27	99214
BLUE CROSS PPO	$168.00	$0.00	$168.00	OA23,PR27	99214
BLUE CROSS PPO	$70.00	$0.00	$70.00	OA23,PR27	96523
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$246.00	$0.00	$246.00	OA23,PR27	92014
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$168.00	$0.00	$168.00	OA23,PR27	99214
BLUE CROSS PPO	$152.00	$0.00	$152.00	OA23,PR27	97750
BLUE CROSS PPO	$101.00	$0.00	$101.00	OA23,PR27	96910
BLUE CROSS PPO	$101.00	$0.00	$101.00	OA23,PR27	96910
BLUE CROSS PPO	$101.00	$0.00	$101.00	OA23,PR27	96910
BLUE CROSS PPO	$101.00	$0.00	$101.00	OA23,PR27	96910
BLUE CROSS PPO	$101.00	$0.00	$101.00	OA23,PR27	96910
BLUE CROSS PPO	$107.00	$0.00	$107.00	OA23,PR27	99213
BLUE CROSS PPO	$939.00	$0.00	$939.00	OA23,PR27	13132

CEDI Clearinghouse Tools

» TIP: Filter for Adj. Group Code: Does not contain 'Contractual Obligations'. Also, change the 'Drill Down Order' to 'Scenario' then 'Payor'.

Search and Display

Search | Cancel

Date Submitted: Custom Time | Last 6 | Calendar Month(s) | 01/01/2014 - 07/01/2014

Group: All Groups

Payor:

Category: Contains | ALL

Rendering Provider:

Billing Provider:

Adj. Group Code: Does Not Contain

- ALL
- PR - Patient Responsibility
- OA - Other Adjustments
- CR - Correction and Reversals
- CO - Contractual Obligations
- PI - Payor Initiated Reductions

Reason:

Remark:

Procedure:

Drill Down Order: Scenario, Payor, Group, Category (Up) (Down)

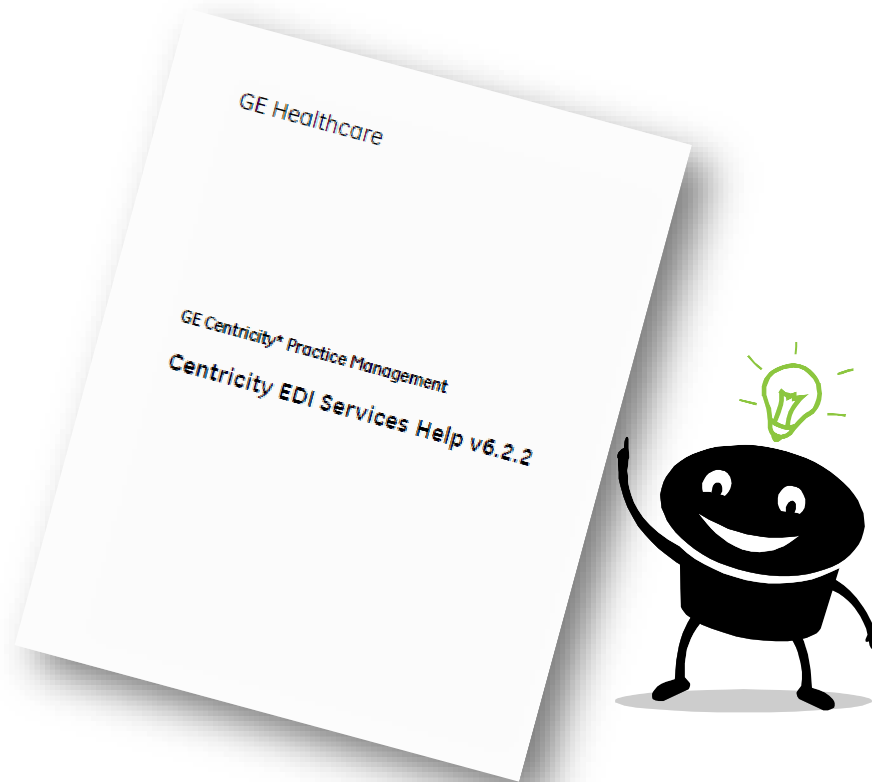
Sort: Count | Asc | Desc

Chart: Billed Amount

Scenario = non payment reason + remark code.
Tells a better story!

CEDI Clearinghouse Tools

» TIP: Click the 'HELP' button on the CEDI website to download a free 200+ page manual!



Step 1. Define

- I don't use the CEDI clearinghouse. Now what?
  - Contact your clearinghouse and ask what kind of reports are available. (free or for purchase)

Step 1. Define

» Do you have any other suggestions that are FREE?

- Create a denial tracking spreadsheet in Excel
- A simple spreadsheet will allow you to see the top payors and reasons for denial for $ and volume. Use the 80/20 rule to focus priority.
  - Possible columns: Claim Status, Provider, Patient ID, Payer Name, Denial Code, Denial Reason, Date of Denial, Actionable?, Appeal/Refile Date,$ of Denial, $ Recovered, Notes

	A	B	C	D	E	F
1	Status	Provider	CPS Pt ID:	Payer	Denial Code	Denial Reason
2	Appeal Sent	Dr. J	0.12345	Aetna	CO 150	Payer deems the information subm not support this level of service
3						
4						
5						

Resources – WPC website

- Claim adjustment reason codes and definitions can be found online at the WPC website
- Also check out the Medicare Remit Easy Print Tool

Store | Terms | Help

WPC Washington Publishing Company

Reference

Code Lists and X12 Registry

Reference > Code Lists > Health Care >

Claim Adjustment Reason Codes • ASC X12 External Code Source 139 LAST UPDATED 7/1/2014

Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

Minutes from the June 2014 Meeting. Minutes from previous meetings can be found in the FAQs.

Change Request Form | Online Conference | FAQs | Purchase

Filter Codes by Status: Show All Current | To Be Deactivated | Deactivated

1	**Deductible Amount** *Start: 01/01/1995*
2	**Coinsurance Amount** *Start: 01/01/1995*
3	**Co-payment Amount** *Start: 01/01/1995*
4	**The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**

http://www.wpc-edi.com/reference/

Step 1. Define

- Once you identify your most common codes, gather metrics so that you can have a “before” and “after” benchmark for reporting purposes and tracking
- $ of insurance denials per month
- Percentage of denials/charges ratio (three month average)
- Volume of denials

Step 1. Define

» Not all denials or non-payments are “actionable”. But, for the ones that are, the next steps will be helpful.

6 Steps to Denial Management

- » Step 1. Define
- » **Step 2. Track**
- » Step 3. Analyze and Improve
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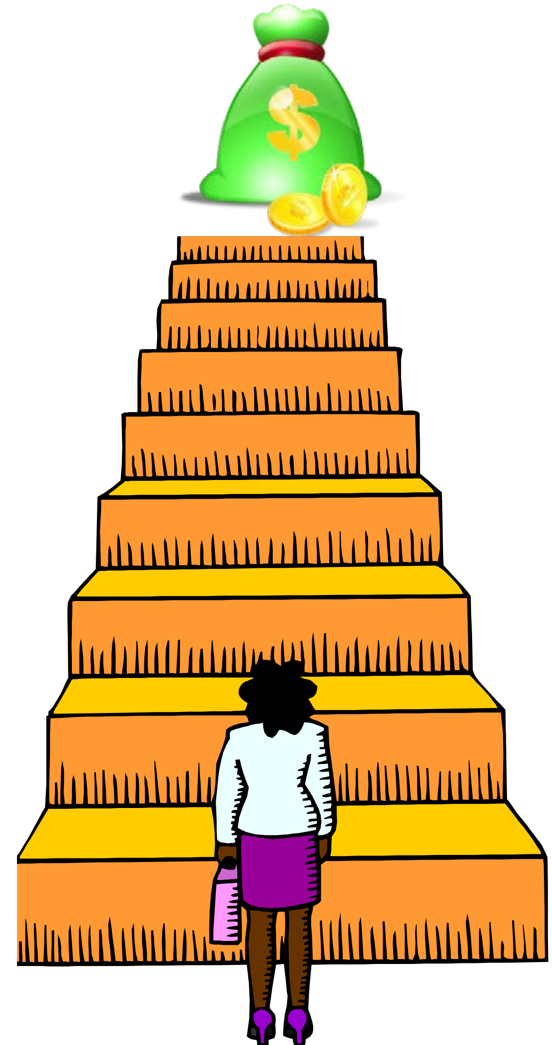
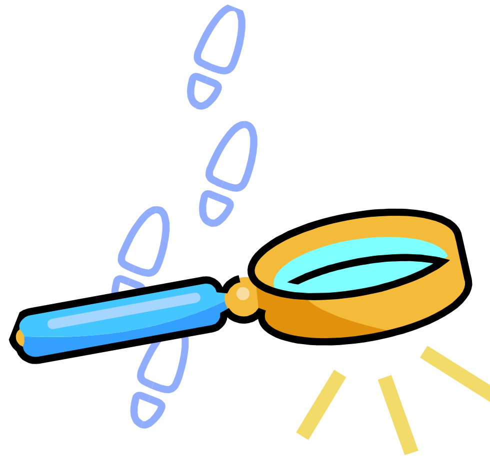


Step 2. Track

- Step 2. Track
- Now that you have your common codes, let’s discuss some ideas on how to track and automate workflows in Centricity



Step 2. Track

- Sign up for electronic remittance for as many payors as possible
- Review the payors you are still getting paper EOBs and sign up for remittance!

Step 2. Track

- Paper EOBs promote a more manual process. Electronic EOBs sent in the 835 remittance file contains structured data which is reportable and promotes automation.
  - 835 EOBs are easier to look up and find than paper EOB(s) that have been scanned in
  - The 835 file fills out line information and even preps the claim for secondary electronic filing

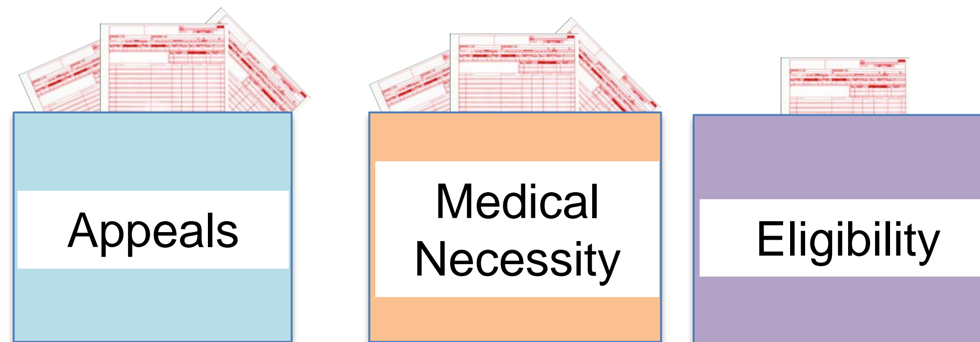
Step 2. Track

» Group your most common nonpayment codes into categories. Here are some suggestions:

- Registration
- Eligibility
- Non-Covered
- Charge Entry/Coding
- Referrals/Pre-Auth
- Waiting on Patient Info
- Duplicate
- Medical Necessity
- Documentation
- Bundled
- Credentialing
- Patient Responsibility
- Timely Filing
- Other
- Appeals

Step 2. Track

» Build your denial categories as visit owners in CPS
- Better organizes denial management by creating “buckets” of actionable items to work on
- Visit owners can be assigned within the visit in billing or payment entry



Step 2. Track

» Review your remittance setup. Include the non-payment codes and "auto-assign" the visit owner during remit processing

Some offices even choose to "reject" the visit during payment posting. This throws the whole ticket into Filed Rejected when these non-payment codes are in the 835 remit file.

Procedure Level Non Payment Actions

Non Payment Action

Group & Reason Code PR 49,29,22

Action Ignore

Action Type

Apply To Tax Line

Apply To Primary Only

Ignore Actual Allowed (B6)

Calculate Actual Allowed

Reject Visit ☑

Split Visit

Assign Owner Denials/Remittance Review

Use more specific visit owner?

Claim Level Processing

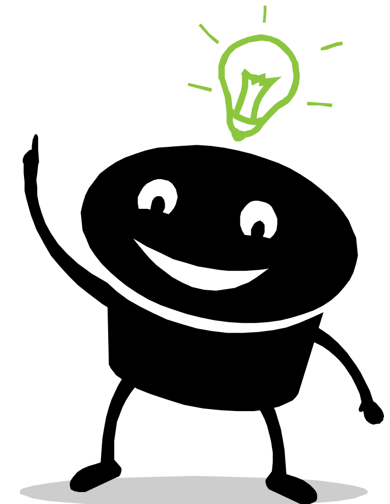
Process at Claim Level

Do Not Post Visit

Log In Remittance Report

Step 2. Track

- BONUS TIP: EDI Response Processors pull from the insurance carrier with the 'Payer Literal' with the lowest Centricity ID
- Technically, the response processors only need setup on the carrier with the lowest ID, but you will need to review your carrier settings for any carrier that has the same payor ID if you want to be thorough



Step 2. Track

- Even when hand posting non-payments, manually assign the visit owner as appropriate
- You can also manually change the visit status as appropriate to your workflows
- It is helpful to also put the denial reason code or CPT code in the visit description for easy viewing later

DOS	Code	Fee	Pat Balance	Ins Balance	Payment	Payment Type	Adjustment	Adjustment Type	Transfer
	National City Bank F					Payment			
08/06/07	99213	100.00	15.00	85.00	-15.00	NSF Check		(none)	
08/06/07	nsf	30.00	30.00	0.00		Payment		(none)	
	Totals	130.00	45.00	85.00	-15.00		0.00		

Quick Pay - $0.00 Amt. Remaining 0.00 Payment -15.00 Adjustment 0.00 Transfer 0.00 ICN

Resp. Provider: Bailey MD, William R
Facility: River Oaks Main
Status: In Progress - Primary
Show Payment: 15.00

Current	Carrier
*	Anthem BCBS

Billing Note
Visit Note
Visit Description
Owner: Unassigned

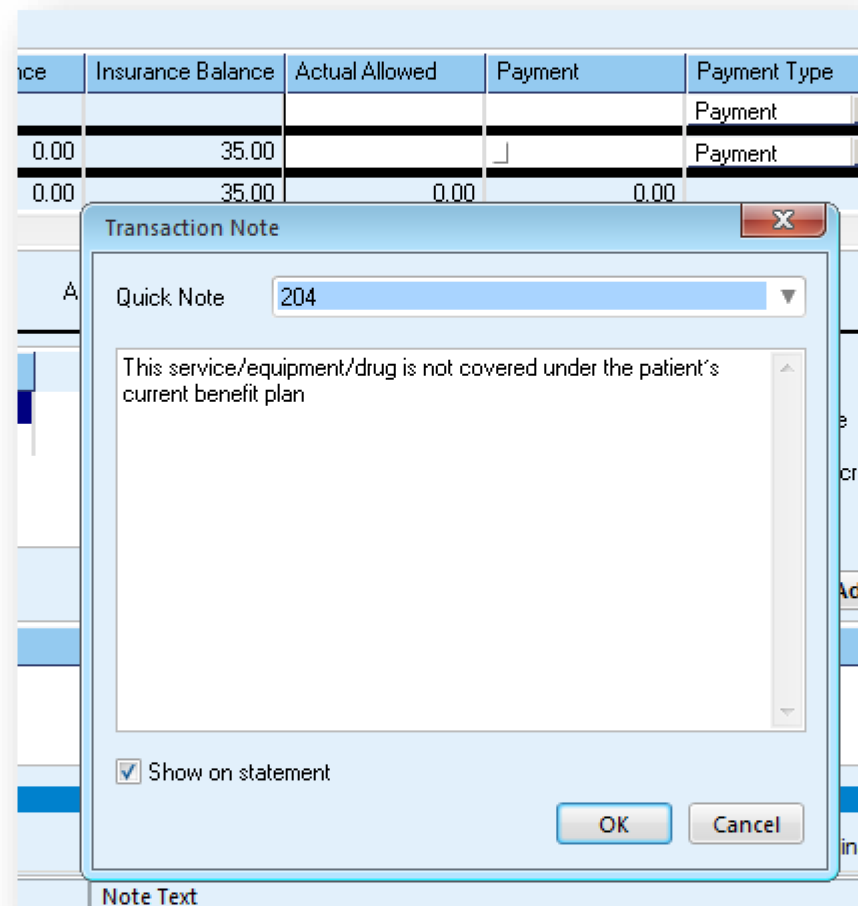
Transaction History

Claim Level Adjust... COB Information Medicare OP Adjud. Medicare IP Adjud.

Payer	Payment	Adjustment	Date	Source	Transfer	Batch	Created By	Modified By
Payment, Suzie J	15.00	0.00	08/06/2007	Patient	0.00	culp.angela_20070	culp.angela	culp.angela

Step 2. Track

- Some offices have built Quick Notes for common non-payment code reasons
- You can choose if these notes show up on patient statements or not
- This can be easily referenced by staff during payment posting



Step 2. Track

» Enter 'HC' for "hard copy EOB" in the 'Visit Note' or 'Visit Description' during payment posting so that it is easy for staff to know when to look for the paper/scanned EOB if needed

ent 0.00 Transfer 0.00 ICN

Visit Note HC
Visit Description
Owner Unassigned

Claim Level Adjust... | COB Information | Medicare OP Adjud. | Medicare IP Adjud.

rce | Transfer | Batch | Created By | Modified By

Step 2. Track

- Some offices have even used the "Collection" billing status and created sub-collection statuses to categorize and follow up on appeals, non-payments

Collections Criteria

Patient
All
Range To
Patient
(all)

Date in Collections
From 08/05/2014 To 08/05/2014
Range All

Next Contact Date
From 08/05/2014 To 08/05/2014
Expired Range All

Guarantor (all)
Ticket #
Status (all)
Resp. Provider (all)
Resource (all)
Facility (all)
Company (all)
Owner (all)
Current Insurance Carrier
(all)
Current Insurance Group
(all)

Minimum Days In Collections 0
Minimum Visit Balance
Minimum Visit Insurance Balance
Minimum Visit Patient Balance
Minimum Visit Deposit
Collections Group (all)

Reset OK Cancel

Step 2. Track

» Setup Task Management to "catch" all the visit owners and organize them into queues

Queue Name

Appeals v8-5-14

☑ Automatically exit tasks when they no longer meet criteria

Queue Users

Hunsberger, Angela

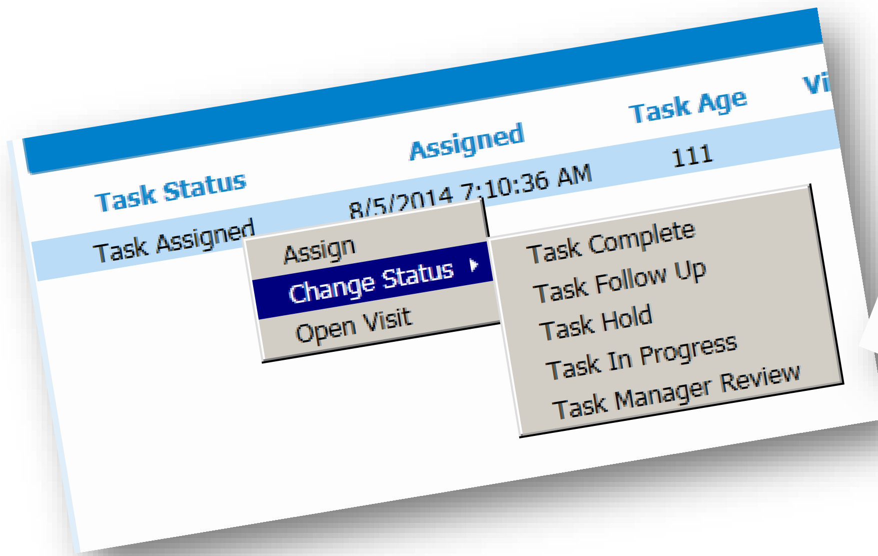
Queue Criteria

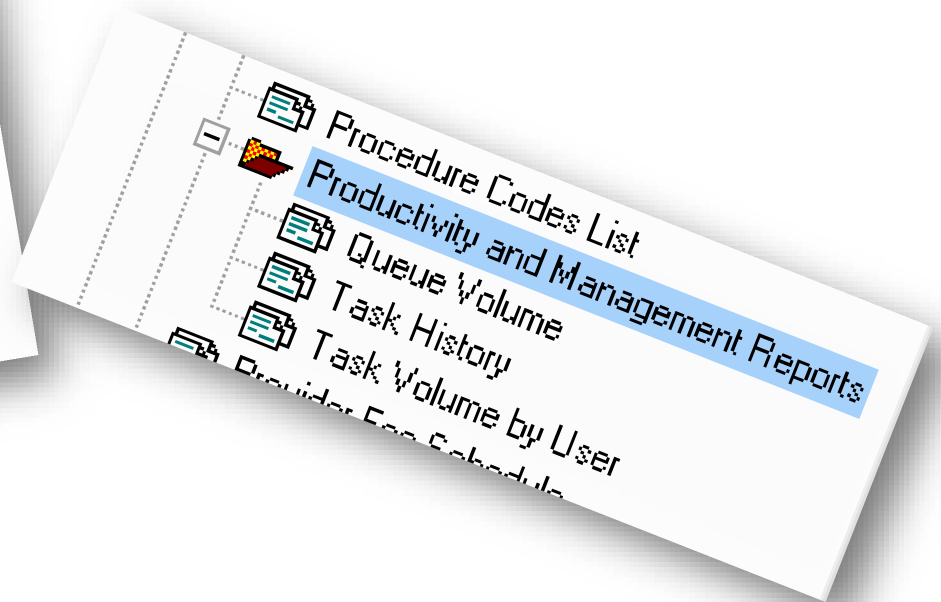
Add Criteria ▼

Insurance Group	Medicare	☐ Exclude Selected	✕
Visit Owner	Medicare Appeals	☐ Exclude Selected	✕

Step 2. Track

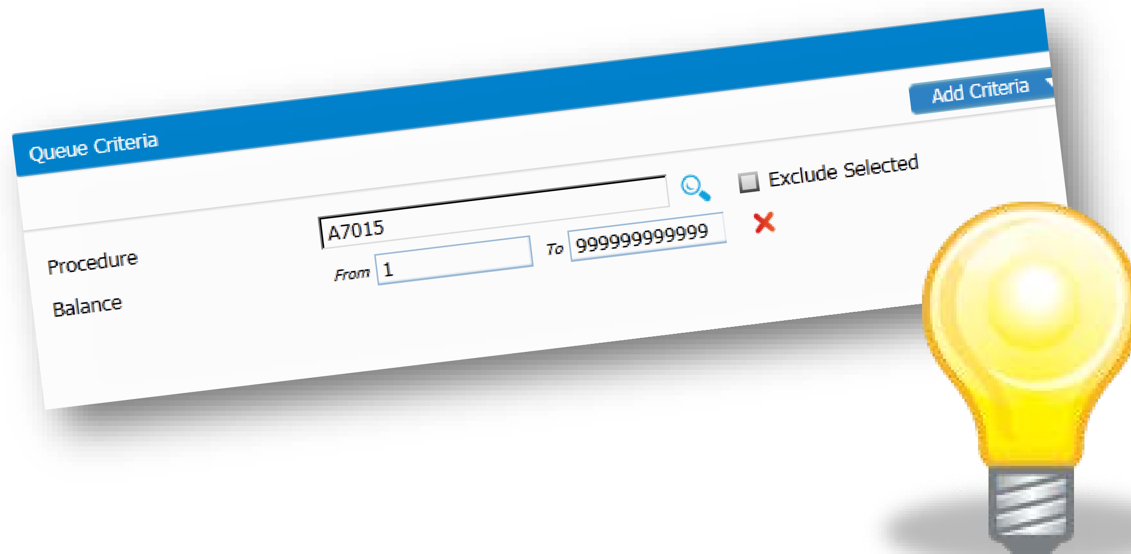
» Task Management not only gives you additional tools to manage denials (such as task statuses), you also get reports from the queues!





Step 2. Track

- Task Management queues can also be built. Not just by visit owner, but you can also build queues to monitor tickets with certain CPT codes or even to monitor new provider claims.

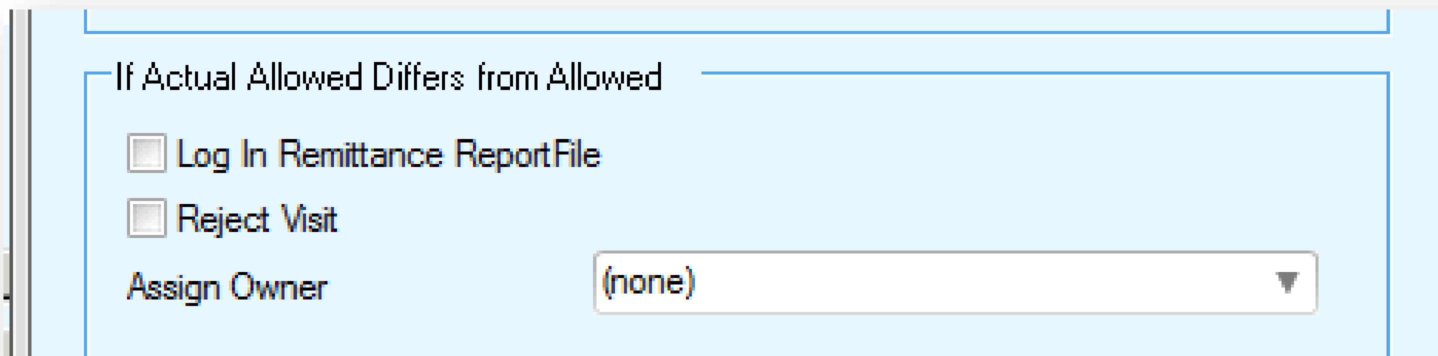


Step 2. Track

- Revisit your Fee Schedules
- Storing allowed amounts "what's expected" for procedures/services in your fee schedules and tracking the actual allowed "what you got paid" will help you identify underpayments/partial payments

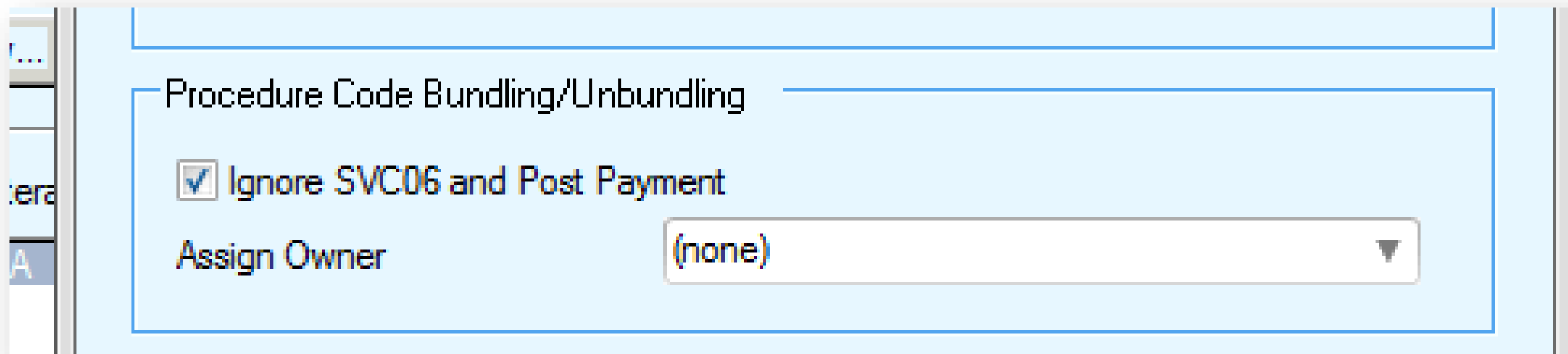
Step 2. Track

- There are even remit settings that you can "flag" and auto-assign visit owners when the actual allowed amount does not match the allowed.
  - Make a task management queue to investigate allowed amounts and update the fee schedule or follow up with the payor as needed



Step 2. Track

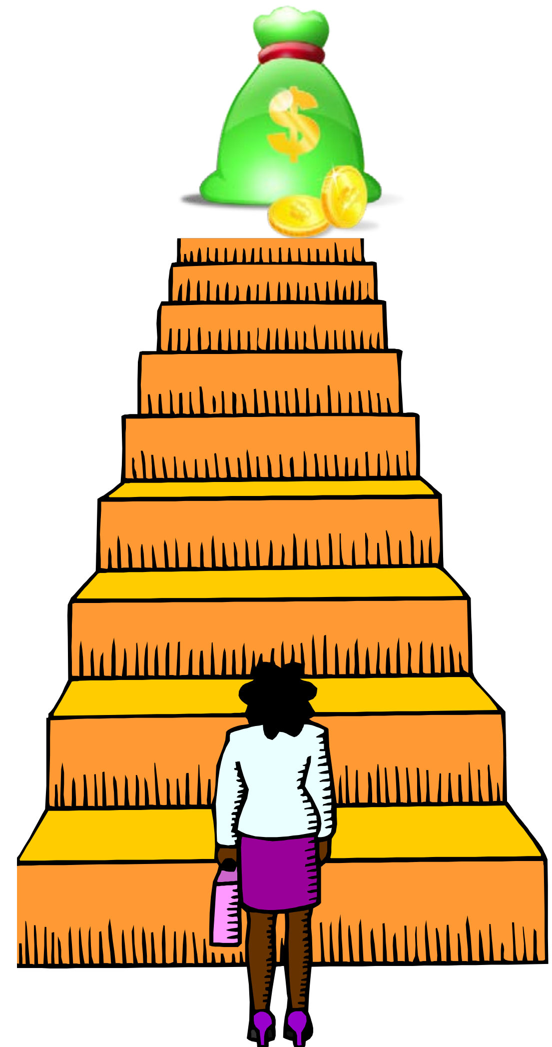
- There are even remit settings you can even "flag" and auto assign visit owners for bundled payments



- Note: One CHUG user reported bugs with this setting. Specifically, having this setting and the 'Ignore Line Item Control Number' on at the same time can cause lost transactions.

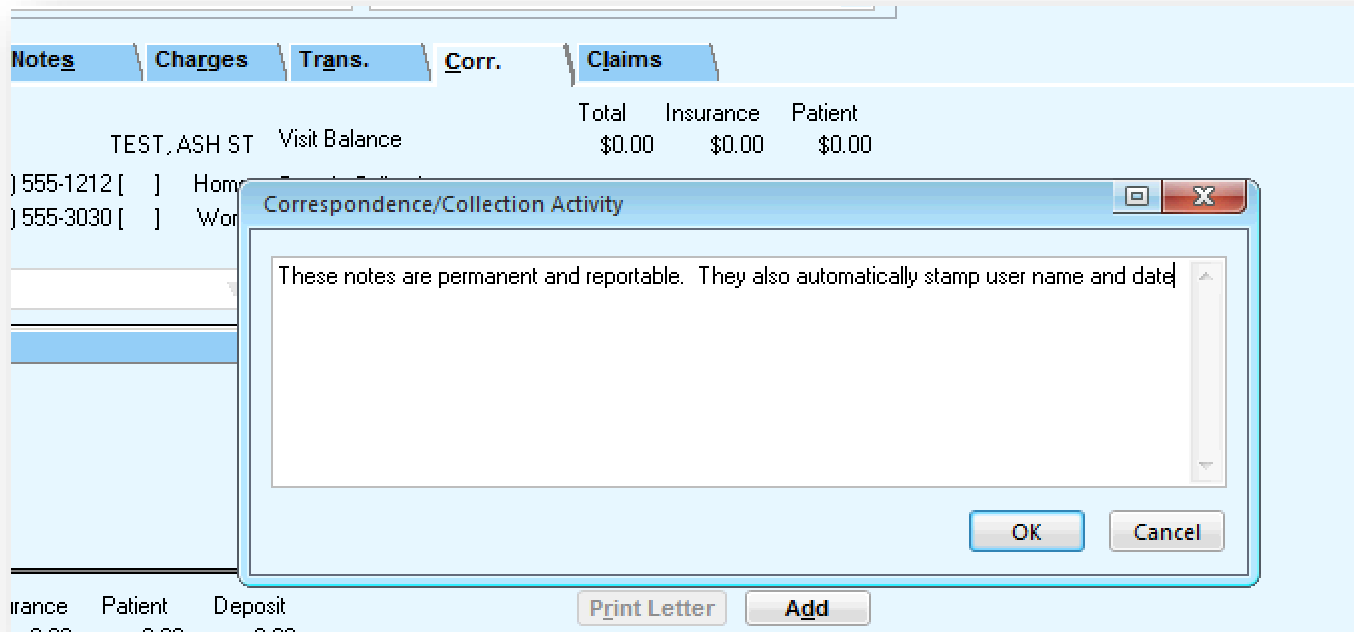
6 Steps to Denial Management

- Step 1. Define
- Step 2. Track
- **Step 3. Analyze and Improve**
- Step 4. Measure and Control
- Step 5. Just Do It
- Step 6. Share and Celebrate Success!



Step 3. Analyze and Improve

» Best practice: use correspondence notes in visits when following up on unpaid tickets/line items

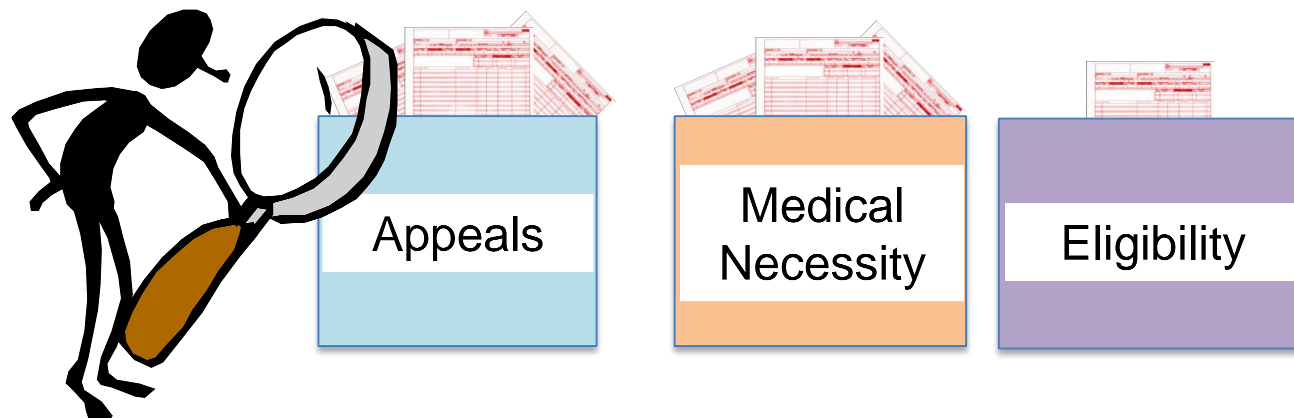


Step 3. Analyze and Improve

- Meet as a group in cross-functional meetings and look at tickets together to find trends. Discuss details as you peel back the layers.
  - The PM Outstanding Insurance Report is great for group discussion
- Reorganize billing tasks and assign dedicated “A/R Specialists” for insurance carrier follow up

Step 3. Analyze and Improve

- Assign responsibility to queues and monitor productivity
- Analyze the denial reasons and seek knowledge regarding the details for payor-specific or state-specific non-payments



Step 3. Analyze and Improve

- Understand the payor contract language and coding. Defend your coding and provide supporting documentation as appropriate.
- Involve your payor representative when terms of the contract are not met or when your supporting documentation could provide better terms
- Refine coding policies and procedures and train staff for workflow corrections as needed

Step 3. Analyze and Improve

- Load Appeal letters right into Centricity for easy access and to save time by defaulting information and pulling in info right from the visit

Provider Appeal Form

Please complete the following information and return this form with supporting documentation to the applicable address listed on the corresponding appeal instructions. Send only one appeal form per claim. Appeals must be submitted within one year from the date on the remittance advice.

Date 6/18/2014

Appeal Type (check one)

☐ Utilization Management (see below)	☐ Adverse Determination (Medical Necessity or Experimental/Investigational)	☒ Coding and Payment Rule	☐ Other

If a Utilization Management appeal, complete the following:

Type: ☐ Authorization ☐ Precertification	Authorization of Precertification Number

1. Provider Information

Provider Name			Provider Number
Street Address	City	State	Zip

Step 3. Analyze and Improve

- Create multiple appeal letters for carrier or common appeals. Include supporting images/documentation as needed based on common appeals
- This can be accomplished with a custom Crystal Report!

Authorization #:
Total Charges:$1,540.43
Total Paid:$374.23
Total Balance:$160.38

System will list any codes not paid

Dear Sir or Madam:

The above named patient was seen in our office for diagnosis code: V54.01 - Encounter for removal of internal fixation device on 02/11/2014. This appeal letter will provider further description of codes that still have balances.

20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail

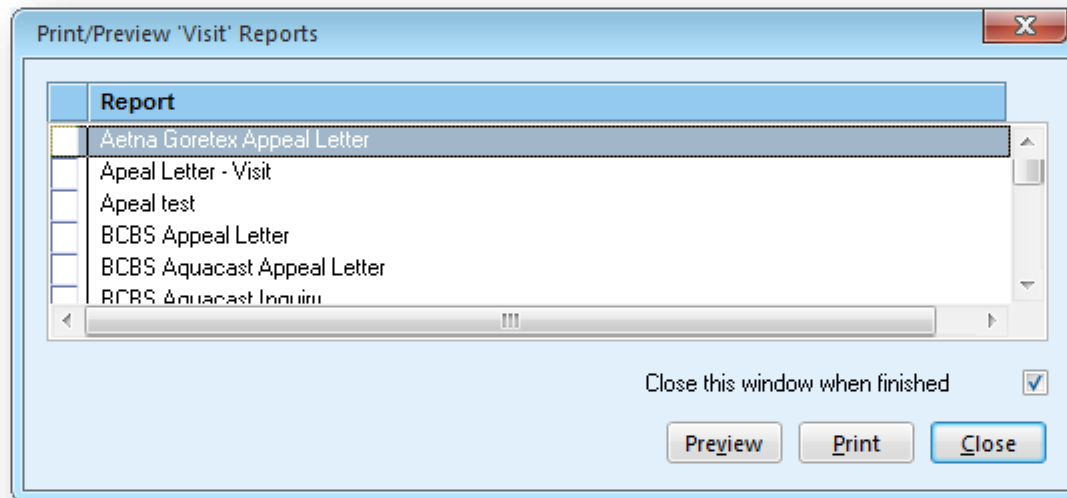
We hope this will clarify why we are using this material and that this was billed correctly and should be paid. We will be looking forward to hearing from you regarding this matter. If you have any questions please feel free to contact Account Receivable department at

Sincerely,

Patient Account Representative

Step 3. Analyze and Improve

- Once your custom Crystal Report is loaded, the appeal can be filled out by going to File > Reports> in billing. Then the appeal can be scanned and viewed by clicking on the “paperclip” within the visit in billing.



Step 3. Analyze and Improve

- TIP: Avoid “duplicate rejections” by using the Resubmission Code of “7” when sending corrected claims. Must Include the ICN too!
- ‘7’ flags the claim as a “replacement” claim

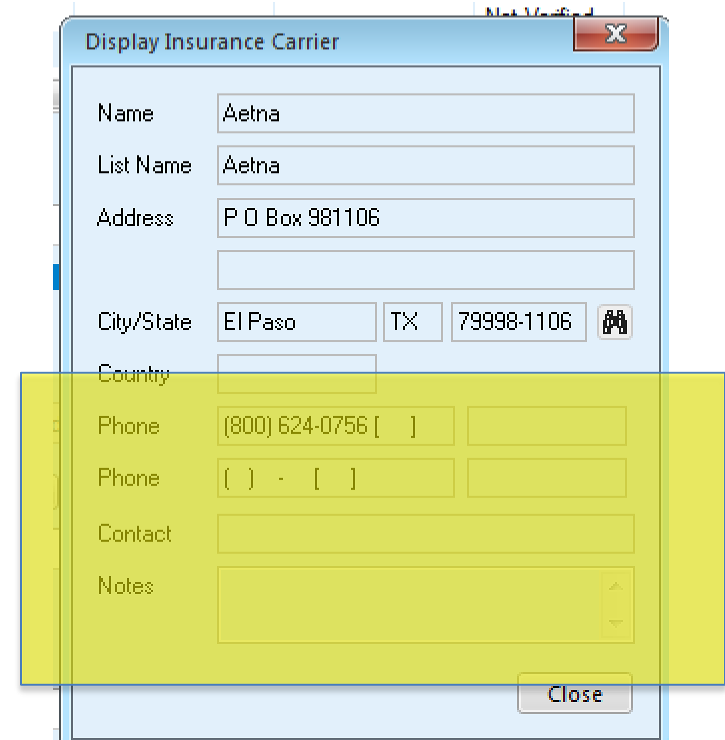
Step 3. Analyze and Improve

Decide how each "notes" field could be best used:

Note Type	Location in CPS
Visit Billing Note	Can be viewed/edited from within the visit on the notes tab or from payment entry. Helpful for notes regarding one DOS.
Visit Description	Can be viewed/edited from within the visit, in payment entry. Can also be viewed in Task Management and from the Billing spreadsheet. Helpful for quickly identifying info for a ticket.
Correspondence Notes	Can be viewed within the visit. Reportable. Best practice to document all activity for a ticket. Can be auto-copied to multiple tickets.
Patient Billing Notes	Can be viewed/edited from within the visit on the charges tab and in payment entry. Helpful for notes regarding an entire patient account.
Patient ALERT Notes	Important notes that "popup" every time the patient is accessed
Patient Appt. Notes	Can be viewed in Registration or when booking an appointment. Helpful for storing copay amounts for PCP vs. specialist.
Line Info	Viewed/edited within payment entry. Displays info on how a claim was processed by payor. Required for secondary electronic filing.

Step 3. Analyze and Improve

- Remember to utilize payor websites for claim research and drill down for more specifics on denied claims
  - TIP: On the insurance carrier setup, enter your insurance customer service number and contact for easy access
  - You can view this information from billing, payment entry, and registration



Step 3. Analyze and Improve

- TIP: On the insurance carrier setup, you can use the Subscriber ID Mask field as appropriate to ensure patient insured ID numbers are entered correctly
  - Test to see what this looks like before making changes and provide staff education right away

Edit Insurance Carrier

Information | Service | EDI | Identification | Orders

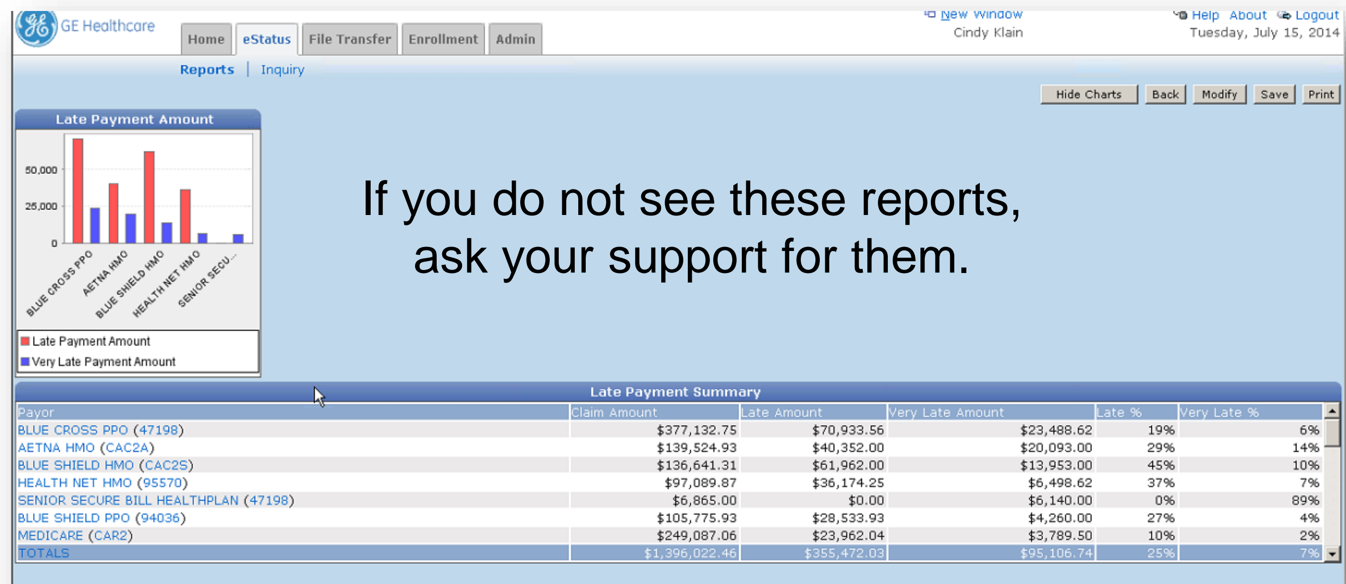
- Inactive
- Name: Aetna
- List Name: Aetna
- ID: 13
- Address: P O Box 981106
- City/State: El Paso, TX, 79998-1106
- Country:
- Subdivision:
- Phone 1: (800) 624-0756 [ ]
- Phone 2: ( ) - [ ]
- Contact:
- Notes:
- Alert Notes:
- Include Claim Office Number
- Payer ID # Type:
- Other Payer ID #:
- Filing Method: None / Paper / Electronic
- Carrier ICD-10 Implementation Date: 10/01/2014
- Carrier Type: Commercial insurance company
- Financial Class: Commercial
- Allocation Set:
- Insurance Group: Aetna
- Trans. Column Set: Aetna
- Collections Group:
- Ledger:
- Alternate Payer:
- Requires Authorization
- Reference Carrier
- Benefit Assignment: Assigned
- Policy Type: Other
- ID:
- Subscriber ID Mask:
- Method: HCFA

OK | Cancel

CEDI Clearinghouse Tools

» CEDI Late Payment Summary Report. The CEDI Clearinghouse offers reports on your website to predict when a claim is expected to be paid based on your claim and payment history.

- If a claim has not been paid by the expected payment date, the Clearinghouse will "flag" the claim and it will be listed on the report



Late Payment Summary

Payor	Claim Amount	Late Amount	Very Late Amount	Late %	Very Late %
BLUE CROSS PPO (47198)	$377,132.75	$70,933.56	$23,488.62	19%	6%
AETNA HMO (CAC2A)	$139,524.93	$40,352.00	$20,093.00	29%	14%
BLUE SHIELD HMO (CAC2S)	$136,641.31	$61,962.00	$13,953.00	45%	10%
HEALTH NET HMO (95570)	$97,089.87	$36,174.25	$6,498.62	37%	7%
SENIOR SECURE BILL HEALTHPLAN (47198)	$6,865.00	$0.00	$6,140.00	0%	89%
BLUE SHIELD PPO (94036)	$105,775.93	$28,533.93	$4,260.00	27%	4%
MEDICARE (CAR2)	$249,087.06	$23,962.04	$3,789.50	10%	2%
TOTALS	$1,396,022.46	$355,472.03	$95,106.74	25%	7%

CEDI Clearinghouse Tools

- The Late Payment Reports are a powerful tool to bring down your A/R days
- At a minimum, use the late payment detail report and at least work the high dollar claims. You will start to see patterns.

Reports | Inquiry

Back | Modify | Save | Print | Update Payment Status

Page 1 of 25

Late Payment Detail Report

	Claim No.	Patient No.	Patient	DOS	Date Submitted	Payment Status	Expected Payment Date	Claims Affected	Payor
	5784187988	9752162097		06/22/2014	07/09/2014	Very Late	07/12/2014 - 07/14/2014	$3,472.00	AETNA HMO (CAC2A)
	9094564289	9722494585		07/03/2014	07/09/2014	Very Late	07/10/2014 - 07/13/2014	$2,128.00	AETNA HMO (CAC2A)
	8436836919	7236543209		06/22/2014	07/09/2014	Very Late	07/12/2014 - 07/13/2014	$2,002.00	AETNA HMO (CAC2A)
	7789889999	1353192089		07/03/2014	07/09/2014	Very Late	07/12/2014 - 07/14/2014	$1,572.00	AETNA HMO (CAC2A)
	1643647714	3915907939		06/30/2014	07/09/2014	Very Late	07/10/2014 - 07/13/2014	$959.00	AETNA HMO (CAC2A)
	2058481365	5268532251		06/24/2014	07/09/2014	Very Late	07/10/2014 - 07/13/2014	$500.00	AETNA HMO (CAC2A)
	2483677396	4972424889		07/02/2014	07/09/2014	Very Late	07/10/2014 - 07/13/2014	$478.00	AETNA HMO (CAC2A)
	5559932258	1918361927		07/01/2014	07/09/2014	Very Late	07/10/2014 - 07/11/2014	$428.00	AETNA HMO (CAC2A)
	2287232304	5981014846		07/02/2014	07/09/2014	Very Late	07/10/2014 - 07/12/2014	$428.00	AETNA HMO (CAC2A)
	6925163988	7297429391		06/24/2014	07/09/2014	Very Late	07/12/2014 - 07/14/2014	$409.00	AETNA HMO (CAC2A)
	5763216302	6534702535		07/02/2014	07/09/2014	Very Late	07/13/2014 - 07/14/2014	$330.00	AETNA HMO (CAC2A)
	8951203677	3979032344		06/29/2014	07/09/2014	Very Late	07/13/2014 - 07/14/2014	$321.00	AETNA HMO (CAC2A)
	1674745407	2762977756		06/30/2014	07/09/2014	Very Late	07/11/2014 - 07/14/2014	$304.00	AETNA HMO (CAC2A)
	2509496295	1260156488		07/01/2014	07/09/2014	Very Late	07/11/2014 - 07/14/2014	$244.00	AETNA HMO (CAC2A)
	5997413239	1952355810		07/02/2014	07/09/2014	Very Late	07/11/2014 - 07/13/2014	$214.00	AETNA HMO (CAC2A)
	1669562504	2907560389		06/30/2014	07/09/2014	Very Late	07/13/2014 - 07/14/2014	$214.00	AETNA HMO (CAC2A)
	3828016877	9429117664		07/02/2014	07/09/2014	Very Late	07/11/2014 - 07/14/2014	$204.00	AETNA HMO (CAC2A)
	6274741673	7089149950		07/05/2014	07/09/2014	Very Late	07/11/2014 - 07/13/2014	$197.00	AETNA HMO (CAC2A)
	5966738292	2621260002		07/01/2014	07/09/2014	Very Late	07/10/2014 - 07/13/2014	$186.00	AETNA HMO (CAC2A)
	8237168111	2534935362		06/25/2014	07/09/2014	Very Late	07/10/2014 - 07/11/2014	$168.00	AETNA HMO (CAC2A)

CEDI Clearinghouse Tools

- » Rumored to be coming soon…you may start to see (or have to ask for) the auto-claim status inquiry so that the CEDI automatically pings the payor and the payor response can be viewed here. Note, the information received about the claim will vary but it's still a nice feature.
  - You will be able to see this when you click on a claim, there will be a new tab that says 'Claim Status Information'
- » If you have 'Hosted Claims Manager' you will also see additional reports on your CEDI website
- » These features are mentioned in this presentation to highlight otherwise missed tools for denials and proactive A/R management

6 Steps to Denial Management

» Step 1. Define

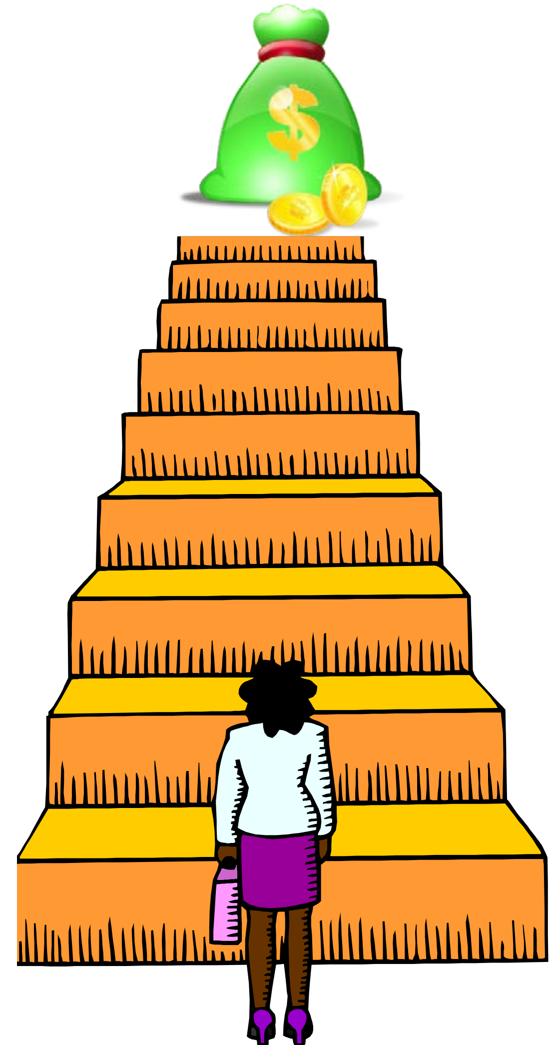
» Step 2. Track

» Step 3. Analyze and Improve

» **Step 4. Measure and Control**

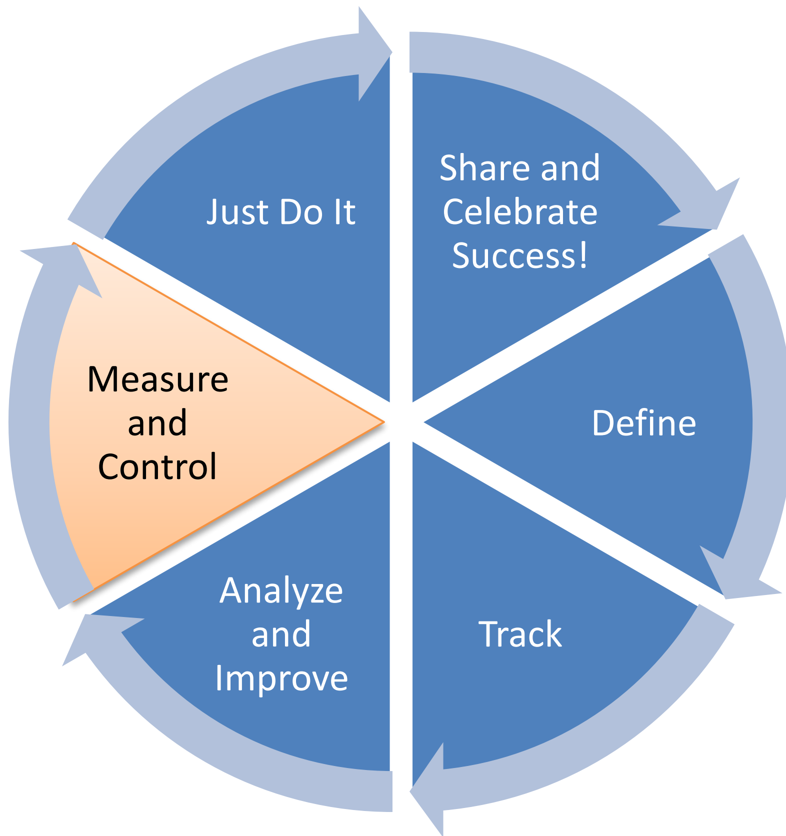
» Step 5. Just Do It

» Step 6. Share and Celebrate Success!



Step 4. Measure and Control

» Measure and Control = part of a constant cycle



- Track your progress by taking periodic metrics
- Assign subject matter experts for monitoring, improving workflows and training staff
- Stay on top of payor changes, shift efforts as needed

Step 4. Measure and Control

» On the CEDI website, the Remit Trend report shows denial trends over time

- Filter for specific reason codes and see if the changes you made have been effective

Step 4. Measure and Control

» PM Reports in Centricity

- The PM reports are typically a weak area for many organizations. They are limited, and contain static data unlike a dashboard where you can “play” with the data.
- However, you can CUSTOMIZE these reports or get custom reports created to meet your needs. If it is a great report, the return on investment pays for itself.

6 Steps to Denial Management

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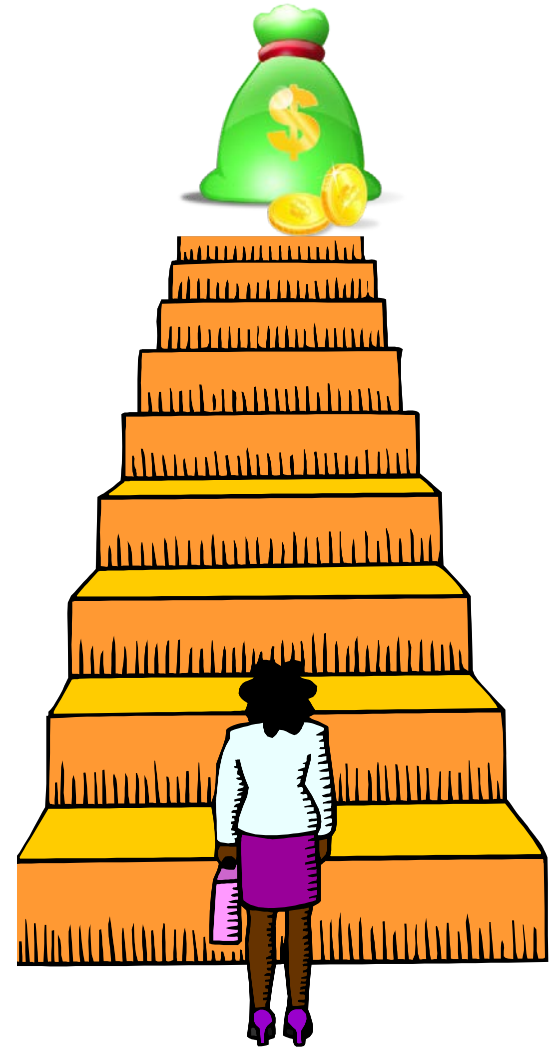

Step 5. Just Do It

- Just do it, but keep it simple
  - If you are overwhelmed, start small because even the smallest changes can make a big impact
  - If you are ready to start big, set thresholds of A/R (ex. all visits over $1,000 and then all visits over $500)
- Ask for help! There are many resources out there for help, including Hayes.
  - The “Life of a Visit” CPS training is helpful because it covers the entire patient visit from A-Z and includes the entire claim lifecycle
  - Email me if you want hands-on learning focusing on your unique office, workflows, and needs

Denials/Non Payments

» The Do's and Don'ts of Denials/Non-Payments

DO	DON'T
Use the CPS tools and tips to streamline workflows for denial follow up. Keep processes transparent by holding regular group meetings and share experiences.	Adjust off the line item as "contractual" and file the EOB away for good
Have each payor specialist document processes and create a denial/appeal playbook. Store it on a central shared location.	Don't let all the knowledge walk out the door if an employee leaves. Don't be a knowledge hoarder or stay stuck in a rut of "this is the way I've always done it".
Reorganize billing tasks if appropriate and assign dedicated "A/R specialists" for insurance carrier follow up	Don't be afraid to shake things up a bit. If the new plan is not working, try a different approach.
Use the data to leverage terms when negotiating with payors	Don't turn the other cheek and "allow" payors to keep monies for services that have been earned by your organization

6 Steps to Denial Management

- Step 1. Define
- Step 2. Track
- Step 3. Analyze and Improve
- Step 4. Measure and Control
- Step 5. Just Do It
- **Step 6. Share and Celebrate Success!**

Step 6. Share and Celebrate Success!

» When you see positive changes, share the news and celebrate success

- Provide employee or team recognition incentives or rewards
- Share the news company-wide
- A job well done deserves recognition and rewards provide further motivation!

Additional Resources

» Several vendors provide Business Intelligence solutions for denial tracking, denial management, and A/R for insurance and patient collections

Additional Resources

» Check out these solutions:

- GE Hosted ClaimsManager – front-end and back-end tools help find the root cause of rejections and denials
- GE Reimbursement Analytics – denial trending, dashboard, excellent features to check out
- Unlimited Systems – there is a whole suite of CPS-friendly products that can streamline denials and A/R
- Summit Software Technologies – automate patient phone calls based on nonpayment codes received in the 835 remit file

*Note: Hayes Management Consulting is not endorsing any particular vendor or product mentioned above. The products mentioned are of my professional opinion because they offer valuable data mining, reporting, and denial management tools.

Hayes' Contact Information

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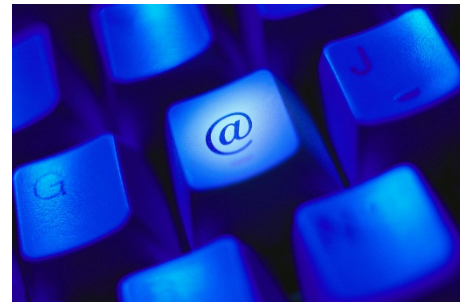
- Visit our website – sign up for our blog!
  www.HayesManagement.com



In Closing:

- Questions?