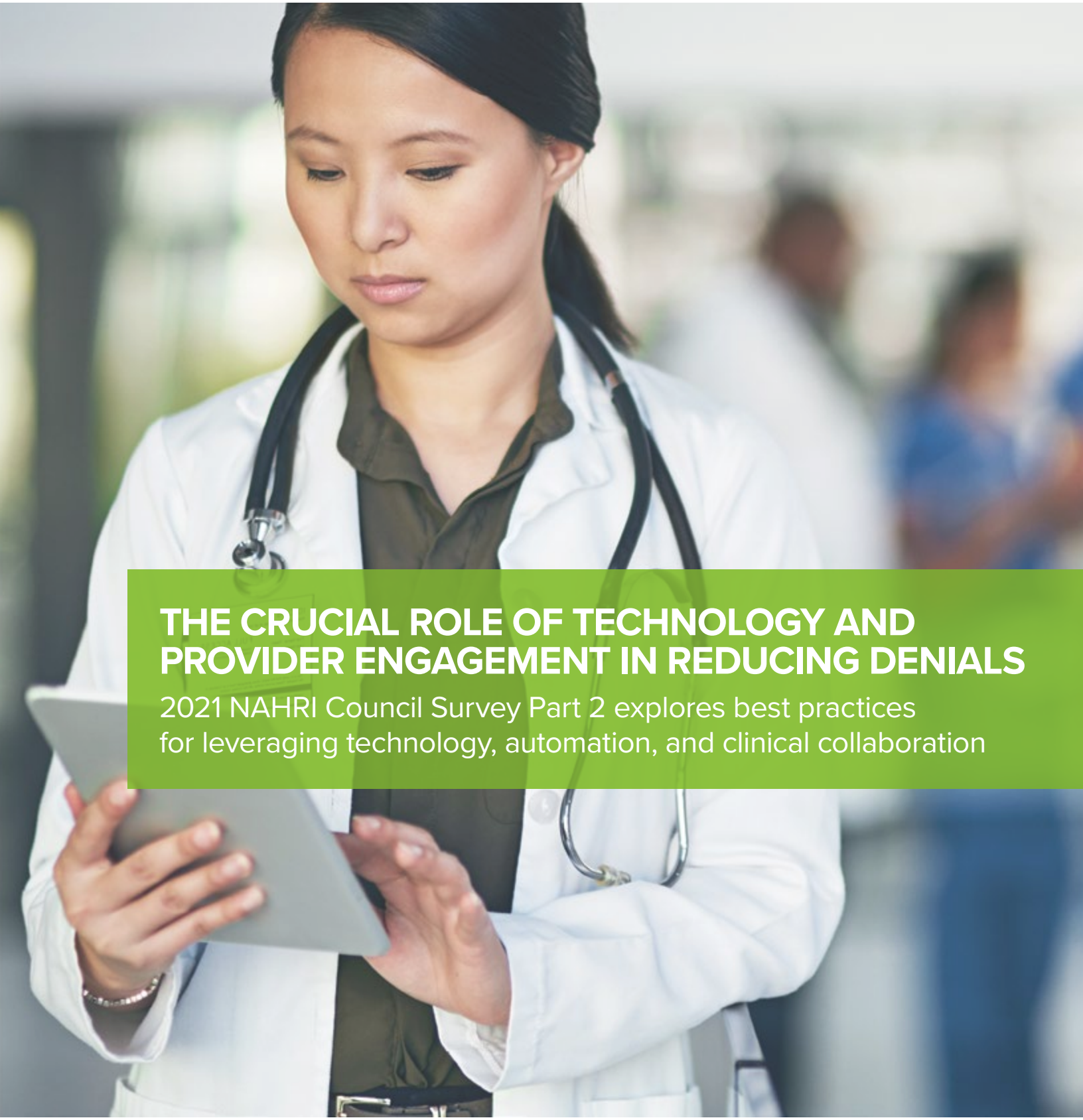
NAHRI National Association of Healthcare Revenue Integrity



THE CRUCIAL ROLE OF TECHNOLOGY AND PROVIDER ENGAGEMENT IN REDUCING DENIALS

2021 NAHRI Council Survey Part 2 explores best practices for leveraging technology, automation, and clinical collaboration

SPONSORED BY 3M | mModal

The Crucial Role of Technology and Provider Engagement in Reducing Denials

2021 NAHRI Council Survey Part 2 explores best practices for leveraging technology, automation, and clinical collaboration

ROUNDTABLE PANELISTS

TRACY CAHOON
Director of Revenue Integrity, Southwest General Health Center

SHAWISHI T. HAYNES, ED.D., MS, FACHE
Director of Revenue Cycle Operations, Valley Presbyterian Hospital

VRINDA KOSGI
Director of Revenue Integrity, Augusta University Medical Center

TERRESA ODUM, MBA, PMP, CCS, CPC
Cardiovascular Institute Revenue Operations Manager, Carilion Clinic

MICHAEL RANT
Engagement Manager, 3M

CARLA SEXTON, CCS, CCS-P, CPC, COC
Director of Provider Reimbursement, Anthem

Healthcare organizations are looking for better ways to stem the flow of denials, which have been even more challenging to manage in the last year and a half. The pandemic triggered a significant shift to virtual care services and many other changes that impacted billing, claims, and coding processes. As hospitals and provider organizations resume normal operations, they are looking to kick into high gear with a fresher perspective and approach to denials management.

In Spring 2021, the NAHRI Council Survey, Denials Management, polled 100 leaders from revenue integrity, revenue cycle, compliance, and HIM to explore how coding and documentation issues, current processes, and process changes, along with the use of technology, were impacting denial rates.

In the second half of our research, we take a deep dive into the impact of technology and provider interactions on analyzing and reducing denials. More than half of providers (52%) analyze denials using in-house automation or technology. Similarly, more than half of respondents (56%) indicated they have provider reporting and education processes. Despite denials being a substantial financial drain on healthcare systems, nearly one-third of participants do not have technology or automation processes in place to analyze denials.

We gathered a roundtable panel of experts from provider and payer organizations to continue our discussion on denials management. During the roundtable, panelists shared candid views on denial hot spots, the growing role of technology and automation in evaluating denials, and different tactics for helping providers achieve accurate documentation. A summary of this discussion follows.

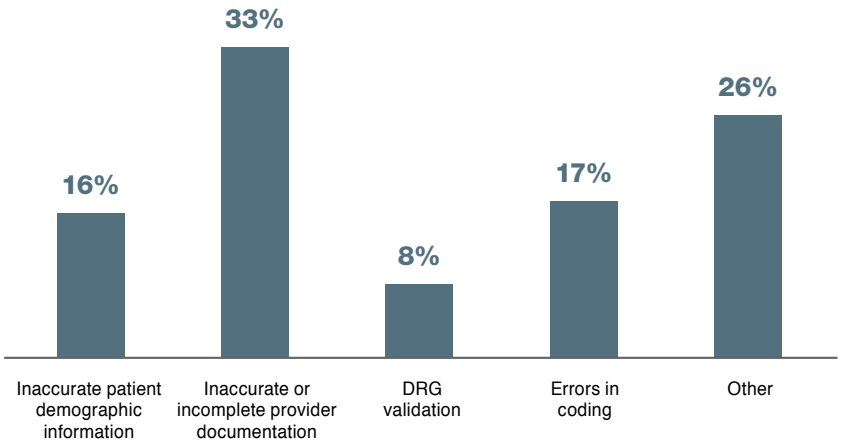
Analyzing denials: Technology, automation, and provider engagement

According to respondents, inaccurate or incomplete provider documentation is often the top cause for denials (33%), followed by coding errors (17%) and inaccurate patient demographic information (16%). Twenty-six percent of respondents selected "other," providing write-in responses, most of which point to denials related to authorizations/pre-authorizations and payer criteria for

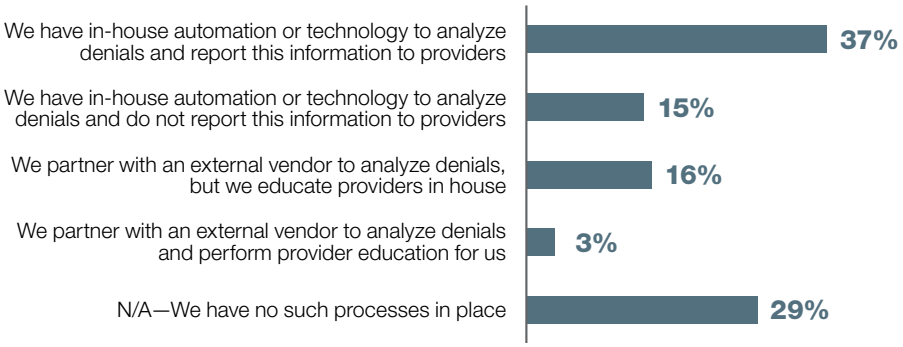
medical necessity. The roundtable panelists generally agree that inaccurate or incomplete provider documentation is a top denial area. It is worth noting, an earlier report with different NAHRI Leadership Council roundtable participants but the same set of survey respondents indicated that while there is much emphasis on coding and documentation, most respondents say these areas represent less than 10% of denied claims, which points to a need for a broader approach to denials management.

At the same time, more than half of survey respondents (52%) are using in-house automation or technology to analyze denials, although not all respondents opting for this type of technology are reporting their findings to providers for educational purposes—15% indicated the data gathered in this fashion does not make its way back to providers. The 16% who partner with an external vendor to analyze denials say they educate providers in-house. Surprisingly, 29% do not have automation or technology processes in place.

What is your facility's top cause of denials?



Which of the following best describes the use of automation or technology to analyze denials at your facility?



SOURCE: 2021 NAHRI Council Survey—Denials Management

Roundtable panelists say they deploy various technologies and practices to analyze front- and back-end denials while looping in physicians for feedback. For example, Carilion Clinic in Roanoke, Virginia, uses a Power BI® report to analyze its denials. "It's run twice a month, and we meet once a month to discuss the results," says **Terresa Odum, MBA, PMP, CCS, CPC,** cardiovascular institute revenue operations manager at Carilion Clinic.

"The results are pulled based on the discharging department, and then the clinical stakeholders from that department, including clinical leadership, UM, patient access, and coding, are involved in monthly discussions to go over the denial reasons," she adds. "The coding manager and director are involved at that point to specifically review any

denials that were related to coding that have been sent back to them for correctional review."

Odum says Carilion narrows the meeting topic to preventable denials only, focusing on anything from trouble spots at point of authorization to registration. "We also have the denials management team do pre-work to really nail down what's needed on the account prior to sending it to the different clinical departments," she adds. In this way, Carilion's process, despite relying on Power BI technology, can be a bit manual at times when the denials team needs to go beyond its reporting to identify the root cause.

"In addition to educating the various stakeholders, integrating artificial intelligence and technology within the workflow can have an important impact," says **Michael Rant,** engagement manager at 3M. "Accurate information presented to physicians, documentation specialists, and coders upstream will result in less delays, rework, or denials requiring additional follow-up."

Augusta University Medical Center in Augusta, Georgia, works with a vendor to parse out denials data from the 835 remits, according to **Vrinda Kosgi,** director of revenue integrity. She says, "Denials are separated by CAS codes and fed through smart feeds/work queues in the vendor tool (Med-Metrix) to the applicable areas to work the denials. For example, a coding-related denial goes to the billing follow-up team through a Med-Metrix smart feed/work queue, who review and send multiple patients to HIM via an Excel® spreadsheet for review and recoding as applicable."

"In addition to educating the various stakeholders, integrating artificial intelligence and technology within the workflow can have an important impact. Accurate information presented to physicians, documentation specialists, and coders upstream will result in less delays, rework, or denials requiring additional follow-up."

—Michael Rant, Engagement Manager, 3M

She notes that there are nurse auditors and four new denials analysts on her revenue integrity team who handle different work queues, including clinical and billing. However, performing reviews and root cause analyses can be challenging, especially when payers misuse CAS codes, she adds. "We get a big data dump, and then we have to try to identify the top five payers and the top five reasons for denials using manual processes using Excel pivots."

Unlike Carilion, AU Medical Center presents all preventable and non-preventable denials data at its monthly denials meetings, says Kosgi. "We go over the denials with senior revenue cycle, finance, and clinical leadership and try to work on root cause analysis," she says. Although providers do not currently attend the monthly denials meetings, they are looped in on denials data when the root cause is linked to an authorization not being obtained up front or a change in a surgical procedure. "It's a mixed bag because there was not a very robust denials management program until now," Kosgi says. "So, we're trying to put processes in place and involve the providers."

Kosgi also expresses that physicians have difficulty adapting to some process changes since certain hard stops can cause delays. "I see pushback for medical necessity for radiology—for example, for high-dollar PET scans. If the right ICD-10 codes and procedure codes are not provided on the physician order up front, there is only so much the nonclinical frontline staff can do to get an authorization. So, we are approaching that in different ways, including trying to partner with the physicians and bring the denial issues to light," she adds.

Odum offered up a solution for some of Kosgi's challenges with provider engagement, having faced similar pushback in the past with high-dollar cardiology and vascular procedures. "We hired a coder who reviews the authorizations that are in place on the day of the procedure or the day after so they can get a retro auth within 24 hours, which is what some of the providers require. By doing this, we've reduced our authorization issues and authorization denials," Odum says. "I think a lot of the buy-in from our providers has been from being a participant in the process and seeing the success and how valuable their participation has been in getting our denial rate reduced."

Shawishi T. Haynes, Ed.D., MS, FACHE, director of revenue cycle operations at Valley Presbyterian Hospital in Van Nuys, California, says much of the work around reporting denials is manual as the facility is undergoing a system update. "You can imagine the time that it takes. We do look at it from the standpoint of technical and clinical denials and then go more granular from there." Valley Presbyterian brings together its chief medical officer, physician advisor, director of managed care, director of revenue cycle operations, CDI supervisor, and coding leader to analyze the different denials and write-offs that crop up.

"We don't see a lot of denials due to our providers, and I think that's due to the work that our CDIs are doing," says Haynes. Staffing the CDI department with individuals who possess a medical background means providers are more receptive to feedback about their documentation, she says. "For the most part, our physicians are pretty good about working with our CDIs to resolve any knowledge deficits they have that are impacting our denials and causing write-offs."

Once leadership reviews denial trends, information is funneled to the team through various methods, including staff huddles and one-on-ones. Haynes' team has also hosted quarterly lunch-and-learn sessions to address denials due to incorrect orders for procedures (e.g., inpatient-only procedures scheduled as outpatient).

"A variety of different departments that impact the process came to educational sessions where we talked about different issues that we were having and helped them understand what was needed."

—Shawishi T. Haynes, Ed.D., MS, FACHE, Director of Revenue Cycle Operations, Valley Presbyterian Hospitals

While providers were not at the table for these sessions, their office staff, surgery scheduling staff, patient access, and other departments were invited to relay lessons learned. "A variety of different departments that impact the process came to educational sessions where we talked about different issues that we were having and helped them understand what was needed," Haynes says. "Over

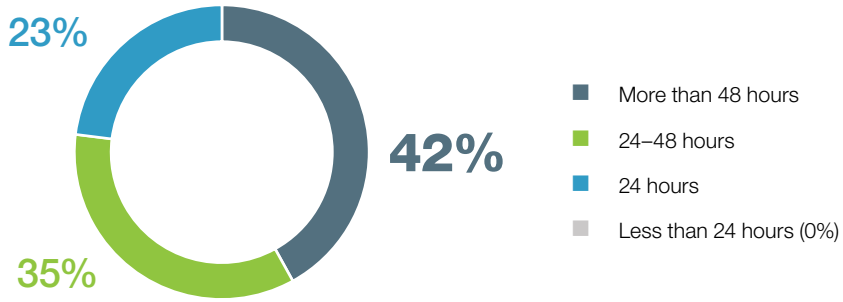
time, we started to see some improvements in that area, and that's why we don't have as many challenges now."

Southwest General Health Center in Middleburg Heights, Ohio, works with a vendor to outsource some of its billing and back-end revenue cycle functions, including denials analysis. "We have our vendor that analyzes the data and provides us a monthly report of our remit denials," says **Tracy Cahoon,** director of revenue integrity at Southwest General Health Center.

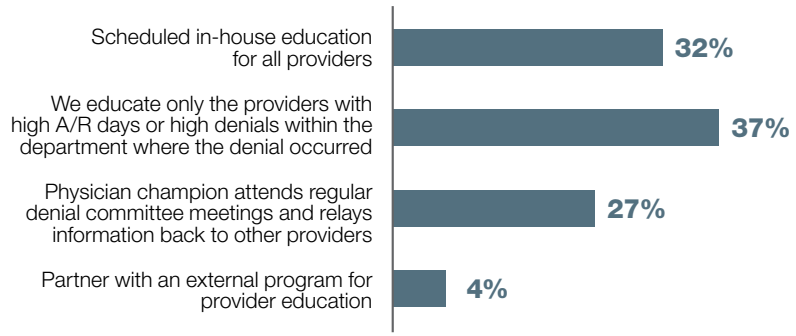
The internal team then looks at that data during its monthly denials meeting, which does not currently include providers. Southwest General also established breakout teams—including behavioral health, chemical dependency, waste management, utilization review, and prior authorization—that gather prior to the monthly denials meeting. "The various teams meet before the big summary of our denials to prepare for that meeting and figure out root cause," Cahoon says.

On the health plan side, **Carla Sexton, CCS, CCS-P, CPC, COC,** director of provider reimbursement at Anthem in Newport News, Virginia, says clinical and coding experts manage denials and appeals. "Anthem has a grievance/appeals department, which consists of clinical and coding staff, which handles all facets of coding denials and appeals. All levels of the appeals and grievance process are clearly defined in direct communication with our providers. If education and training are required based on the findings of the grievance/appeals process, those efforts will be coordinated."

How much time are providers given to post charges?



How do you engage providers in understanding the importance of timely and accurate filing to avoid denials and late charges?



SOURCE: 2021 NAHRI Council Survey—Denials Management

Provider processes and education

Taking steps to ensure providers file timely and accurately can improve denial and late charge rates. Nearly half of respondents (42%) give their providers more than 48 hours from discharge to post charges, while 35% cap provider charge entry at 24–48 hours. Roundtable panelists agree that the first two responses are standard across the industry. They also have specific processes in place to ensure providers post charges on time.

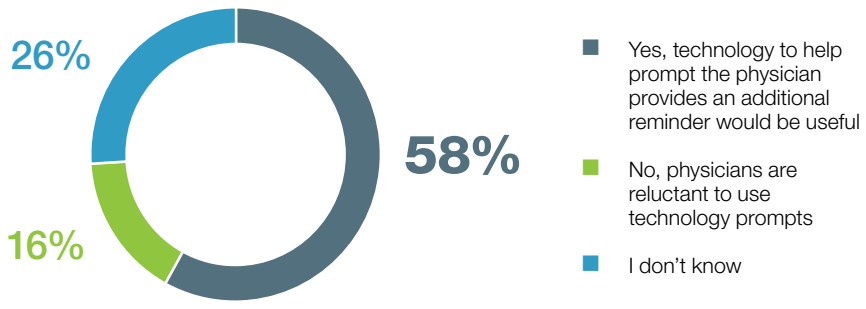
"Our bill hold days vary by patient type and have to meet certain criteria, beyond which it is deemed as a late charge," says Kosgi with Augusta University Medical Center. "The expectation is for departments to get the charges ideally within 24–48 hours. But even with the 3–7-day bill hold, there are still a lot of late charges that drop after the bill has been processed. However, we are in the initial stages of developing an automated department-specific charge reconciliation process, which includes daily reconciliations and late charge compliance reporting at the CFO level," she adds.

Southwest General has a similar time frame for posting charges. "Charges are supposed to be posted within 24–48 hours of discharge. However, because we have an outsourced back-end process, sometimes a department has up to 40 days to enter charges late," says Cahoon.

Respondents also shared how providers are educated on timely and accurate filing to avoid denials and late charges. The responses were near evenly split between educating only the providers with high A/R days or high denials within the department where the denial occurred (37%), scheduling in-house education for all providers (32%), and collaborating with a physician champion who attends regular denial committee meetings and relays information back to other providers (27%).

"The challenge with all of these communication and education methods is information and feedback is based on retrospective data to the providers," says Rant with 3M. "Providers understand the importance and the need for accurate and timely documentation. However, their key concern is managing the immediate patient care and capturing the data throughout the patient engagement. This is where the combination of awareness, education, and proactive technology can have an impact on the process," he adds.

Could point of care technology (not EMR specific) help your providers to better document patient care during the patient encounter?



SOURCE: 2021 NAHRI Council Survey—Denials Management

Point-of-care technology improves documentation

Accurate documentation processes on the front end of the patient encounter are key to ensuring fewer denials on the back end. Technology prompts at the point of care help busy providers document more accurately, causing a trickle-down effect of fewer coding errors and ultimately accurate reimbursement. Providers are increasingly taking advantage of point of care technology (not EMR specific) to improve documentation practices during patient visits. More than half (58%) of respondents state that technology to prompt providers for optimal documentation during a patient encounter could be helpful.

While roundtable panelists share the same enthusiasm for front-end technology prompts, they also caution that the technology should

focus on high-denial areas, ease of use, and timeliness. Kosgi, with Augusta University Medical Center, observes that physicians are more likely to respond to prompts and reminders when time allows. "We have checklists, drop-downs, and radio buttons to help them click through faster during the patient visit. However, if there is a hard stop, there is pushback for fear of delay in patient care," she says.

Likewise, Southwest General offers reminders to ensure providers capture key elements of the patient visit, according to Cahoon. "We have templates, dot phrases in the notes, and drop-down fields with questions such as start and stop times, type of visit, and for telehealth, we make sure they specify their physical location versus the patient's location," she says. Cahoon notes there are also categories to prompt correct documentation related to medical necessity denials for LCDs and NCDs. "Additionally, we remind providers to enter notes on coverage determination categories such as therapy services. There are prompts and fields for start and stop for timed therapy, so therapists remember to capture that information," she says.

"We have templates, dot phrases in the notes, and drop-down fields with questions such as start and stop times, type of visit, and for telehealth, we make sure they specify their physical location versus the patient's location."

—Tracy Cahoon, Director of Revenue Integrity, Southwest General Health Center

The survey results and roundtable discussion reveal that organizations are making significant progress in analyzing denials and decreasing denial rates. As revenue integrity and coding leaders continue to optimize denial management processes, they remain committed to technology adoption, front-end to back-end provider engagement, and new workflows to drive down coding and documentation denial rates. Moving forward, technology, automation, and strategic physician engagement during critical stages in documenting, coding, and billing processes will continue to break down siloes, expose gaps, and drive meaningful change. ■