



## CAPTURING LOST REVENUES

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### *Best Practices for Minimizing Managed Care Denials*

#### **Diagnostic Tools and Practice Portfolio for Chief Financial Officers and Hospital Administrators**

- ∞ Maximizing Reversal Rates
- ∞ Hardwiring Verification and Authorization
- ∞ Ensuring Appropriate Clinical Documentation
- ∞ Minimizing Payer Discretion

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## ADVISORS TO OUR WORK

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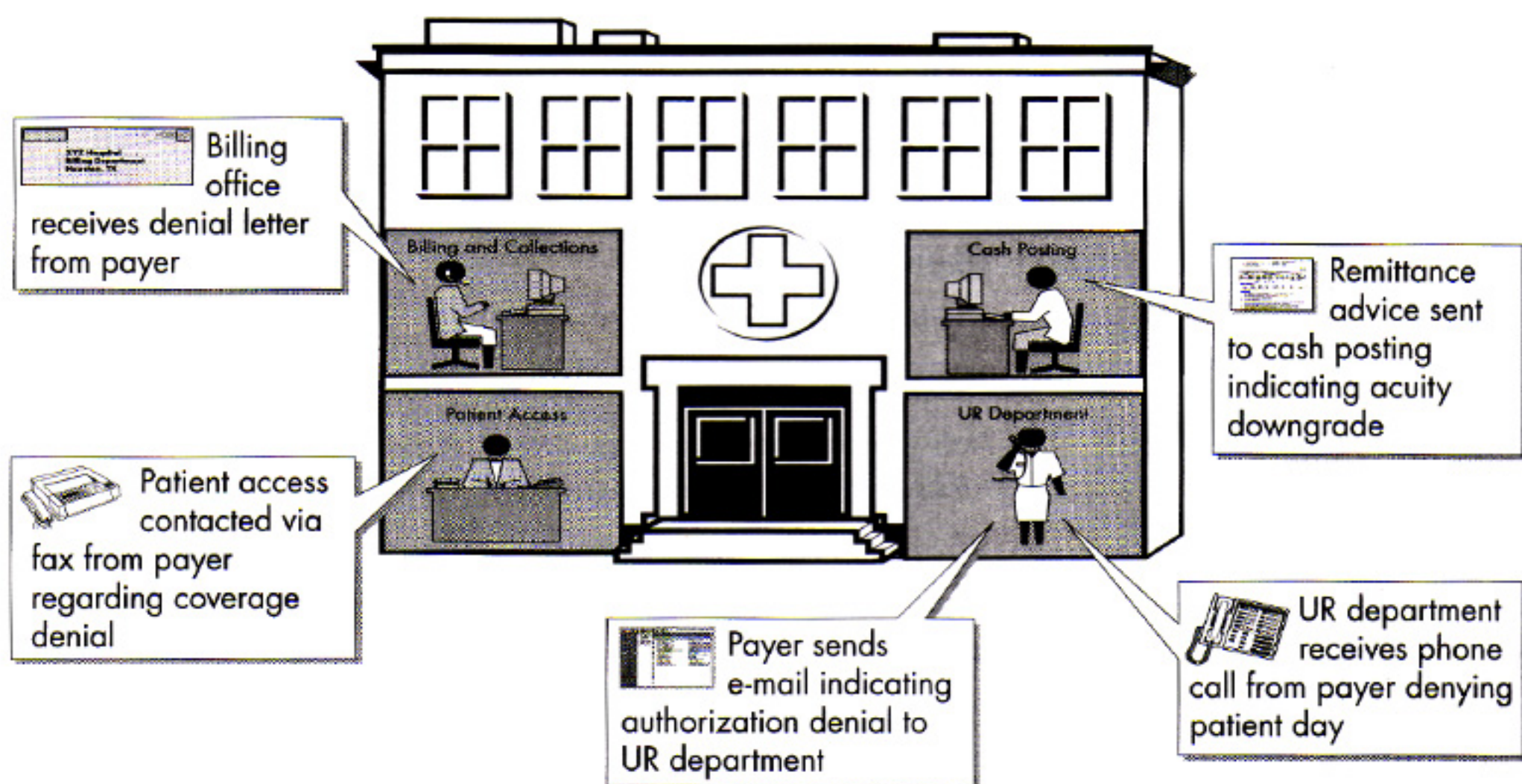
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## RATIONALE

### Poor denial capture hampers both targeted denial prevention and effective denial recovery

Denial “feedback” from payers is often received through a variety of channels, such as a phone call to case management or EOB letters to the billing office. These disparate payer communications typically supply only cursory explanations for a given denial and rarely help to identify the internal root causes that produce consistent patterns of denials across the revenue cycle. At Redbrook Health, a multihospital system in the Southwest, lack of aggregate denial information prevented administrators from assessing the extent or location of the system’s denial problem. Efforts to improve revenue capture were consistently stymied, as appeals coordinators and contract negotiators lacked the information necessary to deal effectively with payers, and administrators lacked the information required to launch effective denial prevention programs.

### Disparate Forms of Denial Feedback



## IMPLEMENTATION

### Develop a comprehensive database to track denials in real time

As a first step, administrators install a multi-access database to consolidate all incoming denial information. Best-practice denial databases have three principal functions. First, they capture specific denial case information in real time to allow for more effective appeals and targeted recovery efforts. Second, they aggregate information from across the revenue cycle into a single, fully searchable database to facilitate a comprehensive denial trend analysis. Finally, they provide a set of preformatted charts and reports to enable senior executives to make timely and accurate decisions.

### Database Aggregates Denial Information

#### Denial Case Information

- Patient name
- Payer/plan
- Physician
- Amount denied
- Reason for denial

The screenshot shows a software window titled "Denial Log - [Main Screen]". The main area contains a table with the following columns: Patient Name, Payer, Amount, Age, and Owner. The table lists various denial cases, such as "aines, alaina" with a Medicare/Medicare payer and a \$4,000.00 denial. To the right of the table, there are two summary sections: "Quick Statistics" and "Quick Reports".

Patient Name	Payer	Amount	Age	Owner
aines, alaina	Medicare / Medicare	\$4,000.00	731	Morris
alas, rene	NYLCare / Active Care	\$5,000.00	299	Unassignec
ali, morgan	Pacificare / Sunrise PPO	\$10,000.00	231	Smith
allen, martin	Medicare / Medicare	\$3,400.00	689	Unassignec
alyn, joseph	Blue Cross / Blue HMO	\$2,000.00	566	Eirich
alvarez, james	Medicare / Medicare HMO	\$6,000.00	427	Smith
anderson, ben	United / Open Access	\$9,000.00	613	Ehrhart
andree-en, simone	United / Open Access	\$2,000.00	570	Unassignec
andrews, catrina	United / Open Access	\$4,000.00	522	Smith
angst, alanis	Aetna / Choice Plus	\$19,000.00	1029	Sposito
bailey, hilary	Aetna / Choice Plus	\$2,000.00	699	Ehrhart
banks, edward g.	Blue Cross / Blue HMO	\$21,000.00	572	Unassignec
banks, ernest	Aetna / Choice Plus	\$4,000.00	293	Chopra
barker, theodore	Blue Cross / Blue HMO	\$2,000.00	1053	Flemming
basset, catherine	Medicare / Medicare HMO	\$3,100.00	787	Eirich
benatar, janice	Pacificare / Sunrise PPO	\$8,000.00	244	Sposito
bendrez, anthony	United / Open Access	\$3,000.00	995	Smith
benet, eric	Pacificare / Sunrise PPO	\$1,800.00	494	Eirich
benning, arnette	Medicare / Medicare HMO	\$3,300.00	552	Ehrhart
benson, tian	Medicare / Medicare	\$3,050.00	383	Morris

**Quick Statistics:**

- Total Current Denials: 300
- Current Value: \$2,965,458
- Avg. Age of Denial: 657.2
- Recovered Denials: 8
- Unrecovered Denials: 2
- Recovery Rate: 80.2%
- Total Lost \$: \$63,135

**Quick Reports:**

Buttons: Add New Denial, Edit/Update Denial, Remove Denial, Setup and Administration, Reports and Documents.

Sort by: Patient Name | Facility: All Facilities (System/Aggregate) | Search:

#### Preformatted Charts and Reports

- Executive summaries
- Account summaries
- Customized reports packages



#### Comprehensive Trend Analysis

- By payer
- By physician or DRG
- By reason for denial
- By percentage of total revenue

### Establish discrete, actionable codes for denial follow-up and trending

Staff enter and categorize every incoming denial using an internal set of denial reason codes. To facilitate trending, best-practice institutions typically practice "dual coding," where payer denial reason codes are systematically translated into internal hospital denial reason codes. Unlike payer denial reason codes, these internal codes, such as "payer not notified," correspond directly to specific hospital operations and are linked to the particular department responsible for follow-up. At Redbrook Health, administrators limited the number of denial codes to 20.

### Catalog of Internal Denial Codes

	 Internal Denial Code	 Follow-Up Responsibility
<b>Technical</b>	01 Payer not notified of admission	Admissions
	02 Coverage/benefits not verified	Registration
	03 Patient status incorrectly assigned	Registration
	04 Diagnosis/procedure code conflict	Coding
	05 UR clinicals not given to payer	Case management
<b>Clinical</b>	06 Inadequate clinical documentation	Attending physician
	07 Admission/continued stay not authorized	Case management
<b>Avoidable Days</b>	08 Delay in procedure	Scheduling
	09 Delay in discharge	Case management
<b>Unknown</b>	10 Other	Denial coordinator

### Deploy uniform denial capture tools to standardize data collection

Department staff are required to complete standardized denial tracking forms within 24 hours of payer notification of a denial. The standardized forms, used hospitalwide, ensure that all relevant clinical and financial denial information is collected and appropriately entered into the database. These forms are distributed in advance to all departments that receive denial feedback from payers.

### Denial Tracking Form Standardizes Information Capture

Forms distributed to all departments that receive denial notifications

<b>DENIAL TRACKING FORM</b>		Case #:	Account #:				
Initiated by:		Clinical <input type="checkbox"/>	Letter <input type="checkbox"/>	EOB <input type="checkbox"/>	Phone <input type="checkbox"/>	Fax <input type="checkbox"/>	
Administrative <input type="checkbox"/>		Service:					
Date sent to DMC:		Date logged:					
<b>DENIAL INFORMATION:</b>							
Dated:	Date received:	Date appeal due:	Denial amount:				
Dates denied:	Total days denied:	Payer reason code:					
Dates ALOC:	Total days ALOC:	Hospital reason code:					
<b>PATIENT INFORMATION:</b>							
Patient name:		DOB:					
Address:							
Insurance company:		Plan:	Insurance ID #:				
Medical record #:		Physician:					
Dates of stay:		to	Total LOS:				
<b>ACTION:</b>			<b>REASON: (Check one)</b>				
Rebill carrier <input type="checkbox"/>	<input type="checkbox"/> All days concurrently certified.		<input type="checkbox"/> Change in level of care/patient status.				
Bill patient <input type="checkbox"/>	<input type="checkbox"/> Ins. co. denial valid. Patient notified.		<input type="checkbox"/> Denial upheld.				
Other <input type="checkbox"/>	*Explain action and reason in comments section.						
<b>APPEAL DISPOSITION:</b> Appeal <input type="checkbox"/> No appeal <input type="checkbox"/> *Document reason for <u>not appealing</u> in comments section.							
Stage:	Date appeal sent:	Date reply received:	Denied Days		ALOC Days		Signature:
			Upheld	Overtured	Upheld	Overtured	
Level One							
Level Two							
Level Three							
Total # days overturned/written off:							
<b>COMMENTS/SUMMARY:</b>							

All appeals activity documented to support future decision making