NAVIGANT

On Healthcare

HEALTHCARE

THREE KEYS TO REDUCING CLINICAL DENIALS

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil, and today we are discussing clinical denials with Shela Schemel, senior vice president of operations at Navigant. As a leader in Navigant's revenue cycle coding division, Shela brings more than 30 years of supporting comprehensive revenue cycle and modular solutions for hospitals and physician practices nationwide. That experience includes owning your own consulting company, prior to joining Navigant.

Shela, thanks for joining us today.

Shela Schemel: Thank you, Alven. I'm happy to be here today.

Host: So, clinical denials may be a fact of life for healthcare providers and, in fact, estimates claim that gross charges denied by payers have grown to more than 20 percent of all claims submitted. But there are procedures that can be put in place to reduce the denial of payments by payers.

Shela, can you explain what providers can do to achieve payment and provide some examples of those procedures?

Shela: So, Alven, you're absolutely correct. Denials are a fact of life for healthcare providers. In fact, CMS actually denies about 26 percent of all claims, of which 40 percent are never resubmitted, and that's the key. Those end up aging out or being written off. So, resubmission is huge.

And then 90 percent of our denials that we see today are actually preventable. Then two-thirds of the denials are recoverable. I can't emphasize enough about the fact that we need to get these resubmitted to the payers and then also we need to start preventing these denials through education, feedback. The appeals process has to happen, but we also have to look at the causes. The root cause analysis and how do we prevent these from happening in the future?

SPEAKER

SHELA SCHEMEL

Senior Vice President
+1.479.770.0199
shela.schemel@navigant.com

navigant.com

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage, and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

So, communication's huge. Communication from the case managers back to the departments with utilization management involved, well-documented reconciliations with the payers, including level of care and days approved prior to discharges.

Many times, the payer will approve three, four days and then there will be a change in care, continuity of care, due to a newly-diagnosed case or the patient is just not approving of the way that they were originally deemed to do. At this point in time, there will be additional days required, but no one goes back and notifies the carrier and so those days do not get approved. This happens many, many times. That really has to have good, clear, concise communication and education back to the departments to make sure that everybody is watching those days and they're looking at what was approved initially.

We also have to have clear and concise timely requests. If a payer asks for a medical record, after that initial claim has been sent in, there has to be timely requests of those records submitted back to the payer and then a preparation of education that goes back to the providers that has a clear summary of pertinent clinical information so that the provider can ensure going forward that they do everything that they can to document appropriately, based off of the diagnosis in the account.

This is something that the patients and their carriers, and then the providers, they all have to be very, very in tune with what's going on with that provider and their requirements for a particular diagnosis around medical necessity, as well as the documentation of that diagnosis in the chart. On the outpatient side, I do want to let you know that that is becoming more and more of a focus for medical necessity. So, being familiar with the LCDs, anything that we do from an ancillary standpoint, it's very important that those go through a medical necessity checker on the front end, as opposed to waiting till the patient arrives and then we don't have the appropriate documentation or diagnosis to conduct a specific test that has been ordered by the provider.

Host: Shela, how can the appeal process be integrated into processes across other provider departments to achieve the full potential of the revenue cycle?

Shela: Well, Alven, we use a holistic appeal process. Meaning that, all the departments, it's a comprehensive solution. And we've got the right care going on the right place of service and the right value. We involve case management, obviously, PFS, patient access, all your ancillary services. Compliance, health information management, and also your informatics, or information systems. Because in those systems, we build edits and various safeguards in place to ensure that things don't go out the door until they've been, at least, looked at on many occasions. So, those are very important to have in place in order to make sure that we're doing everything we can, on the provider's side, to have a comprehensive denial, root cause in place. Then we analyze everything that comes back for the review of the client's denial. We look at the adjustment codes, we look at retrospective documentation, reviews of records to ensure that that the bill reflects the services that were rendered and that this is supported by the provider documentation in the chart.

That is a key that whatever is done to that patient has to be documented. And again, providers have to be educated. Ancillary staff must be educated and it is our role, as leaders in the healthcare industry, to keep up with these LCDs, with these managed care, anything out there that is in our contract, we need to know what's there and communicate our problems back to that carrier as we see them come up. So, this is critical to have a good tool in place to provide analytics to be able to track and trend what's coming back on these denials.

Host: Shela, can you talk about the professionals involved in this process and then provide a recommendation as to what a team should look like for a full utilization management contract process?

Shela: Sure, Alven. The professional denials team should include, obviously, nurses who can provide clinical education with a focus on case management, utilization management, medical review, coding, claims processing, and all of these things also include professionals with payer experience. Everyone involved must have the payer side of this at the forefront. Because as we register these patients, move them through the healthcare system, we do not complete the care of that patient until that claim is paid. Because the last thing we want is for a patient to go home and have to worry over a claim that has been denied due to not meeting that medical necessity, or not understanding the constraints around their insurance.

So, all of these individuals, and many of them with clinical experience, again, must understand the payer side of it. And then the healthcare providers should be relying on the experienced team, which are physicians, your nurses, anyone caring for that patient. We need to allow them to depend on the experienced team with the evidence-based clinical guidelines where we're using InterQual or Milliman, or any of those systems that align with the payers and then it also aligns the payers and providers with actionable, evidence-based clinical intelligence, which will allow them to support appropriate care and foster optimal utilization of resources in order to ensure that claim is paid and paid without being held up for a soft denial, or months and months of appeals process.

And with all of that in place, then we can provide education so that we stop this. We stop this madness of having to go back to the provider and say: "You should have documented this, but it's too late. We've already submitted it and now this is going to have to be written off, or the burden's going to lie on the patient." We must educate our providers and take every opportunity that we have to get that in front of them with this clinical expertise and also the utilization of individuals in that clinical space that has payer expertise.

Host: Can you speak to the role analytics plays in this process?

Shela: One of the things we're missing with many hospital systems and many physician MSOs is analytics. Being able to categorize where your denials are around reports, know what percentage. Is it at 30 percent on the front end? Is it 10 percent that's due to your provider's documentation? You should have analytics that provides you with that information so that you know where to go to fix the problem. And have a seat at the table with your managed care team so that when you start to renegotiate these contracts with these carriers, that you're bringing this analytics to the table. You're talking about what you're doing to educate your team members, but then, beyond that, if you are still seeing denials, sit down with the carriers and work through those collaboratively. Don't just accept the fact that all the burden has to be on the providers.

Because, at some point, we need to push back and give that feedback to the carriers. I've seen many instances where we have been able to gain some ground doing that. And the providers see you being an advocate for them, as well as the carriers see you watching everything that they're doing and that know you're on top of it.

Otherwise, it's going to be status quo of they're going to deny. You're going to be in this endless loop of trying to go back and appeal, and nothing is going to really show improvement over long term. It's very important to analyze, use your tools, stay abreast of everything that's coming in and going out, educate and communicate with the carriers.

Host: Shela, great information. Thanks so much for joining us today.

Shela: Thank you, Alven. I always enjoy these opportunities.

Announcer: That concludes today's episode. Be sure to check in with us for future installments on the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.