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8911

Subject: ***Claim Denial Management – Phase II***
             Report 2016-31

The final report for Claim Denial Management – Phase II, Report 2016-31, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

David Meier
Director
Audit & Management Advisory Services

Attachment

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AUDIT & MANAGEMENT ADVISORY SERVICES

Claims Denial Management – Phase II
Report No. 2016–31
September 2016

FINAL REPORT

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a Phase II review of UC San Diego Health (UCSDH) Claims Denial Management as a supplemental review on the Fiscal Year (FY) 2015-16 audit plan. We completed a Phase I review in September 2015 which focused on evaluation of new processes related to Denials Management. Our Phase II of the review focused on activities for the period after processes were transitioned to UCSDH management. The objective of our review was to evaluate the effectiveness of UCSDH processes for managing denied claims.

We concluded that Denials Management function has been established and initial efforts appear effective in beginning to formalize a sustainable process for managing denied claims in the UCSDH environment. During this FY, Revenue Cycle has hired a Continuous Improvement (CI) Director to provide leadership to the function, and staffed several key positions in the unit. Monthly Denials Task Force meetings were generally effective in facilitating communication among the various units who have a role in Denials Management. In addition, CI staff have increased use of tools to perform data analytics review of denied claims data. The addition of Clinical Appeals staff in Patient Financial Services (PFS) has improved UCSDH's ability to respond to claims denied for medical purpose.

Denials management efforts continued to evolve during our review, and a number of improvements remain in process. For example, management is developing a comprehensive project schedule for enhancing the HB Denials Management Solution. Also, an Action Item Log was implemented to better track items discussed at Denials Task Force Meetings, and provide additional documentation of Task Force efforts and achievements.

We did note that certain key aspects of the process had not yet been fully and consistently implemented, such as root cause analysis and feedback on solutions identified. In addition, the processes for routing denied claims to Clinical Appeals were not well defined. Management Action Plans to address these findings are summarized below:

> **A. Processes for Root Cause Analysis and Feedback**
>   1. CI and the Denials Task Force members will begin tracking root cause analysis performed in a centralized shared format accessible to the group. Data elements suggested by Epic will be considered for inclusion in the repository, in addition to claim-specific data (i.e., payer, CAS code, service denied, etc.).
>   2. Management will consider strategies for monitoring the effectiveness of solutions implemented to address denials, such as trend analysis for specific claim types, or implementation of a dedicated work queue for tracking.
>   3. Management will implement processes to consistently communicate information on denial data and trends to management in clinical service areas.
>
> **B. Referrals to Clinical Appeals**
>   1. Management is in process of redesigning the workflow for the referral of denials to Clinical Appeals, to ensure the denials with a clinical component are getting correctly routed and reviewed based on the skill and expertise of staff and all pertinent information is communicated at the time of the referral.

Observations and related Management Action Plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a Phase II review of UC San Diego Health (UCSDH) Claims Denial Management as a supplemental review on the Fiscal Year (FY) 2015-16 audit plan. This report summarizes the results of our review.

As Phase I of this project was initiated in FY15, we learned that UCSDH had retained Huron Consulting Group (Huron) for a focused revenue cycle optimization project, which included design and implementation of a Denials Management function. We completed a Phase I review in September 2015 which focused on evaluation of new processes related to Denials Management and the status of efforts to implement this new function. Our Phase II of the review focused on activities for the period after processes were established and transitioned to UCSDH management. This report summarizes the results of our Phase II review.

UCSDH implemented the Epic Enterprise system in October 2013, including the Resolute Hospital and Professional Fee billing modules. Focused efforts on Denials Management had not been initiated in the Epic environment since the system implementation. Initial Denials Management efforts have been focused on Hospital Billing (HB) receivables.

The revenue cycle starts with registering a patient, recording insurance (payer) data, providing the appropriate care, and then submitting a claim to the payer for services provided. An integral part of the cycle is responding to Denials, or the claims that payers have returned unpaid. Payers may deny claims for a variety of reasons as indicated by several hundred Claim Adjustment Codes (CAS). These are in addition to the informational CAS codes that are informational regarding the status of the claim. Consequently, the first step in the process is selecting true payment denials data from those that are informational.

The core of a Denials Management function involves investigating the reason for the denial, working with the appropriate department to obtain additional documentation in order to satisfy the payers' inquiry, and resubmitting the claim for payment. The process is spread across a number of separate departments. With assistance from Huron, UCSDH implemented a Denials Task Force model that is essentially a working group consisting of key revenue cycle departments. These departments are:

- *Continuous Improvement (CI)* is a group is lead and supported by the Continuous Improvement (CI) Director and team. This unit was established in February 2016 with the hiring of the Director, and is involved in many improvement and training activities within Revenue Cycle. With respect to Denials, this unit coordinates the monthly Denials Task Force meetings, analyzing monthly write-off data and identify trends. Unit managers or directors attend the task force meetings along with various subject matter experts from other units in Revenue Cycle and Care Coordination (described below). The subject matter experts perform root cause analysis, draft preliminary action plans, and update the action item log.

- *Patient Financial Services (PFS)* is the department which facilitates the submission of claims and interfaces with payers. PFS receives notifications from payers regarding the status of the claims received. In addition to the ongoing processing of new claims, PFS coordinates a response to denied claims in order to pursue collection. Failure to provide a timely response may result in the ultimate write-off of a portion or the entirety of the associated claims. During

FY16, PFS added two Clinical Appeals (CA) staff to facilitate the review of medical-related denials.

- *Patient Access* registers patients, records payer information, and directs patients to the most appropriate inpatient or outpatient setting. The Financial Clearance Center (FCC) unit within Patient Access verifies insurance coverage and secures preauthorization for surgery, radiology and imaging services. Within the Epic environment, FCC staff work to secure authorizations from payers for a predefined work queue of patients scheduled for procedures for the next seven days. The accurate recording of patient, payer and authorization information is vital so that payers may validate patient coverage status.

- *Utilization Management/Review (UR)* is section within the Patient Care Coordination department which oversees overall case management duties for inpatients. Having access to medical records, case management files and a medical advisor, UR researches and answers specific aspects involving patient care as documented in the medical records. When payers request medical justification for services, UR provides the medical record, and explains the standard of care provided via various tools such as InterQual[1]. For inpatients, UR reviews the patients' records for clinical justification of admission status prior to the hand-off for inpatient coding.

- *Health Information Management (HIM)* coders complete inpatient claims by assigning the applicable International Classification of Diseases – Tenth Revision, Clinical Modification (ICD-10-CM)[2] or Diagnosis Related Group (DRG)[3] codes based on clinical documentation within the medical record. Upon completion, the claims are returned to PFS for submission to payers.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to evaluate the effectiveness of UCSDH processes for managing denied claims. In order to achieve our objective, we performed the following:

- Reviewed Epic's *Hospital Billing Denial Prevention and Management Strategy Handbook* and information available in Epic UserWeb and community forums;
- Reviewed documentation from the Huron Consulting engagement;
- Attended monthly Denials Task Force meetings;
- Reviewed monthly the monthly Denials Dashboard reports;
- Interviewed the following individuals:
  o The Director and Nurse Manager of Care Coordination/UR
  o The Assistant Director of Patient Access
  o The Clinical Appeals staff

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[1] InterQual, part of McKesson's Decision Management solutions suite, is one of several standards of medical necessity. This tool provides a shared language to help payers, providers and other organizations determine the clinical appropriateness of settings of care, diagnostic and therapeutic interventions and surgical procedures.
[2] ICD system was developed by the World Health Organization (WHO) for internationally tracking morbidity and mortality statistics in a comparative way.
[3] DRGs group related ICD codes based on diagnoses, procedures, ages, sex, discharge status, and presence of comorbidities. Some payers pay based on DRGs.

- o   The Senior Administrative Analyst and Certified Professional Coder (CPC), Continuous Improvement
- o   The Continuous Improvement Director;
- Evaluated Clinical Appeals workflow and business process;
- Reviewed processes for production of Denials reports using available tools;
- Evaluated processes for conducting and documenting root cause analysis in review of denied claims; and
- Performed a high level trend analysis of denied claims.

This review focuses on processes related to the evaluation of HB claim denials only, and does not include procedures for the management of Professional Fee Billing (PB) claim denials.

IV. CONCLUSION

Based on our review, we concluded that Denials Management function has been established and initial efforts appear effective in beginning to formalize a sustainable process for managing denied claims in the UCSDH environment. During this FY, Revenue Cycle has hired a CI Director to provide leadership to the function, and staffed several key positions in the unit. Monthly Denials Task Force meetings have been transitioned to UCSDH management, and these meetings were generally effective in facilitating communication among the various units who have a role in Denials Management. In addition, CI staff have increased use of tools to perform data analytics review of denied claims data. The addition of Clinical Appeals staff in PFS has improved UCSDH's ability to respond to claims denied for medical purpose. As the CI unit and Denials Management processes formalize, additional processes could be implemented to conduct analysis focused on clinical service lines.

We did note that certain key aspects of the process had not yet been fully and consistently implemented, such as root cause analysis and feedback on solutions identified. It did not appear that denials data was consistently communicated to leadership in clinical service area, limiting management's visibility into this data. In addition, the processes for routing denied claims to Clinical Appeals were not well defined.

Denials management efforts continued to evolve during our review, and a number of improvements remain in process. For example, management is developing a comprehensive project schedule for enhancing the HB Denials Management Solution. This project schedule is expected to include initiatives to establish a framework for denials management, improve reporting processes, increase training for staff, refine data analysis techniques, implement changes to prevent future denials, and improve the efficiency of denials review through work queue optimization.

Also, an Action Item Log was implemented to better track items discussed at Denials Task Force Meetings, including the description of the action item, the anticipated benefit, the priority, responsible party, estimate volume and dollar value of denials, and milestone completion dates. Current efforts on the Action Item Log include opportunities for automation, increased efficiency in review of denials, focused analysis of problem areas, and enhanced skill development for staff. This log provides additional documentation of Task Force efforts and achievements.

Additional opportunities for improvement are discussed in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Processes for Root Cause Analysis and Feedback

The results of root cause analyses conducted by Task Force members was not consistently documented in a central repository or communicated to stakeholders. This limited the ability to track issues over time, identify trends, and measure the success of implemented solutions on reducing denials.   In addition, information on denial data trends had not yet been consistently communicated to management in clinical service areas.

Risk Statement/Effect

The lack of documentation for root cause analysis precludes the tracking of issues over time and feedback mechanisms.

Management Action Plans

A.1	CI and the Denials Task Force members will begin tracking root cause analysis performed in a centralized shared format accessible to the group. Data elements suggested by Epic will be considered for inclusion in the repository, in addition to claim-specific data (i.e., payer, CAS code, service denied, etc.).
A.2	Management will consider strategies for monitoring the effectiveness of solutions implemented to address denials, such as trend analysis for specific claim types, or implementation of a dedicated work queue for tracking.
A.3	Management will implement processes to consistently communicate information on denial data and trends to management in clinical service areas.

A. Processes for Root Cause Analysis and Feedback – Detailed Discussion

Members of the Denials Task Force complete root cause analysis in their monthly process of working denials. The findings of root cause analysis were discussed during the monthly Denials Task Force meetings; however, there was no central repository or log of exactly what was shared with the group over the last year. In addition, CI analysts may perform additional analysis in between monthly meetings and these results were also not tracked.

Without a centralized repository, the ability to fully utilize the cross functional expertise of the Denials Task Force members is limited. Recording of root cause analysis could enable identification of trends by payer or CAS code, or tracking solutions that have been enacted for specific issues resulting in denied claims to determine whether these solutions or process improvements are successful in reducing similar future denials. The lack of a central repository also increases the risk that institutional memory of denials management analysis and solutions is lost, should there be a change in staff. This is especially important since the analysis of root causes and solutions would not be apparent for approximately 60-90 days – the typical time for claims to be processed with the system improvement(s) and payers to respond to the new claims.

A centralized repository may also facilitate with evaluation of any changes in denial patterns due to changes in payer contracts. As root cause analyses are completed, and solutions stemming from this analysis implemented, it is expected that additional denials of the same type will not reappear. However, new payer contracts may result in re-interpretation of terms which can result in those solutions no longer being effective. Without documentation there is no institutional memory with sufficient detail to determine what was done in the past. In addition to the elements that Epic lists, adding in key but basic fields such as payer, CAS code and date(s) may allow analyst to filter the repository and review the history of denials which fit the facts at hand.

Epic's *Hospital Billing Denial Prevention and Management Strategy Handbook* recommends the systematic recording of key findings from such investigations. The following fields are suggested in Epic documentation for tracking of root cause analysis denials. This data, combined with the data typically available for denied claims (such as payer, CAS code, etc.) can provide the basis for identifying trends and measuring the effectiveness of the Denials function.

1. <u>Source area</u> – The area that caused the denial. Each remittance code can be configured with this information to automatically enter the source area of the denials with the remittance code. Source area might include registration or medical records/coding.
2. <u>Root cause</u> – Defines the action that caused the denial (i.e., what was wrong with the claim). If more information is required about what caused the denial, this can be used to record toot causes like lack of authorization or inadequate documentation.
3. <u>Clinical root cause</u> – Defines the clinical action that caused the denial. Often refers to medical necessary procedures that might not have been covered by a patient's insurance.
4. <u>Source user</u> – The user who caused the error that led to the denial.
5. <u>Source department</u> – The department that caused the error that led to the denial.

Tracking of root cause analysis also enables monitoring to measure the ongoing effectiveness of improvements. The aim of root cause analysis is to remedy the denial and to provide feedback, and ultimately to resolve the underlying issue that caused the denial in the first place. There are a number of ways that this monitoring could be implemented. One is in trend analysis of denied claims for which specific solutions have been enacted. Epic's *Hospital Billing Denial Prevention and Management Strategy Handbook* suggests setting up a dedicated account work queue to catch denials that should have been prevented by past efforts. Any records that end up in this work queue should be investigated to determine why they were not prevented. These options should be considered by management to measure the success of Denials Management efforts.

Finally, we noted that communication of denial data and trends appeared to be contained within members of the Denials Task Force. While some focused review of denials data has been initiated for certain areas (such as Moores Cancer Center), processes had not been established to consistently communicate information on denial data trends to management in the clinical service areas.   This limits management's visibility into these trends, and precludes collaboration to implement solutions to reduce denials in their areas.

B.	Referrals to Clinical Appeals
Processes and criteria for referral of denied claims to Clinical Appeals were not well defined.	
Risk Statement/Effect	
Lack of clearly defined processes could increase the risk of ineffective processes, which may impact the timeliness of filing appeals on denied claims.	
Management Action Plan	
B.1	Management is in process of redesigning the workflow for the referral of denials to Clinical Appeals, to ensure the denials with a clinical component are getting correctly routed and reviewed based on the skill and expertise of staff and all pertinent information is communicated at the time of the referral.

B.   Referrals to Clinical Appeals – Detailed Discussion

PFS staff reviewing denied claims as part of routine follow-up activities may route claims denied for clinical reason to the Clinical Appeals staff. All PFS staff working denials may make a determination that the denied claim under review should be forwarded to CA. However, the criteria for how this referral was conducted, and the information gathered in the process, was not clearly defined. Currently, CA receives all medical related denials from PFS, including simple requests for medical records. Consideration should be given to coordinating efforts between Clinical Appeals and other teams within PFS (commercial and governmental payer teams) so that the appropriate denials triage could be performed by these units. The goal of such coordination is to ensure that the appropriate denials are sent to CA, and everyone works denials based on their ability and skill set.

We also noted that information regarding a denied claim, that has been verified and potentially updated by PFS staff as they review the claim with the payer, has not been consistently communicated to Clinical Appeals when the claim has been referred to them. This may include the reason for the denial, specific dates of service denied, the level of appeal requested, appeal deadline, and address appeal should be sent to. Clinical Appeals staff reported that obtaining this information often required additional research, increasing the time it takes for them to process an appeal. Standardizing the information that is forwarded to Clinical Appeals, and perhaps including a list of smart phrases that would appear on the screen once the referral was made would ensure that key elements of the denials would be captured.

We also noted that the two-step process by which PFS staff triaged and referred denials to CA was confusing. Some menu choices have been misinterpreted by staff such that their selection lead them to inadvertently send the denial back to themselves. For example, the Denial Status "Clinical Appeal Requested" will route the record to Clinical Appeals. Other menu selections included "Level 1 Clinical Denial Appealed", "Level 2 Clinical Denial Appealed", or "Level 3 Clinical Denial Appealed" which may lead to confusion. The issue is further complicated by the fact that the error may not be noticed immediately because the denials winds up back in PFS staff's queue. These repeated "touches" of a denial add no value and just further delay a claim that may be time-sensitive to appeal.

Management is in process of redesigning the workflow for the referral of denials to Clinical Appeals. This will include a triage process performed within Clinical Appeals to better ensure that all necessary information is captured, and denials of this type are appropriately routed and reviewed.