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FEATURE STORY

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dedicating the right resources to denials management

Full-time physician attention helped reduce one health system's denied claims and length of stay.

ABOUT MERCY HEALTH SYSTEM

Mercy Health System (Mercy), a member of Catholic Health East, is a diverse, integrated system providing comprehensive health-care services to the Philadelphia community. Based in Conshohocken, Pa., Mercy comprises five acute-care hospitals, several ambulatory care centers, physician practices, two skilled nursing facilities, an independent living facility, a home healthcare company, and managed care plans. With more than 8,000 employees, the health system serves over 500,000 patients and 600,000 HMO enrollees annually.

In early 2000, Conshohocken, Pa.-based Mercy Health System decided to carefully evaluate the rate at which its managed payers were denying payment of claims. Mercy's leaders learned that the organization was experiencing a denial and downgrade rate of 25.4 percent for managed care medical/surgical days, excluding particular services such as obstetrics or behavioral health, amounting to \$13.3 million each year in lost revenue to the system. They realized that in addition to having a profound fiscal impact on hospital revenue, managed care denials were undermining the organization's mission. Something had to be done.

Managed care denials and length of stay (LOS) issues are profoundly affecting the bottom line of hospitals throughout the United States. Many U.S. hospitals are experiencing denials as high as 20 percent of total patient days, affecting 10 to 15 percent of overall revenues. According to the Advisory Board Company, denials are usually split fairly evenly between medical-necessity denials and technical denials. (See the Advisory Board white paper *Capturing Lost Revenues: Best Practices for Minimizing Managed Care Denials*, September 2001). While these denials have been traditionally written off, many of them are recoverable.

Most hospitals are aware of the importance of denials management and have some type of ad hoc solution in place. The program that Mercy created to address its problem is in many ways exemplary.

A Case Study: Mercy Health System

To aggressively address managed care denials, Mercy recognized that a comprehensive approach to denials and LOS management was needed. The health system's first order of business was to assess the extent of the problem.

Under the leadership of the health system's chief medical officer, Mercy's denials team evaluated denials by calculating their percentage and dollar impact on managed care days excluding particular services, such as obstetrics or behavioral health. Hospitals that examine denials only as a percentage of total revenue or total days often dilute the perceived impact that they have on the bottom line.

ADDITIONAL RESOURCE

Check out HFMA's "Tip Sheet: Medical Claims Denial Management," www.hfma.org/resource/focus_areas/patient_financial_svcs/tools/claims_denial_management.htm. This document suggests different ways of appealing denied claims and methods to prevent future denials.

The analysis by Mercy's team turned up the dismaying results described. When they looked at Mercy's appeal processes, they found that an unacceptably small percentage of denials and downgrades were appealed while the patient was still in the hospital, and too few were overturned. Moreover, cases were rarely followed through multiple levels of appeal.

The managed care organizations with which Mercy contracted were performing daily utilization review and regularly issuing denials and downgrades based on lack of medical necessity. Yet Mercy had no standard, quantifiable approach to appeal these medical-necessity denials. After a patient was discharged from the hospital, it fell to the case management department to write letters of appeal, track results, and navigate multiple levels of the appeal process—a cumbersome, time-consuming routine that was often relegated to the bottom of a long to-do list.

Mercy's team reviewed best practices at other institutions both locally and nationally, but could not identify any organization with an internal solution focusing *solely* on reducing days denied and downgraded due to questions of medical necessity. The team understood, however, that Mercy could never meet the day-to-day challenges posed by medical-necessity denials without dedicating sufficient resources to the effort.

Mercy's denials team recommended that the denials management program should be managed by a team of physician advisers who could build solid, professional working relationships with the managed care organizations, develop a standard process for managing denials, and assume accountability for results. These individuals would be charged with evaluating past performance and establishing benchmarks for future performance, including facility-specific goals. Progress would be tracked monthly.

Faced with a "buy-versus-build" decision, Mercy decided to outsource for several reasons. First, the organization estimated that it would take six to 12 months to build an internal team to tackle the job, versus several weeks for an outsourced solution. Second, Mercy had limited internal resources to devote to this important activity.

Implementation

Mercy initially introduced the denials management program at three hospitals. In the first full year of operation, all concurrent denials were referred to the physician advisers, who were able to overturn inappropriate denials and downgrades while the patient

was in the hospital in almost half of the cases. In the retrospective appeals process, Mercy appealed almost 75 percent of the days that were denied or downgraded, with an overturn rate of 40 percent when the physician advisers wrote the appeal letters. Mercy was then able to track appeals through multiple levels of complex appeals processes, adhere to mandated timelines, and pursue appeals to the fullest extent possible.

One of the strategies used was to mandate that *all* denials, not just those deemed inappropriate by the clinical staff, be referred to the physician advisers for review. Having a full-time team of well-qualified physician advisers was a key success factor. The advisers were able to look beyond the intensity-of-service and acuity-of-illness criteria typically used to assess medical necessity and examine a case for clinical uncertainty—asking questions such as "How sure are we that this patient is headed in the right direction?" For a clinician, such questions can be the most difficult part of patient management, yet they often are neglected by criteria-based utilization review.

Results

In the year following implementation of the denials management program, Mercy tracked a consistent decrease in medical-necessity denials. Although results varied among Mercy's facilities, denials declined by 18 percent annually, on average, amounting to a \$2.2 million savings for the health system in the first year of the program.

A major contributing factor to this success was improved communication that was facilitated by the physician advisers. They were speaking with Mercy attending physicians to obtain more information about cases. These conversations led to a positive change in physician behavior and an improved working relationship with Mercy's case management staff. The case managers were relieved of one of their most frustrating responsibilities, serving as the intermediary between attending physicians and the payers, and freed for more productive clinical case management work.

Focus on LOS

With the approach to medical-necessity denials and downgrades established, Mercy turned its attention to managing LOS. They recognized that when a denial is appropriate and a patient does not need to be in the hospital, or when payment is in the form of a case rate and the hospital does not efficiently move a patient through the process of care, the hospital loses revenue and incurs additional costs. The hospital not only fails

STEPS TO EFFECTIVE DENIALS/LENGTH OF STAY (LOS) MANAGEMENT

Managing denials and LOS requires a multistep plan involving multiple departments. The following outlines the most important steps:

Develop resources specifically dedicated to denials and LOS.

Depending on your organization's size, appoint a denials/LOS coordinator and/or denials management team to provide physician support specifically devoted to identifying problems leading to medical-necessity denials or high LOS and implementing solutions. The dedicated coordinator or task force should be responsible for receiving and consolidating information on denials and/or LOS, ensuring the data are entered into the system, assigning follow-up duties, and communicating results with senior management.

Relatively few healthcare providers have such a resource. All too often,

denials/LOS coordination falls to a hospital administrator who already has many other responsibilities. A vice president of medical affairs, for example, rarely has time to devote to the day-to-day medical support necessary to manage denials.

The program should have a dedicated and experienced physician adviser resource available 24/7 to give case management access to physician support when and where they need it. The physician adviser should be focused on this as a career, not a secondary responsibility. Part-time advisers or administrators with other responsibilities often lack the training, experience, or incentives to meet the hospital's goals. At a minimum, the physician adviser's qualifications should include thorough training in utilization review, managed care, and contract negotiation.

Analyze the reasons behind denials and increased LOS.

To ensure the program is on target to achieve its goals, systematically analyze trends of denials and downgrades, identify the root causes of underpayments, and focus on the core reasons for LOS variances. And be sure to compare "apples to apples." For example, when analyzing Medicare LOS for congestive heart failure, compare July 2002 with July 2003 rather than July 2002 with August 2002. Seasonal variation in patient demographics makes consecutive-month analysis misleading.

Also, continue the analysis over a long period, and be willing to change focus. For example, the data initially may show that outpatient testing in an inpatient setting is the largest contributor to clinical denials, but later, delayed

discharges may become the leading culprit, necessitating a significant change in the denial reduction strategy. Monthly and rolling quarterly reports, therefore, are a minimum analytical requirement.

Don't let workplace "silos" obstruct information sharing.

Communication between the business office and clinical participants in the revenue cycle should be easy and frequent. Physician advisers and case managers should work closely with directors of managed care and revenue-cycle managers. Clinical denials can often be addressed contractually, but only if the contractors understand that a problem exists and recognize its potential financial impact. For example, a hospital with adequate market leverage might be able to negotiate a contract provision ensuring payment for weekend stays

while patients wait for cardiac catheterizations scheduled for Monday. Also, case managers and physician advisers who understand contractual terms and payer responsibilities will be able to enforce those terms. For example, payers may pledge to assist in discharge planning, but they will never be referred cases if case managers are not aware of this obligation.

Monitor and internally publicize results. Many root causes of denials and downgrades may be ingrained and accepted as a "fait accompli." Publicizing results shows staff that they can make a difference, empowering future change. But change also depends on the resources brought to bear—the greater the effort put into decreasing denials and LOS, the greater the impact on the bottom line.

to obtain payment to cover the direct expense of caring for the patient, but also must divert patients in the emergency department to other facilities because of a lack of available bed space.

Mercy's analysis focused on one of the organization's hospitals as a pilot facility. This facility felt that patient throughput was a problem and that its LOS could be reduced to fall under benchmark goals. On further analysis, it became clear that the high LOS was attributable to repetitive patterns among certain physicians and among certain groups of diagnoses. Accounting for only the direct cost of caring for patients (one conservative industry estimate being \$300 per day), the extra days were costing Mercy well over \$1 million annually and were hurting hospital throughput.

Mercy placed a physician adviser on-site at the pilot hospital for four hours a day, with the sole purpose of facilitating communication and the process of care. While other physician advisers worked aggressively on reducing denials, this adviser's role was to assist and educate physicians on ways to appropriately improve

LOS. Because the physician adviser had no referring relationship with any of Mercy's physicians and was not involved in hospital politics, he was able to work with each case solely on its merits, building credibility with both attending staff and case managers.

The physician adviser's LOS process included the following key steps:

- > Review problem cases with the case management team each morning.
- > Review charts and speak with the attending physicians, as appropriate.
- > If a plan of care has not been established, work with the physician to ensure one is developed, documented, and communicated to case management and discharge planning.
- > If multiple physicians are managing a case, ensure that they all have communicated with each other and that one lead physician is in charge of overall management.
- > Assist the attending staff in prioritizing and organizing workload, and serve as a resource to reduce the workload and improve patient care.

10 QUALITIES OF A GOOD PHYSICIAN ADVISER

- Strong diplomatic skills
- Solid clinical skills, with a respect for different approaches to the same clinical issue
- Excellent phone skills
- Exceptional negotiation skills, with the ability to win friends and influence enemies
- Strong ability to review, understand, and implement regulatory rules
- Well versed in usual standards used by managed care plans, such as Interqual and Milliman
- Not involved in a referral relationship with attending staff
- Respected by attending staff
- Well informed about the financial impact of denials and LOS
- Passionate about not only making a financial difference, but also improving quality of care

Source: Executive Health Resources, "Bringing Clinical Solutions to Revenue Cycle Management," HFMA's Fall 2003 Revenue Cycle Strategies Conference, Las Vegas, Nevada, October 18-21, 2003.

The pilot hospital saw an immediate decrease in LOS upon implementing the program. Within two months, LOS had normalized within the benchmark goals. More importantly, the attending staff became more open and accustomed to using the physician adviser as a resource. An anecdotal indicator of the program's success came when one of the physicians who was least open to the physician adviser model began to request that the physician adviser be notified on the day his patients were admitted.

Looking Ahead

Mercy is currently evaluating how best to expand on the lessons learned from the LOS pilot throughout the entire system. Recognizing that each hospital in the system has specific challenges, Mercy is brainstorming to create custom solutions on a facility level within the existing framework.

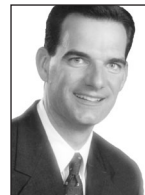
The pilot program has evolved, as well. The program's progress in educating the hospital's physicians and controlling LOS reduced the need for the physician

adviser to be on-site at the pilot organization. The adviser is now on-site only two days a week and handles LOS issues remotely on the other days, freeing him for assignment at Mercy's other facilities. In addition, Mercy is rolling out a program to focus on managing LOS for particular problem diagnoses, in which the physician adviser intervenes early in a hospital stay to ensure a plan of care is formulated, documented, and communicated throughout the care continuum.

Coordination Is Key

Whether your organization has the internal resources to develop an in-house denials/LOS management program or believes an outsourced solution is more beneficial, such a program should be regarded as critical to the bottom line. The sidebar on the previous page offers some tips toward optimizing your organization's approach. But it is important to remember that success depends on the awareness and full involvement of *everyone* involved in the revenue cycle. Whoever is charged with coordinating denials/LOS management must be personable and persuasive—able to establish relationships with your staff that foster cooperation and a commitment to being a part of the solution. ■

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