

# MANAGED HEALTHCARE EXECUTIVE®

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## Denial management programs can improve the revenue cycle, decrease AR

Physician advisor programs help with concurrent and retrospective appeals, length-of-stay management

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**T**HE TRADITIONAL NOTION, “It is not accounts receivable (AR) if I write it off,” can undermine not only revenue, but process improvements aimed at maximizing the revenue cycle. By artificially decreasing AR measurements, you contaminate the outcome of your financials. More importantly, this problem is magnified when revenue cycle analysis leads you to correct the wrong problems and worsen your overall performance. AR metrics are valuable, but when evaluating AR, it is important to remember what it is and what it is not.

■ AR is not just the last step in the revenue cycle; it is a critical aspect of the revenue cycle continuum.

■ AR is not a silo; it is not an end in itself, rather it is

part of the larger financial picture.

■ AR is a valuable metric; it is a tool that can help an institution evaluate why it is not getting paid up front.

But the goal is not having the shortest AR turnaround; the goal is turning your AR into the hard dollars your institution deserves.

One of the issues that is paramount in today's AR milieu is denials. By appropriately overturning denials and underpayments, an institution can drastically reduce AR days, increase collections, and save a significant sum of money. For example, one 700-bed, Philadelphia-based institution that implemented a comprehensive, outsourced physician advisor program decreased denied and downgraded days from 8% to 4% (as a percentage of total managed care days) and AR days from 80 to 58 over a year, increased cash collections by \$50 million in the past 18 months, and saved close to \$1.9 million.

When looking at implementing a denial management program, it is important to remember that the earlier a denial is overturned, the greater the positive impact on AR.

### THE NATURE OF DENIALS

There are three different types of denials: clinical denials, underpayments and technical denials. Clinical denials are issued by managed care after performing utilization review and are based on “a lack of medical necessity.” Underpayments are essentially denials and occur when a complex contract is not applied appropriately, resulting in a reimbursement that is less than the amount owed. Usually underpayment issues can be solved with software that helps to appropriately apply the payer contracts.

Finally, technical denials occur when a hospital fails to comply with administrative procedures required by the payer company in order to receive payments. Avoiding technical denials requires an understanding of the admissions and care process.

Most hospitals have some type of ad hoc solution in place to try to manage the denial process. But effectively managing denials requires a comprehensive, multistep plan involving multiple departments and coordination of each element of the revenue cycle. Some organizations are putting more dedicated, full-time resources into physician advisor programs while others are moving to an outsourced model that allows them to focus on their own core competencies. In broad terms, a physician advisor program can help a hospital in four areas:

- Concurrent appeals;
- Retrospective appeals process;
- Accurate, thorough documentation; and
- Length-of-stay management.

**ADMINISTRATIVE CONCERNS**

Concurrently appealing denials helps hospitals and care facilities:

- Identify process breakdowns in real time;
- Track and solve root causes more easily and efficiently;
- Reduce administrative processes; and
- Keep payers accountable by requiring a “personal” justification for denials made by a payer’s medical director.

Most importantly, establishing a process for managing concurrent denials turns the issue of denials from a liability to an asset.

Not only are denials eliminated up front so denied days never hit your AR, but also the high cost of variance collections is avoided. A denial management program creates point-of-service physician education, which can impact future compliance—improving documentation and resulting in fewer future denials. Additionally, a denial management program can impact patient safety and improve quality of care.

The financial impact of denials creates an impetus for a review of the entire system



**Managing concurrent denials turns the issue of denials from a liability to an asset.**

of care, including clinical and operational implications that ultimately benefit both hospital and patient.

Retrospective appeals are often long and onerous. The cost of collection rises dramatically (often 600% to 700%) once a patient leaves the hospital.

Both concurrent and retrospective ap-

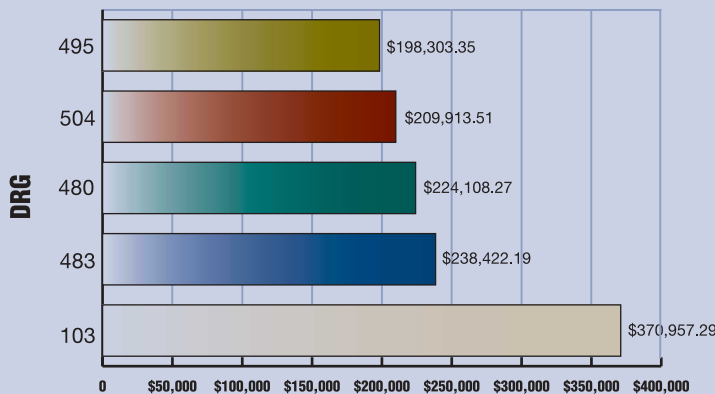
peals have the same financial result on AR, but the latter leaves denied days hanging on AR for three months to a year. From a financial standpoint, a hospital has two options: Write off denials that can potentially be overturned retrospectively, or aggressively work to appeal them. To be successful with the retrospective appeals process, however, it is important to develop a comprehensive program and follow through on cases that are in the retrospective-appeals pipeline at every level of appeal.

Hospitals have several options when looking to implement physician advisor programs and denial management processes. Some use one or a few attending physicians or a part-time physician advisor to implement a denial management program.

However, many hospitals are moving to hire full-time physician advisors, build in-house teams of physician advisors, or outsource denial management programs to businesses that create, implement, and maintain full-service physician advisor programs. MHE

**DATA INSIGHTS**

**Top DRG by Average Charge per Case**



DRG	Description
103	Heart Transplant
483	Tracheostomy Except for Face, Mouth & Neck Diagnosis
480	Liver Transplant
504	Extensive Third-degree Burns with Skin Graft
495	Lung Transplant

MHEGRAPHIC

MHE Source: HealthMarketInsights

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