Prevent denials. Win appeals.

A best practice playbook for revenue cycle teams

Xtend Healthcare

This playbook provides best practice insights to help you and your revenue cycle team **identify and address** the root causes of denials to **prevent** them from happening.

For denials that do happen, you'll also **find our time-tested appeal strategies**.

Denied claims are a large and growing problem for healthcare providers, impacting cash flow velocity, staff workloads, and patient outcomes.

- **12%** of claims are initially denied, resulting in **$3B** in denied claims nationwide
- **89%** of health systems saw an increase in denied claims during the past three years
- Each claim worked manually takes up to **51** additional minutes of administrative time
- Patients experiencing denied claims are more than **twice as likely** to experience a decline in their health status, versus those who don't

The good news? It's an addressable problem.

- **90%** of denied claims are preventable
- It's more efficient and effective – for workflow and cash flow – to prevent denials before they happen
- **51%** of revenue cycle leaders report plans to be more aggressive in challenging denial claims

Prevention

Dig down to the roots

Start by uncovering the source of your denials. As a reference point, consider the results of an Experian Health survey of 200 healthcare professionals. Respondents shared the factors that most often played a role in denials. Their top three cited factors were:

- **Prior authorization** issues, impacting **48%** of denials
- **Eligibility** issues, impacting **42%** of denials
- **Coding** inaccuracies, impacting **42%** of denials

Once you understand your own key drivers of denials, find the issues that are causing them. These may include:

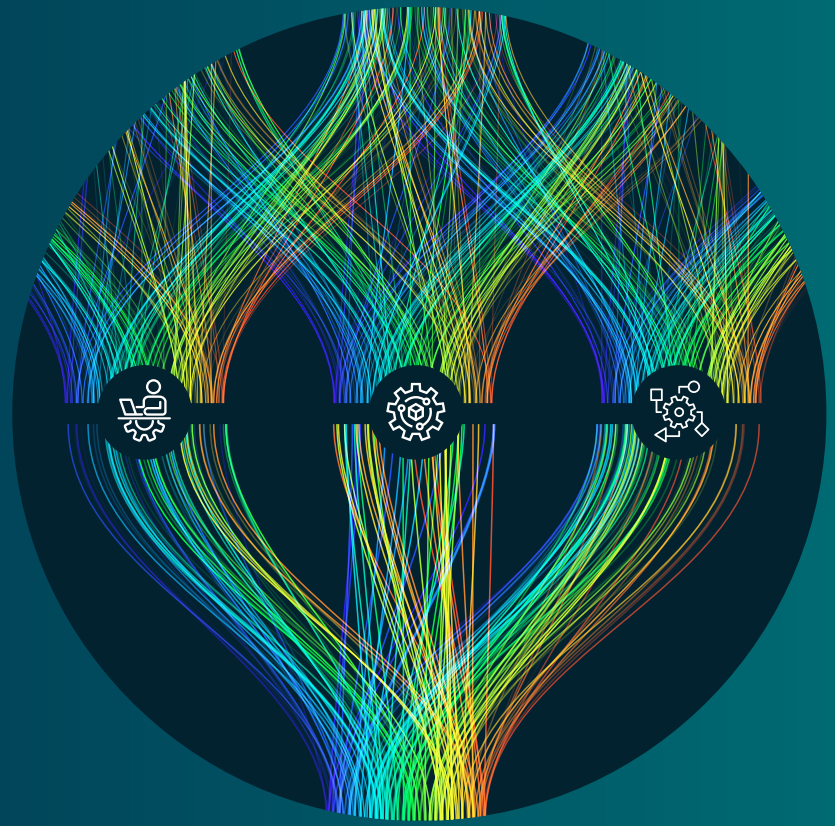
- Insufficient data and analytics
- Lack of automation
- Staff attrition and insufficient training
- Technology challenges
- Inefficient tracking of payers' policy changes

Equip your staff with tools and training to keep up with payer policy changes. Data from just a single issue of Health Affairs highlight the pace of change in this area.

995
new Aetna clinical policy bulletins describing coverage rules

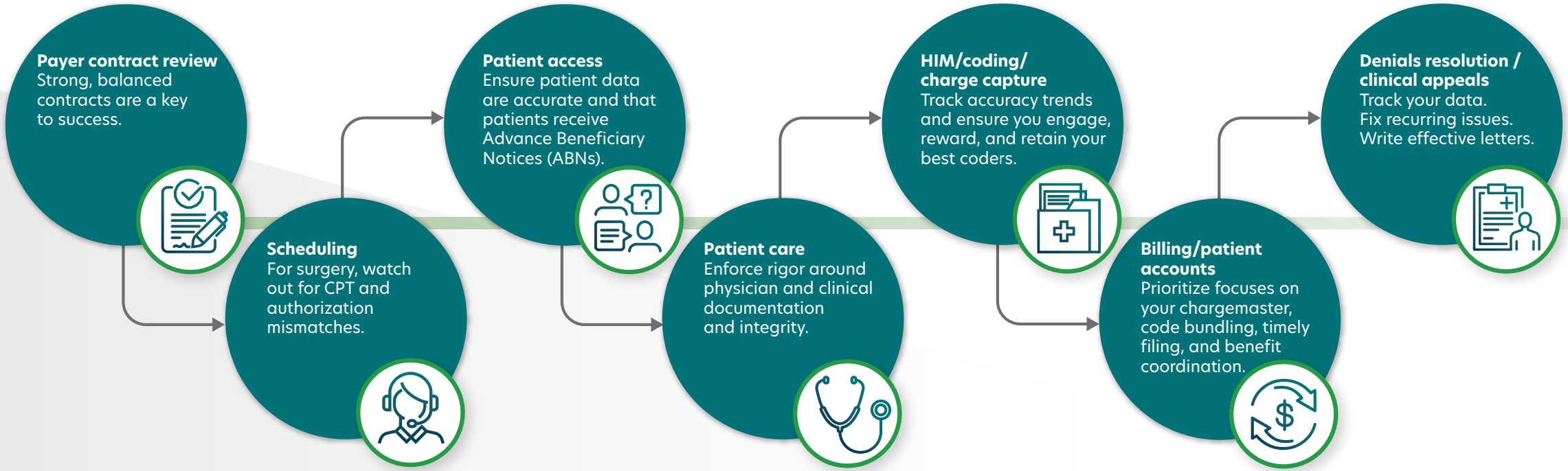
348
new national Medicare coverage determinations issued

1,007
new local Medicare coverage determinations issued



Take an end-to-end view

At every step along your revenue cycle workflow, there are opportunities to reduce the likelihood of denials. Here are just a few suggestions that can make a big difference...



Harness predictive insights from your data

Using denial data to identify root causes is critical. Your data analysis should be able to identify trends by payer, provider, specific diagnostic tests, and other key factors.

Document and track denial reasons using remittance advisements

Keep a close eye on Claim Adjustment Reason Codes (CARCs), as they indicate the reasons for payment adjustments and denials. In particular, watch for the "not medically necessary" reason. Look into the underlying causes of these denials, and conduct internal reviews to drill down and address on core issues.

Identify patterns and trends to inform your denial-management strategies

In addition to CARC codes, analyze coding data from across your entire process to uncover trends that can help you improve coding accuracy.

For example, your data can assist you in identifying particularly denial-prone codes, so you can anticipate and address related denials before they even happen.

Add intelligent automation and targeted training too, for a foundation that will help you solve denials at a macro-level scale.

SPOTLIGHT ON
prior authorization

Given the outsized role prior authorizations can play in your denial prevention strategy, let's look at a few key best practices you should consider.

- **Establish** policies and procedures that:
  - Lay out the **services and medications** requiring preapproval
  - Specify the **information** that must be included in the approval request
  - Spell out **timelines** for each step and for the overall process
- **Follow** evidence-based guidelines to optimize process efficiency, provider performance, and patient outcomes
- **Automate** whatever you can to improve data accuracy, accelerate cash velocity, and maintain a positive patient experience
- **Train** staff on tools and processes, and keep their training current over time
- **Monitor** trends and outcomes, and adjust as needed to improve over time

78%
of organizations that automate prior authorization processes see positive results for both patients and revenue

SPOTLIGHT ON
prior authorization

Activate the power of people

Transparent, timely, frequent, and customized communication can help you avoid prior authorization issues that cause denials.

Partner with health plans

Ensure you and your staff understand the criteria and requirements of prior authorization and have avenues for staying on top of changes.

Employ dedicated specialists

Hiring a dedicated prior authorization specialist can help your team:

- Stay current on the latest policies and procedures
- Collaborate effectively with health plans to resolve issues
- Process authorizations quickly and efficiently

Engage patients in the process

Open lines of communication with patients can:

- Keep patients apprised of the status of their authorization
- Reduce volumes of incoming calls and other queries to your staff

SPOTLIGHT ON **eligibility**

Eligibility denials are costly because they always result in an entire claim being denied. They're also administratively expensive, due to their significant manual data entry and verification demands.

Automation can solve these challenges by **reducing errors and accelerating processing times**. For example...

Use a combination of machine learning and application programming interfaces (APIs) to streamline the eligibility process: **integrate with online real-time eligibility (RTE) verification systems** to automatically verify a patient's coverage under Medicare, Medicaid, and numerous commercial health insurance plans and update your system accordingly.

ONLY 24%

of practices check eligibility at every visit. This leaves the door open to errors, denials, and lost revenue.

Appeals

A strong, consistent appeals strategy can benefit your system in many ways.

- **Financial stability:** Successful appeals ensure you receive rightful reimbursement for services rendered, prevent financial instability, and support ongoing goals and operations.
- **Patient advocacy:** By challenging claims, you demonstrate your commitment to helping patients achieve the best outcomes and avoid unexpected expenses.
- **Compliance and regulatory adherence:** Through denial challenges, you demonstrate your adherence to coding and billing guidelines and mitigate your risk of regulatory penalties.
- **Data-driven decision making:** The appeal process generates data on denial reasons, data you can then use to make informed investments in training, technology, and other resources.

Make it a goal to submit appeals for

85-90%

of denied claims, wherever there is documentation to support the original coding

Don't just appeal the big charges

Failing to appeal numerous smaller charges can leave money on the table and affect your patient experience. Use automation to resolve smaller-value denials and free up your staff to focus elsewhere.

5 TIPS

for writing effective appeal letters

No denials strategy can succeed without effective appeal letters. Assemble a talented, dedicated team to write your letters, empower them with the authority, access, and time they need, and follow these five practices to ensure positive appeal outcomes:

Be brief

Keep letters concise and focused on the reason for the denial. Payers don't want to sift through unrelated information to get to the point.

Involve both clinical and coding experts

Make sure clinical nurse appeals specialists and coding teams are involved, whenever appropriate.

Cite the record at hand

Include documentation as supporting content.

Provide detailed context to support the appeal and how it specifically relates to the denial reason.

Reference pertinent guidelines

These can include commercial medical necessity screening criteria, federal regulations, and coding clinic guidelines.

Demonstrate your authority

Include the relevant credentials of those who reviewed and were involved in the appeal (e.g., physicians, nurses, and pharmacists).

Xtend Healthcare

Time to address your organization's denials situation?

It's time for Xtend Healthcare.

Our revenue cycle solutions will help you optimize your cash flow – and your patient experience – so you can deliver on your mission.

Contact us today for a no-obligation analysis of your revenue cycle.

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