SUCCESS STORIES - SUMMARY

Project Name	Client	Brief Description	Key Analyses
Claims Denial Analysis	LTAC Provider (Long-term acute care)	**Analyzed claims denial data to identify denial reasons, monitor and track denials** leading to effective denial management strategies and reduction in revenue loss, AR (accounts receivable) and bad debt.	Claim denial analysis

ANALYZING CLAIM DENIALS TO MINIMIZE REVENUE LOSS AND ACCELERATE CASH COLLECTIONS

ABOUT THE CLIENT

Client is a healthcare services company that operates long-term acute-care hospitals and provides rehabilitation services across U.S.

SITUATION

- Client wanted to **analyze their Claim Denials** to **identify reasons for denials and recognize opportunities to prevent/correct** the issues that cause denials
- Merilytics partnered with the Provider to understand, clean and analyze the **denial data to build reports in order to track denials by insurer, hospital & region and help them develop effective denial management strategies**

VALUE ADDITION

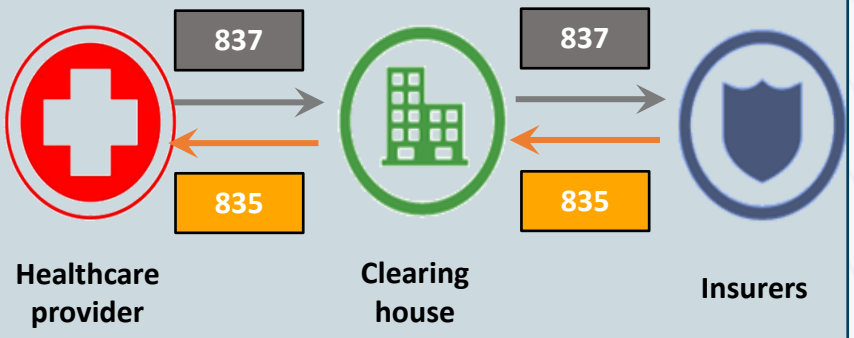
- **Developed a methodology** to bring all relevant claims for a patient together across the claims process. **Created a mapping** to assign denials by technical and clinical types using the reason codes (CARC/RARC)
- Cleaned up the denials (835 claim remittance) data and **integrated it to the billing data** to analyze denied amounts and reasons
- **Built reports / Dashboards on Design Studio (SAP)** to track the top denial reasons, denied amount, turnaround time by payor, facility and region
- Developed a model to estimate **the potential impact on cash and P&L for 2020 budget** due to revenue cycle management initiatives
- **Developed Payor score cards** that drive on-going Payor management and discussions during contract negotiations

IMPACT

- **Reduction in revenue loss, AR (accounts receivable) and bad debt** caused by denials
- **Accelerated cash collections** from insurers due to proactive identification of bills for appeal or resubmission
- **Increased transparency into the denial data** enabled the company to better monitor and track denials

835 DENIALS ANALYSIS – DATA OVERVIEW

Claim and Remittance communication



- **837** – Sent by Healthcare provider regarding **claim information** to payors (Insurance companies)
- **835** – Sent by Payors regarding **payment (remittance) information** to the providers

- 835 files provide **what charges were paid or denied** and **reason codes** for denials (CARCs, RARCs)
- **CARC** (Claim Adjustment Reason Code) – Communicates a reason for a payment denial
- **RARC** (Remittance Advice Remark Code) – Provides additional info to what already said by CARC

- Reason codes are classified into two types – Technical and Clinical Denials
- **Technical Denial** – related to administrative features of claim
- **Clinical Denial** – related to medical necessity or authorization

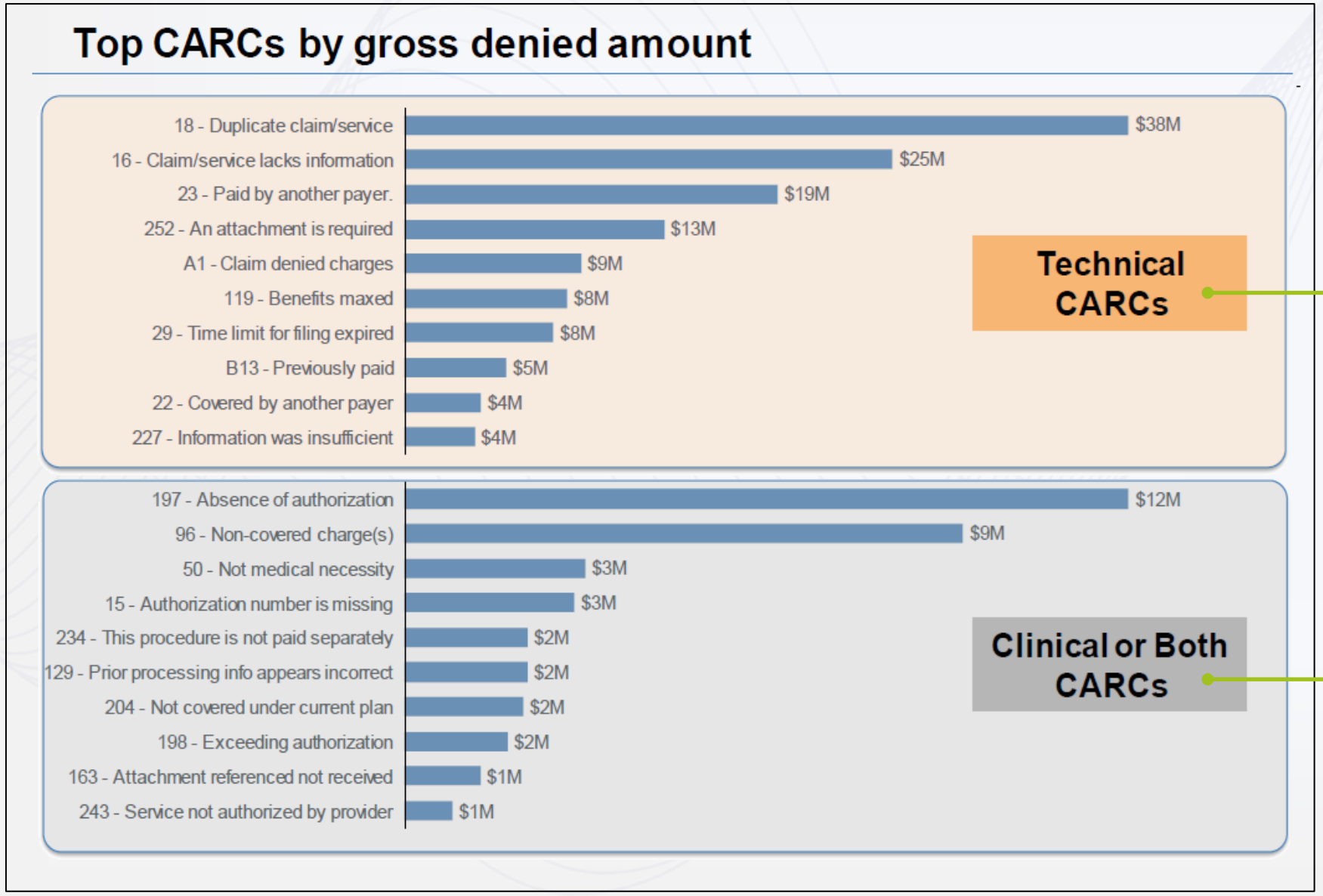
What is tracked?

Denied amount ($)	Outstanding AR ($)
Denial rate (%)	Collection rate (%)
# Days to Pay	# Days to Closure
Denial Reasons by $ share	Top Payors by $ share
Top facilities by $ share	Bad debt and Write-offs

Some challenges

- Data in 835 is **encrypted** and needs **parsing** – requires manual effort and delay in accessing data
- **Multiple claims** in a **single 835 file** – difficult to reconcile/track at a claim level
- **Inconsistent filing** across multiple insurers
- **Duplicate** submitted claims by insurers – needs deduplication
- **Multiple RARC/CARC** codes used for same reason at different locations/payors
- Identifying the actual **contractual adjustments** vs. **denied claim amount**

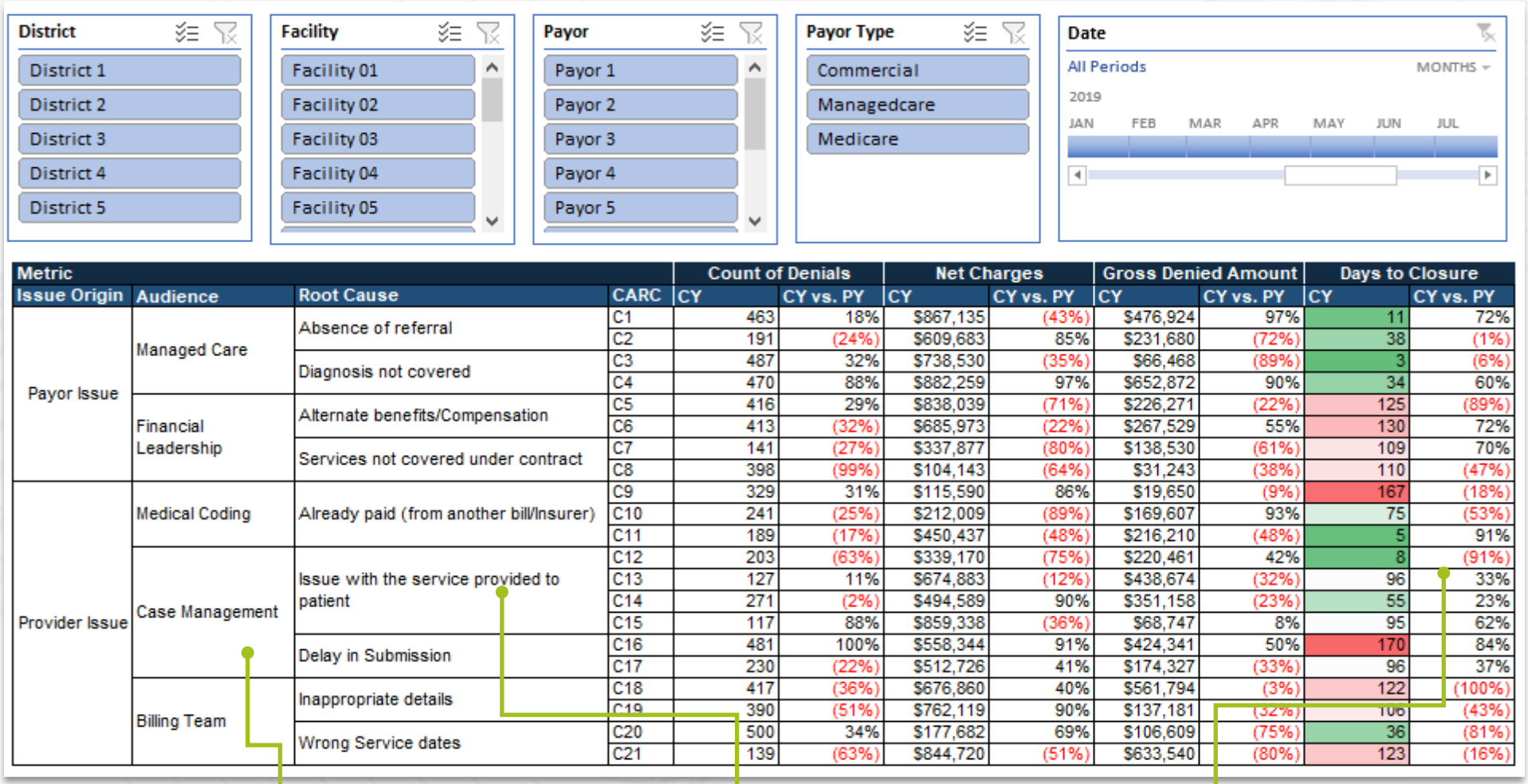
ASSIGNED CARC CODES TO EACH BILL AND IDENTIFIED TOP CARC CODES BY GROSS DENIED AMOUNT



- **Top 10 Technical CARCs** by gross denied amount
- The reasons are due to administrative or technical aspects of the claim

- **Top 10 Clinical/Both type CARCs** by gross denied amount
- Clinical CARCs are of clinical/medical in nature such as non-medical necessity or authorization
- A CARC is classified as 'Both' if it has the features of both Technical and Clinical CARC

DENIAL REPORTING - IMPACT OF MULTIPLE REASONS ACROSS ALL PAYORS



Metric				Count of Denials		Net Charges		Gross Denied Amount		Days to Closure	
Issue Origin	Audience	Root Cause	CARC	CY	CY vs. PY	CY	CY vs. PY	CY	CY vs. PY	CY	CY vs. PY
Payor Issue	Managed Care	Absence of referral	C1	463	18%	$867,135	(43%)	$476,924	97%	11	72%
			C2	191	(24%)	$609,683	85%	$231,680	(72%)	38	(1%)
		Diagnosis not covered	C3	487	32%	$738,530	(35%)	$66,468	(89%)	3	(6%)
			C4	470	88%	$882,259	97%	$652,872	90%	34	60%
	Financial Leadership	Alternate benefits/Compensation	C5	416	29%	$838,039	(71%)	$226,271	(22%)	125	(89%)
			C6	413	(32%)	$685,973	(22%)	$267,529	55%	130	72%
		Services not covered under contract	C7	141	(27%)	$337,877	(80%)	$138,530	(61%)	109	70%
			C8	398	(99%)	$104,143	(64%)	$31,243	(38%)	110	(47%)
Provider Issue	Medical Coding	Already paid (from another bill/Insurer)	C9	329	31%	$115,590	86%	$19,650	(9%)	167	(18%)
			C10	241	(25%)	$212,009	(89%)	$169,607	93%	75	(53%)
			C11	189	(17%)	$450,437	(48%)	$216,210	(48%)	5	91%
	Case Management	Issue with the service provided to patient	C12	203	(63%)	$339,170	(75%)	$220,461	42%	8	(91%)
			C13	127	11%	$674,883	(12%)	$438,674	(32%)	96	33%
			C14	271	(2%)	$494,589	90%	$351,158	(23%)	55	23%
			C15	117	88%	$859,338	(36%)	$68,747	8%	95	62%
		Delay in Submission	C16	481	100%	$558,344	91%	$424,341	50%	170	84%
			C17	230	(22%)	$512,726	41%	$174,327	(33%)	96	37%
	Billing Team	Inappropriate details	C18	417	(36%)	$676,860	40%	$561,794	(3%)	122	(100%)
			C19	390	(51%)	$762,119	90%	$137,181	(32%)	106	(43%)
		Wrong Service dates	C20	500	34%	$177,682	69%	$106,609	(75%)	36	(81%)
			C21	139	(63%)	$844,720	(51%)	$633,540	(80%)	123	(16%)

The reasons are segregated by the **owner/audience** for immediate action

The **most frequent reasons** bucketed into categories that needs to be addressed proactively

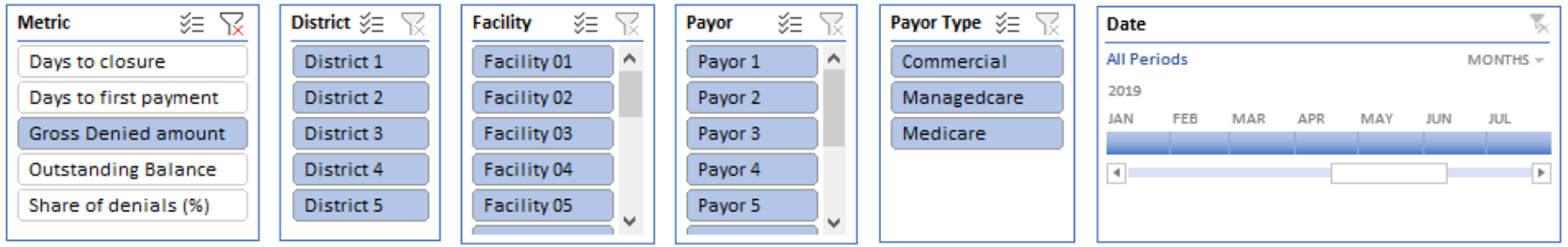
Metrics are **compared against previous periods** to measure the improvement

OTHER REPORTING

REPORTING/ANALYSIS	DESCRIPTION
PAYOR SCORECARD	Tracks the top insurers by various denial and collection metrics across different regions, facilities
RCM DASHBOARD	Tracks all the key metrics related to Revenue Cycle Management on the BI tool and then further split into detail dashboards such 'Billing', 'Sales & Marketing', 'Admissions' etc.
FLIP ANALYSIS	Analyze impact of flips (classification of patients from 'Post Intensive Care (PIC)' to 'Site Neutral (SN)' by Medicare and vice versa) on the average length of stay (ALOS), which would further impact the compliance for LTAC
2020 P&L IMPACT ANALYSIS	Estimate the potential impact on cash (reduction in AR), bad debt and write-offs due to Revenue Cycle initiatives that drive the increase in overturn rates and reduction in denial rates
MARKETING REPORTING	Tracks the marketing metrics (admits, referrals, conversion rate, overturn rate, days to auth, etc.) by month across various regions, facilities and payors
JOINT QUALITY MEETING REPORTING	These presentations consolidate key metrics around referrals, utilization and quality, that would be presented to partner referring facilities/insurers
VENDOR INVOICE RECONCILIATION	Reconciles collections claimed by the third-party collection agency with the collection data to flag the bills that are overclaimed and validate the commission invoices

APPENDIX

DENIAL REPORTING - IMPACT OF MULTIPLE REASONS ISSUED BY EACH PAYOR



Metric				Gross Denied Amount ($)							
Issue Origin	Audience	Root Cause	CARC	Payor 1	Payor 2	Payor 3	Payor 4	Payor 5	Payor 6	Payor 7	Others
Payor Issue	Managed Care	Absence of referral	C1	$212,787	$6,673	$608,817	$302,806	$1,120	$559,302	$713,176	$531,148
			C2	$804,355	$7,830	$12,162	$91,976	$101,632	$684,164	$169,929	$120,902
		Diagnosis not covered	C3	$357,804	$367,924	$117,985	$576,992	$242,882	$435,778	$118,746	$7,207
			C4	$13,193	$164,915	$398,182	$166,994	$111,821	$454,458	$103,663	$36,762
	Financial Leadership	Alternate benefits/Compensation	C5	$5,123	$265,192	$9,470	$78,597	$38,039	$217,525	$670,093	$697,774
			C6	$519,663	$40,337	$82,175	$784,678	$238,332	$102,471	$601,805	$283,437
		Services not covered under contract	C7	$190,532	$77,038	$194,074	$20,197	$104,147	$938	$191,263	$131,238
			C8	$67,808	$226,559	$1,289	$15,244	$143,746	$100,823	$604,718	$59,305
Provider Issue	Medical Coding	Already paid (from another bill/Insurer)	C9	$821,345	$3,927	$526,285	$267,964	$203,867	$631,335	$105,348	$131,365
			C10	$124,718	$15,924	$15,210	$168,584	$259,741	$533,266	$123,402	$448,438
			C11	$221,572	$576,584	$96,241	$440,208	$95,060	$682,201	$153,297	$57,276
	Case Management	Issue with the service provided to patient	C12	$266,112	$294,495	$59,146	$12,293	$209,508	$60,686	$62,448	$109,558
			C13	$612,616	$35,465	$607,673	$76,423	$94,039	$27,903	$72,260	$396,367
			C14	$83,620	$128,597	$322,327	$161,577	$32,165	$152,760	$63,689	$58,906
			C15	$111,862	$347,111	$11,453	$509,755	$5,346	$566	$250,630	$18,131
		Delay in Submission	C16	$28,887	$272,003	$162,209	$254,560	$586,156	$97,471	$442,570	$222,679
			C17	$215,370	$388,977	$701,663	$30,206	$63,176	$796,604	$108,575	$144,946
	Billing Team	Inappropriate details	C18	$33,608	$94,163	$63,240	$23,768	$422,586	$209,049	$132,365	$222,551
			C19	$1,632	$42,258	$55,367	$27,470	$301,150	$358,212	$566,531	$163,888
		Wrong Service dates	C20	$126,662	$554,624	$480,439	$4,816	$8,835	$4,904	$546,226	$486,550
			C21	$121,828	$759,916	$546,334	$53,651	$540	$435,513	$122,300	$35,645

List of **Payors with the most denied amount** help the on-field team to prioritize and initiate further discussions

Frequent reasons by each Payor to customize the action plan based on their historical denial behavior

2020 P&L IMPACT ANALYSIS

	Q1	Q2	Q3	Q4	Total P&L Impact	Total Cash
Denials % of Net Revenue						
Budgeted Net Revenue	$114,114,723	$114,114,723	$114,114,723	$114,114,723		
Historical Denial % of Revenue Baseline	5.6%	5.6%	5.6%	5.6%		
Target	5.6%	5.4%	5.2%	5.0%		
Incr (Decr)	0.0%	(0.2%)	(0.4%)	(0.6%)		
Reduction in Specific reserves and Writeoffs	$0	($2,768)	($5,536)	($8,304)	($16,608)	
Reduction in Bad Debt	$0	$0	$0	$0	$0	
Total P&L Impact	$0	($2,768)	($5,536)	($8,304)	($16,608)	
Reduction in AR	$0	$0	($138,744)	($303,306)	$0	($303,306)
Denials Collections Rate						
Outstanding Denied AR (No Reserve)	19,459,970	20,068,381	20,034,094	19,613,215		
Historical Collections Rate of AR	10.1%	10.1%	10.1%	10.1%		
Target	10.1%	10.5%	10.9%	11.2%		
Incr (Decr)	0.0%	0.4%	0.8%	1.1%		
Reduction in Bad Debt	$0	($63,258)	($126,299)	($185,469)	($375,025)	
Reduction in AR	$0	($163,669)	($490,448)	($970,319)		($970,319)
Total					($391,633)	($1,273,624)

Based on the budgeted revenue and targets for these metrics, the **reduction in reserves and bad debt** is calculated to estimate the P&L impact

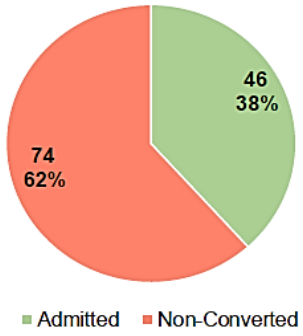
The **change in AR** (Accounts Receivable) is estimated based on change in the denials, average days to collect payments and difference collection rates of non-denials and denials

Impact of denials initiatives on Cash and P&L for 2020 are estimated using target improvements in key metrics such as **'Denials % of Net Revenue'** and **'Collections % on Outstanding denials'**

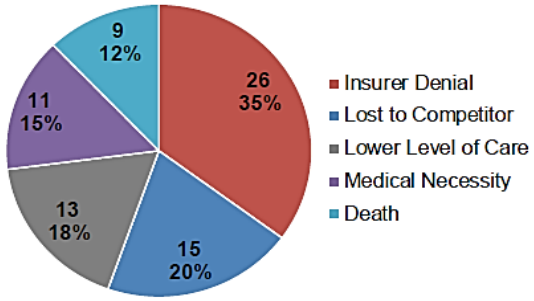
JOINT QUALITY REPORTING

/New York Hospital – Joint Quality Report (YTD OCT 2019)

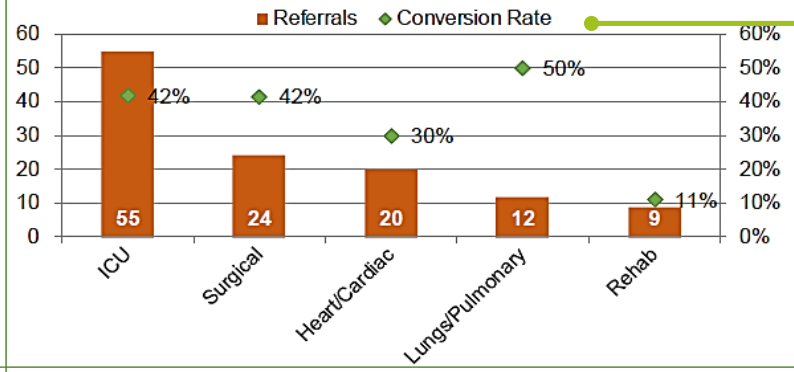
Referral Conversion



Non-Converted Referrals



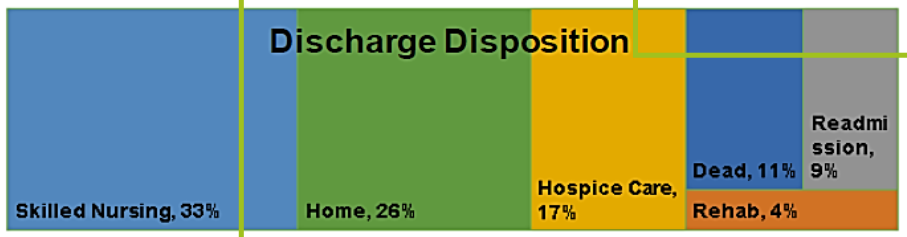
Referral conversions by Treatment Unit



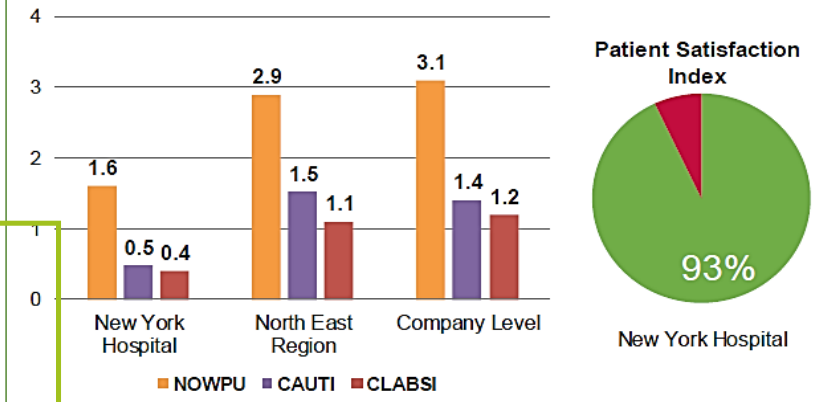
Utilization Summary

Payor Type	Discharges	Case Mix Index	LOS	GMLOS (Benchmark)	Variance
Commercial	28	1.112	18.3	20.6	-2.3
Medicare	14	1.393	26.6	27.9	-1.3
Medicaid	4	0.898	27.1	22.1	5
Total	**46**	**1.179**	**21.6**	**23.0**	**-1.4**

Discharge Disposition



Quality Indices



Quality report for the meeting between Cigna (Insurer) and New York Hospital (Facility).

Shows the **referrals by the type of treatment unit** and the corresponding conversion rate

Shows **Quality indices** like NOWPU, CAUTI, CLABSI and Patient Satisfaction Index. These are tracked against region level and company level numbers to gauge the hospital facility.

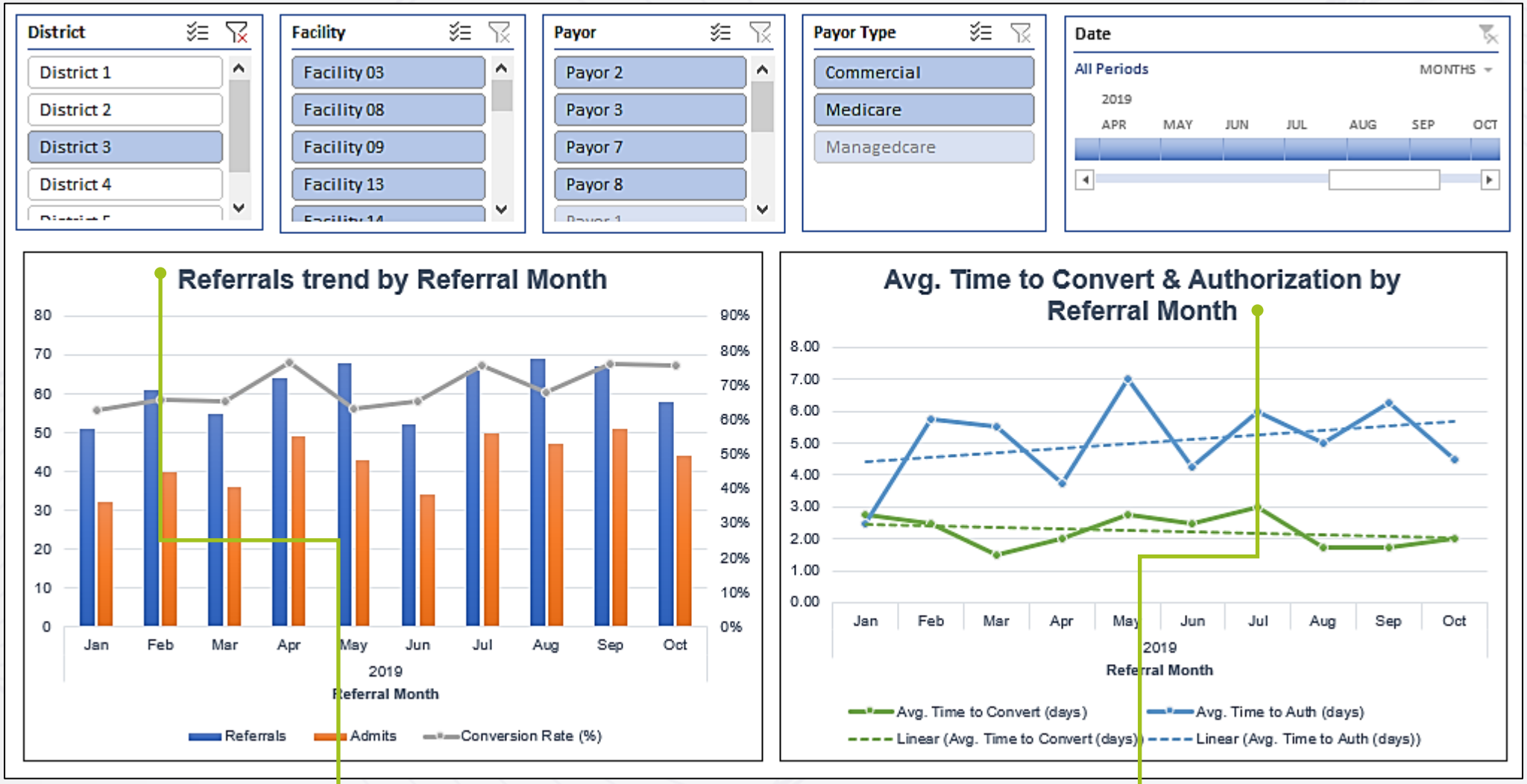
Additional Exhibits for the other reports

Shows **referrals and admits** of the patients with insurance as 'Cigna'. Shows the **reasons for non-conversion** of referrals.

The **utilization** is tracked based on **Case Mix Index** and **Average Length of Stay (LOS)** by payor types. The LOS is tracked against the benchmark GMLOS to comply with the standards. The **discharge disposition** indicates the condition of the patient at the time of discharge.

SALES & MARKETING REPORT

Additional Exhibits for the other reports



Tracks patient **Referrals, admits and conversion rate** by referral month for any selected district, facility or payor.

Avg. time to convert is the average number of days taken to convert a referral to admit.
Avg. time to Auth. is the average number of days taken to get authorization from the insurer