AppRev

Understanding Payer Communication

Anatomy of a denial

March 2014

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Agenda

- Introduction
- Background
- ICD-10 and Denials

Payer Communication

- How does your payer communicate with you?
- Standard data set ANSI 835
- Powerful and complex

ANSI 835 Basics

- Provides information as to why you were paid what you were paid
- If you were not paid in full or what you were expecting to be paid, there should be an explanation as to why
- Used to communicate the results of your claim to your accounts receivable (A/R) system
- It should tell you the reason for adjustments
  - Contractual (Fee schedule etc.)
  - Benefit limits
  - Patient responsibility

ANSI 835 Basics

- How is information communicated?
  - A long string of asterisk-delimited characters
- What are you looking for in that data?
  - Payments/Adjustment/Remarks
- Remittance Advice Remark Codes (RARC)
  - 777
- Claim Adjustment Reason Codes (CARC)
  - 233
  - Used at the claim and the service level

ANSI 835 Basics

- For each 837 (claim) you send you should get a corresponding 835
  - We call them a “couple.” Unfortunately, they quite often have a family!
- Remember its financial transaction.

Definitions

- Denial
  - “A payer transaction (ANSI 835) which has zero in payer payment (CLP 04) and patient responsibility (CLP05)”
  - “A payer transaction with a positive number in payer payment and a Claims Status code of 22, i.e. a take back”
- Response
  - “A provider transaction to address a Denial using a subsequent ANSI 837”
- Appeal
  - “A provider transaction to address a Denial through a process other than ANSI 837, e.g. payer specific appeal form”

Definitions

- Open
  - An account where:
    - a Denial has been received, AND
    - where there is no Response, AND
    - and there is no NEGATIVE amount in a payer or patient responsibility

Others?

HFMA MAP KEYS

Initial Denial Rate – Zero Pay

- **Purpose:** Trending indicator of % claims not paid
- **Value:** Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
- **Equation:** $\frac{\text{Number of zero paid claims denied}}{\text{Number of total claims remitted}}$
- **Target:** ≤ 4.0%

Notice the CARC or RARC is not in this calculation.

HFMA MAP KEYS

Initial Denial Rate – Partial Pay

- **Purpose:** Trending indicator of % claims partially paid
- **Value:** Indicates provider's ability to comply with payer requirements and payer's ability to accurately pay the claim
- **Equation:** $\frac{\text{Number of partially paid claims denied}}{\text{Number of total claims remitted}}$

How do you identify a partial pay?

At AppRev we look for a Claims Status Code of "4" with an allowable amount.

HFMA MAP KEYS

Denials Overturned on Appeal

- **Purpose:** Trending indicator of hospital's success in managing the appeal process
- **Value:** Indicates opportunities for payer and provider process improvement and improves cash flow
- **Equation:**

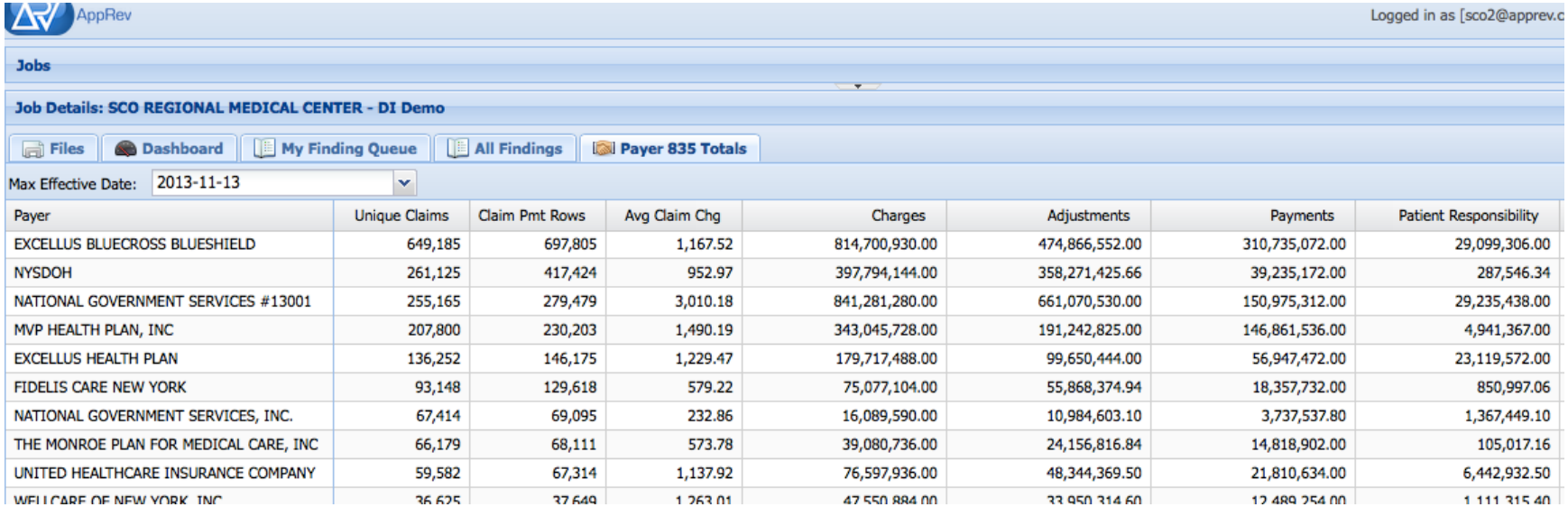
$$\frac{\text{Number of appealed claims paid}}{\text{Total number of claims appealed and finalized or closed}}$$

- **Target:** 40.0 – 60.0%

At AppRev we look for a remit that previously qualified as a zero payment that had a subsequent remit with a payment.

Metrics

- What is the over percentage that your payer has handed off to you to collect?
- How may 837s (claims) do you submit for each 835 (remit)?
  - How big is that family, or how hard is it to finalize the transaction?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Jobs

Job Details: SCO REGIONAL MEDICAL CENTER - DI Demo

Files | Dashboard | My Finding Queue | All Findings | Payer 835 Totals

Max Effective Date: 2013-11-13

Payer	Unique Claims	Claim Pmt Rows	Avg Claim Chg	Charges	Adjustments	Payments	Patient Responsibility
EXCELLUS BLUECROSS BLUESHIELD	649,185	697,805	1,167.52	814,700,930.00	474,866,552.00	310,735,072.00	29,099,306.00
NYSDOH	261,125	417,424	952.97	397,794,144.00	358,271,425.66	39,235,172.00	287,546.34
NATIONAL GOVERNMENT SERVICES #13001	255,165	279,479	3,010.18	841,281,280.00	661,070,530.00	150,975,312.00	29,235,438.00
MVP HEALTH PLAN, INC	207,800	230,203	1,490.19	343,045,728.00	191,242,825.00	146,861,536.00	4,941,367.00
EXCELLUS HEALTH PLAN	136,252	146,175	1,229.47	179,717,488.00	99,650,444.00	56,947,472.00	23,119,572.00
FIDELIS CARE NEW YORK	93,148	129,618	579.22	75,077,104.00	55,868,374.94	18,357,732.00	850,997.06
NATIONAL GOVERNMENT SERVICES, INC.	67,414	69,095	232.86	16,089,590.00	10,984,603.10	3,737,537.80	1,367,449.10
THE MONROE PLAN FOR MEDICAL CARE, INC	66,179	68,111	573.78	39,080,736.00	24,156,816.84	14,818,902.00	105,017.16
UNITED HEALTHCARE INSURANCE COMPANY	59,582	67,314	1,137.92	76,597,936.00	48,344,369.50	21,810,634.00	6,442,932.50
WELLCARE OF NEW YORK, INC	36,625	37,649	1,263.01	47,550,884.00	33,950,314.60	12,489,254.00	1,111,315.40

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Level Two: Payer Scorecards

- Payments
- Adjustments
  - Adjustments by issue
- Denials

Can we make it English?

- What are the “reasons” for denials?

ANSI 835	English
CARC 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	Fee Schedule
CARC 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Bundling
CARC 204 This service/equipment/drug is not covered under the patient’s current benefit plan	Non-covered

Grouping for work flow

- Billing –8 12 13 14 16 29 40 49 58 59 60 78 89 95 96 100 107 109 110 111 112 117 125 129 131 133 135 138 143 150 151 152 155 163 164 165 166 170 171 172 173 174 183 184 186 188 193 195 199 200 204 217 218 219 226 227 228 249 250 251 252 A1 A6 B1 B11 B13 B15 B23 B7 B8 B9
- Certification - 15 197 198 210 243 39
- Coding - 4 5 6 7 9 10 11 50 97 115 146 167 181 182 185 189 194 203 216 220 231 233 236 240 A8 B12 B16 B22 W3
- Coverage - 26 27 31 32 33 34 35 136 140 160 168 177 179 180 238 239 B14 B5
- NPI (provider number) -206 207 208
- TPL (third party liability) - 20 21 Y1
- W/C (workers comp) - 19 191 201 214 W2 W4

Grouping for work flow

- A 8 = Ungroupable DRG
  - You should not have any of these.
- 51 These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF,) if present.
  - We find these in current data.
  - What do they mean? How do you resolve these?

ICD -10 and Denials

- Do you know which payers will use ICD-10 on October 1st, 2014?
  - How are you investigating?
  - Are we sharing results?
- Contractual terms driven by ICD-9 diagnosis or procedure codes
- Authorizations
  - Do you have authorizations that are now ICD-9 but when you bill them in ICD-10

ICD -10 and Denials

- Inpatient
  - What do payers do with ICD-9 on inpatient claims?
    - DRG groupers
      - Certainly MD-DRG
      - Maybe AP-DRG, APR-DRG
    - Contractual terms driven by ICD-9 diagnosis or procedure codes
- Do you have ungroupable DRGs now?
- Any payers outside of MS-DRG impacted?

ICD -10 and Denials

- Outpatient
  - What do payers do with ICD-9 on outpatient claims?
    - Medical Necessity
      - Medicare NCD/LCD
      - Other payers?
    - Contractual terms driven by ICD-9 diagnosis or procedure codes
  - Denials not related to medical necessity should not change (CARC 50.)
    - Bold statement. What do you think?
    - Maybe some of the coding oriented CARCs
      - CARC 4-11

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Discussion