PARAREV

Attacking Denials to Optimize Hospital's Margins

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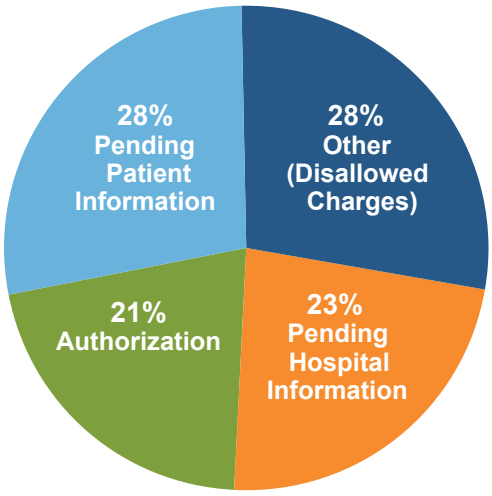
Denials Recovered *After* Hospitals' Best Recovery Efforts

$106.1M
Denial Underpayments Identified

$76.2M
Denial Underpayments Recovered

"Hospitals and health systems have been improving important portions of their revenue cycle performance over the past two years but face rising risks from increased denial write offs, bad debt, and inefficiencies revealed by their persistently high costs to collect"[2]

Overturned Denial Categories



The Revenue Cycle Challenge

Hospital operating margins have decreased by 39% since 2015 to 2017. The recent increase in payer denials has a direct impact on hospitals decreasing operating margins. Claim denials are highly complex and encompass more than what providers see on the Explanation of Benefits (EOB). With the rising prevalence in denials, it is not uncommon for payers to deny or delay claims for expected reimbursement.

Hospitals already are employing best efforts in mitigating denials with front-end efforts, mid-revenue cycle reviews and utilization of denial management systems. Yet, the "claim game" remains immensely challenging to tackle, from obtaining authorizations and ensuring accurate coding and billing of claims to appealing payers on denials. As a result, hospitals resort to writing-off accounts with these claim denials, leading to millions in lost revenues.

ParaRev's Findings

For 20 years, ParaRev has helped top performing hospitals recover substantial revenue through our specialized approach in denial management and revenue cycle optimization. ParaRev's tailored approach involves account-to-account analysis to identify an array of denials often missed by technology-based processes. We successfully recover revenue from false denials and then share our effective strategies to prevent and overturn said denials.

Denials Claw Back Margins

Our team is comprised of experts in navigating complicated insurance denials and maximizing the collection of contractual revenue. In a two-year period for a sample of seven clients, after these hospitals' best efforts, ParaRev identified over $106.11M in claim denials. Out of these denials, ParaRev successfully overturned over 72% and recovered
$76.21M.

1 Masterson, Les. "Hospital Operating Margins Dropped 39% over 3 Years." Healthcare Dive, 13 Sept. 2018, ww.healthcaredive.com/news/hospital- operating-margins-dropped- 39-over-3-years/532205/.

2 Advisory Board. "Hospital Revenue Cycles Showing Strength But Risks Include Denials." PR Newswire: News Distribution, Targeting and Monitoring, 14 Nov. 2017, www.prnewswire.com/news-releases/ hospital-revenue-cycles-showing-strength-but-risks-include-denials-300555731.html.

Pending Additional Information

Revenue Cycle Issue Payers deny claims and issue $0 payments when they do not receive requested information from the patient or provider. This remains a significant challenge for a hospital's business office as many patients may be noncompliant with updating missing information, even after extensive attempts to notify patients. In addition, business offices lack the bandwidth to work accounts for a sustained period, often leaving them no other choice than to write-off these accounts.

Break in the Revenue Cycle

- Disconnect between front end and back end functions/offices
- Amount of administrative effort around identifying and routing denials to correct work queues

Real World Impact Most business offices work on missing information denials for a few months, and generally write off accounts that are not resolved within that period. Denials from missing patient information result in the full account balance being assigned to the patient; these accounts are then transferred to bad debt or collection agencies. ParaRev finds any accounts that fall through the cracks and provide corresponding documents in lieu of missing patient information to drive claim processing and payment.

ParaRev's Solution Business offices do not have the necessary information to overturn pending missing information accounts nor do they have capacity to let accounts age for an extended length of time. This results in them writing these accounts off. ParaRev implements the following best practices:

✔ **Checking for Payer Processing Issues:** With the aging of these accounts, payers may have received the required information from the patient or provider but did not reprocess the claim. ParaRev confirms receipt of these documents and ensure timely reprocessing of the claim.

✔ **Identifying and Providing Necessary Documents:** ParaRev works with payers to determine what can be provided in lieu of requested patient information, thereby streamlining the process of retrieving lost revenue.

Pre-Certification/Authorization

Revenue Cycle Issue Another common denial is when prior-authorization was not correctly obtained for procedures, devices, or recurring treatments such as chemotherapy, resulting in partial or full claim denials and additional delays. In some cases, prior-authorization may have been obtained; however, the number of units allowed for a service/item may have already been exhausted or an incorrect pre-certification penalty was applied by the payer.

Break in the Revenue Cycle

- Inadequate process to appeal correctly and on time
- Disconnect in communication between departments leading to difficulty overturning denials

Real World Impact Payers assign full financial responsibility to the provider for non-preauthorized services. When patients seek services that are specifically outlined as not covered under plan benefits, the full payment responsibility falls on the patient. However, when the provider does not obtain necessary authorization prior to rendering the service, the provider is expected to foot the bill. This type of denial is considered a "hard denial" in that it generally results in lost or written-off revenue. ParaRev goes the extra length for every account by researching account notes and medical records to effectively dispute these denials.

ParaRev's Solution Although these "hard denials" seem difficult to counteract, ParaRev's team of experts in reimbursement methodology are well equipped to dispute authorization denials, and have collected revenue from this risk area through the following approaches

✔ **Extensive Research:** ParaRev performs retrospective analysis on these accounts to identify and dispute on the basis of extenuating circumstances, medical necessity, incorrectly applied pre-authorization denials, and etc.

✔ **Prospective Review:** ParaRev applies best practices on behalf of hospitals which include precise documentation, rebilling authorization on claims, and referencing payer authorization policies in written appeals. Through this implementation, ParaRev strengthens current processes to eliminate authorization denials.

Coding Review

Revenue Cycle Issue Claims may be denied in full or receive reduced reimbursement for coding errors or due to coding lacking specificity. Commonly seen coding errors are Medically Unlikely Edits (MUE), Procedure to Procedure Edits (PTP), National/Local Coverage Determinations (NCDs and LCDs), misused/missing modifiers, incorrectly applied revenue codes, etc. Partial denials from not coding to the full level of specificity are also often associated with ambiguous or unspecified ICD-10 codes or HCPC's.

Break in the Revenue Cycle

- Lack of strategic insight into complexity of payer contracts
- Technology integration delivering insufficient clinical and administrative components

Real World Impact A substantial amount of coding errors stem from not complying with NCD, MUE, PTP, ICD-10, or CPT coding guidelines which are set forth by the Centers for Medicare and Medicaid (CMS). As a result, a hospital's business office dedicates extensive administrative time and effort to tackle these denials. Furthermore, providers must understand when to refer to designated stakeholders such as Medicare Administrative Contractors (MAC) in the absence of NCD guidelines to comply with LCD specificities. ParaRev's capabilities involve solid understanding of how and where to address coding denials to expedite reprocessing of the claim for maximum reimbursement.

ParaRev's Solution ParaRev provides retrospective and prospective consultation services to clients to address these complex coding denials. As a result, ParaRev identifies the root cause of coding errors to minimize future regulation risk while streamlining current processes to maximize contractually due revenue.

✔ **Independent Payment Analysis (IPA):** ParaRev performs retrospective audits on zero-balance accounts to identify potential coding errors. Following the identification of erroneous coding, ParaRev provides claim corrections that are consistent with respect to the payer's contract or policies set forth by CMS.

✔ **Coding Research and Corrections:** ParaRev uncovers these denials and then helps our clients implement preventative measures in reviewing Claim Adjustment Reason Code (CARC), advising the addition of specific modifiers for distinct procedures, following appropriate billing guidelines, etc.

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For more information on how ParaRev can help you stop denials from negatively impacting your operating margins, contact us:

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