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Developmental Evaluation of a Centralized Denials Management Program

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This is to certify that the doctoral study by

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Abstract

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MS, Florida Atlantic University, 2011

BS, Florida Atlantic University, 2011

Project Submitted in Fulfillment

of the Requirements for the Degree of

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Abstract

Health care reimbursement is changing, and hospitals are finding it difficult to receive

payment due to insurers' denial of services already rendered to patients. A denial can be

considered an underpayment by the insurer to the hospital. Using a Six Sigma approach, a

large hospital system in the southeast United States found that individual hospitals were

not focused strictly on denials, but other tasks as well. Hospital administrators conducted

a literature review and found that centralizing denials management team has improved

reimbursement outcomes elsewhere. Therefore, the hospital system implemented a

centralized denials unit to focus on overturning insurer denials while the patient was still

hospitalized. The purpose of the project was to develop an evaluation plan to determine

whether the pilot centralized denials management unit could overturn an additional 5% or

more of the concurrent denials compared with the current individual hospital-based

denials management approach. The quantitative evaluation plan will guide review of data

collected from one organization to determine payer trends on the types of denials

received and reasons for the denials. Understanding the pattern of denials is expected to

uncover opportunities for denials coordinators in the dedicated centralized management

unit to challenge payers based on contract language or medical necessity. If the

centralized denials management unit is shown to reduce denials, it will be considered for

expansion corporate wide. The social change expected through a successful denials

management unit program is that the hospitals in the system will recover payment for

services rendered and will be able to continue to provide quality care in the communities

they serve.

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Section 1: Nature of the Project

Project Overview

Introduction

Since its passage in 2010, the Affordable Care Act (ACA) has highlighted case

management. The ACA has transformed how institutions deliver health care and how

they are reimbursed. According to Granata and Hamilton (2015), The Institute of

Medicine has asked leaders in the health care industry to reshape their delivery systems to

produce better patient outcomes. As a result, management of both private and public

insurance payers is reevaluating organizational systems and structures including case

management, utilization review, and denials management. Hospitals are trying to balance

fee-for-service payment with pay for performance (Granata & Hamilton, 2015). The

collaboration between case management, utilization review, and denials management can

affect hospital length of stay, accounts receivable, throughput data, denial rates for

medical necessity, and numbers of overturned denials, all of which can bring value to the

health care organization (Miodonski, 2011). The ACA has made case management a

focal point of hospitals that contribute to their net revenue nationally. Granata and

Hamilton (2015) have noted that "case managers are charged with compliance oversight,

managing throughput, and ensuring safe care transitions" (p. 15). Having a (a) case

management department that can focus on ensuring safe patient discharge in a timely

manner, (b) utilization review department that can focus on compliance oversight, and (c)

centralized denials management team that can focus on concurrent denials while and decrease overall hospital length of stay.

The coordinated efforts of these three departments (case management, utilization review, and denials management) play an integral role within the hospital to increase revenue, decrease concurrent denials, improve discharge planning, decrease lengths of stay, and provide compliance oversight. Case managers help to facilitate discharge planning in a timely manner by preventing discharge delays that would keep patients in the hospital longer than is necessary, possibly causing continued stay denial due to lack of medical necessity.

Utilization reviewers determine medical necessity through the use of Milliman Care Guidelines or InterQual Criteria. Kreis (2002) *medical necessity* as "health-care services or supplies needed to prevent, diagnosis, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine" (para. 1). Milliman and InterQual are considered the "Gold Standard" for industry guidelines that are used to measure medical necessity and are used by payers to decide whether patients meet the national guidelines for inpatient or observation status in the hospital (Lowes, 2001). Figure C2 is an example of an InterQual Acute Level of Care Criteria. Each of the criteria subsets has additional detailed information that the payers and hospitals use to make medical necessity determinations. Milliman and InterQual guidelines also determine level of care status, such as whether the patient meets criteria for acute care, critical care, observation, or emergency room care in the hospital, or community-based care in a skilled nursing facility or outpatient setting (University of Tennessee, n.d.).

Insurance companies tend to follow Medicare guidelines "wherever Medicare goes, private payers will follow" (Adamopoulos, 2014, p. 1) as well as Milliman and InterQual criteria.

Hospitals are losing approximately $261 million a year from insurance denials (Pelaia, 2013). A denial can be considered underpayment for services rendered. Insurers deny payment when they find lack of medical necessity, when a procedure is not a covered benefit in the insurance contract, or when the procedure can be conducted in a lower level of care setting. A denial can be "a refusal to pay as a result of the provider not adhering to insurance company policy/procedures, or pending receipt of additional information" (Tienken & Clayton, 2010, p. 3). Underpayment occurs when there are discrepancies in pricing or contract interpretation or when there is missed coding or coding errors (Tienken & Clayton, 2010). Hospitals attempt to collect money from the insurance company for taking care of its patients.

Under ACA, in 2015, hospitals with high readmission rates within a 30-day period have been penalized with a 3%decrease in reimbursement (Granata & Hamilton, 2015). Case managers and utilization reviewers will improve the hospital revenue by balancing discharge planning with avoiding Medicare penalties for readmission avoiding insurer denials of payment for unnecessary hospitalizations. To address the problem of lost revenue due to denials, many hospitals are forming teams to focus on overturning denials. Currently, each hospital in the managed care system where the pilot evaluation project took place handles denials management differently, and due to financial constraints, some hospitals cannot dedicate a team solely for appealing denials.

In the system hospitals, case managers have ensured that each patient had a discharge plan from the time of admission. Case managers who work on the unit have the most direct interaction with patients, families, and physicians. Their job is to anticipate any discharge issues that may prevent the patient from being discharged in a timely manner. Discharge planning starts on the day of admission. Utilization reviewers ensure that the patient meets medical necessity throughout the hospitalization process. They work with the nurse reviewers from the insurance plans, and they are the first ones to receive the denials from the payer and inform the physician. Utilization reviewers have continued to implement the initial InterQual evaluation on the patient to see if the criteria for hospitalization were met for each inpatient. They also serve as the first line of defense to try to can get the denial overturned by talking with the nurse reviewer from the insurance plan to see if additional information needs to be provided from the hospital.

In addition to the use of case managers and utilization reviewers, hospitals are trying to find creative ways to increase hospital revenue through efforts that proactively manage patient hospitalization and length of stay. These efforts must include involvement of physicians, nurses, patients, families, executive leaders, and stakeholders to provide maximum care in a minimum length of stay and at a minimal cost. The hospital system has piloted an approach to facilitate this proactive management that involves implementation of a centralized denials unit that reviews concurrent denials and monitors trends and outcomes related to the various insurance payers.

When the hospital utilization reviewers are unsuccessful in dealing with a payer denial and denial is upheld by the payer, the denials management unit receives the denial

through the hospital payer mailbox and then begins to work the denial. Denials management coordinators within the denials management unit review the patient records to ensure that the reasons for denial of payment are justified. These employees are expected to play a vital role in the solvency of the system hospitals that are seeing reimbursement cutbacks every year.

Between January 2014 and December 2015, a pilot project was established that created a centralized denials management team located off-site from the hospitals within a national hospital system. The denials management oversight group consists of members from management; the chief financial officer (CFO); individuals from patient access, coding, and case management; and utilization reviewers with denials management experience. The team members from these four departments who do the daily denials review have an understanding of data entry, reports creation, and the ability to review patient charts in order to challenge denials (Gutierrez, 2012).

The members of the denials management unit have remote access to all the system hospitals' payer mailboxes and access to all patient information. This allows them to look at all concurrent denials and attempt to overturn them or negotiate with the payer to compromise on a lower level of care admission cost. This team of the denials management team is expected to prevent denials from being addressed after discharge. Centralizing denials management into one team, rather than the current individual hospital-based effort, is expected by division to provide the hospital system with a consistent denials management approach by persons trained and experienced in the process. The hospital based approach was not conducted with consistency. The hospital

base was in between tasks of obtaining insurance approvals and making sure patients met criteria for inpatient or observation. The team helps each other work through denials and is particularly useful due to experience in dealing with challenging or contentious denials.

Purpose Statement

The purpose of this project was to develop a plan to evaluate the effectiveness of the centralized denials management unit in decreasing hospital denials and increasing hospital revenue. I developed and proposed quantitative analyses to examine the causes of denials across the hospital system to recommend actions to avoid denials in the future. The primary focus of the denials management unit is examining concurrent denials, allowing the utilization reviewers who are hospital-based to focus on ensuring that patients meet criteria for hospitalization, sending clinical reviews to insurance companies, and communicating with physicians to keep them informed when patients do not meet admission or continuing stay criteria or when additional information is needed to justify admission or continued stay (St. Charles, 2014).

According to Pelaia (2013), medical necessity denials occur for many reasons, such as inadequate staff training in case management and in the billing departments, lack of medical necessity, inappropriate or insufficient documentation, lack of authorizations for procedures, changes in tracking systems from paper to electronic systems, and lack of up-to-date knowledge of changes in Medicare and Medicaid reimbursement criteria. By identifying these issues, the denials management unit can develop a plan to reduce denials and increase hospital revenue, 67% of denials are appealable, the centralized denials management program will focus on these denials and appeal them (Pelaia, 2013).

Both hospital medical necessity denials and longer lengths of stay have causes. Among the factors that can contribute to a patient being in the hospital longer than national criteria deem necessary are physician practice style, the lack of community resources or family support for the patient at home, and the lack of patient ability to follow up with a primary care provider upon discharge or to perform the necessary self-care management tasks at home (Clarke, 1996).

Evidence for best practices in denial management was gathered by this researcher using the CINAHL and MEDLINE databases to search the peer-reviewed literature. The Center for Medicare and Medicaid (CMS) website was reviewed for changes in reimbursement policies and procedures that could possibly affect concurrent denials.

Project Questions

I answered the following questions using this project study:

1. What is the best quantitative approach to determining whether the pilot centralized denials management unit resulted in a reduction in overall number of denials and length of stay, and increased the number of overturned denials?

2. What are the financial benefits, if any, to a centralized denials management team, and how can they be demonstrated?

The data to answer these questions will be from hospital insurance claims and reviews. The goal for this developmental project was to create a quantitative evaluation plan to show whether having a centralized denials management unit aided in the reduction concurrent denials within a pilot program in one of the organization's hospitals. To achieve this goal, the objectives related to the evaluation of the new centralized

denials management program were as follows: (a) compare the number of denials in 2014 to those in 2015 (b) compare the lengths of stay between 2014 and 2015 to see whether there was a decrease in the number of days, and (c) compare the number of denials overturned in 2014 with those overturned in 2015. Hospital A was the first hospital to go live with the denials management team, and 1 full year of data are available for the comparisons.

Significance and Relevance to Practice

Hospitals throughout the United States are now seeing the importance of a team of individuals with the right knowledge to deal with insurance denials. The evaluation of the pilot project will help to determine whether a centralized denials management team has provided a financially sound and effective approach to payer denials of care payment.

Evidence-Based Significance of the Project

Evidence-based practice (EBP) has become the corner stone of nursing. It takes "the best evidence from well-designed studies (i.e., external evidence) and integrates it with a patient's preferences and values and a clinician's expertise, which includes internal evidence gathered from patient data" (Melnyk, Ford, Long, & Overholt, 2014, p. 5). Improving quality and reliability of health care through the use of EBP can reduce the cost of health care delivery. Keckley (2004) found that health plans incorporated EBP across five areas of management: (a) pharmacy processes and how they impacted delivery of patient care; (b) management of disease, giving particular attention to prevention of secondary disease or disease acquisition within the health care setting; (c) a

process for consistent adherence to best practices; (d) pay-for-performance and adhering to financial obligations; and (e) methods to improve patient compliance with treatment.

This project was focused on EBP to improve the fourth area, which includes financial accountability. Keckley (2004) found that managed care plans played a vital role in reducing misuse, underuse, and overuse of health care. It promoted cost-effective quality care and improved outcomes (Grove, Burns, & Gray, 2013). It is this practice evidence that can determine whether a centralized denials management team, if implemented at the system level, can be cost effective and promote quality of care to support the proposed DNP clinical practice project.

Social Change Expected as a Result of the Project

This developmental project can provide benefits for social change beyond the clinical site for the project. The current emphasis in health care is for hospitals to balance medical necessity and length of stay with reimbursement. Having a centralized denials unit that focuses strictly on concurrent denials may allow utilization review nurses to focus on whether or not a patient meets criteria to remain in the hospital. It is no longer individual physicians who dictate patient care, but the insurance companies that determine whether and when a patient can remain hospitalized or must be discharged. Improved denials management will lead to better coverage of medically necessary services, reduced direct costs to patients, and improved hospital revenue. Improving hospital revenue may allow hospitals to invest in technology advances, patient documentation databases, and other vital resources to maintain growth within the community and competitiveness for the hospital system (Rauscher, 2010).

Project Design and Methods

In order to determine whether centralized denials management will increase hospital revenue as compared to hospital-based denials management, a quantitative descriptive project design is planned. According to Grove et al. (2013), quantitative research allows researchers to use (a) structured interviews, observation, and questionnaires; (b) numerical data; and (c) scales. Statistical analysis can be conducted to describe the variables, examine relationships among the variables, and determine the differences among groups. Grove et al. (2013) said, "controlled, precise measurement methods, and statistical analysis are used to ensure that the research findings can be generalized" (p. 25). In looking at the new centralized denials management program, information for the evaluation needs to be concise and objective. Information gathered must be collected in a format that can be compared to data from other hospitals to benchmark the current status of the piloted hospital in relation to overturned denials nationally so it can be determined if a trend can be identified by payers, demographics, or hospital environments.

The data for the evaluation will be obtained from the organization's denial log and will be uploaded into the denial log from Hospital A. The data for Hospital A will be by insurer (payer) and denial type so that patterns can be recognized. These quantitative data will help determine whether having a centralized denials department increased hospital revenue by decreasing denials and overall lengths of stay, which impacts reimbursement. This is an evaluation developmental project. If the data has shown increased hospital revenue, decreased lengths of stay, and a decrease in denials between

2014 and 2015, this pilot program will be reviewed for permanent implementation throughout the corporation.

The project uses information that already exists on denials historically (2014 data) and compares it to the denials information obtained after implementation of the denials management team (2015 data). It will be through the information gathered that the effectiveness of the centralized denials management during 2015 can be determined. The results of this developmental project will show whether centralized proactive denials management is worth the investment compared to hospital-based utilization reviewers' managed denials as they come into the hospital after the hospitalization or procedure has been completed.

Definitions

Case management is "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs" (Commission for Case Manager Certification, n.d., p. 1).

Centralized denials management is "to establish and execute activities that increase the provider's ability to predict revenue collection" (RN Case Manager, n.d., p. 1).

Length of stay is defined as the "average number of days hospitalization per patient during the individual study period" (Kim & Soeken, 2005, p. 256).

Utilization review "provides both a review function as well as a support function for the provider and staff related to the admission decision, continued stay and resource utilization" (St. Charles, 2014, p. 1).

Limitations and Assumptions

This health care system 13 hospitals, and not all have the same bed capacity nor offer the same services. In addition, each hospital has different case management services and numbers of utilization review personnel. Not all facilities have a physician advisor who can challenge denials issued by peers in insurance companies. In peer-to-peer reviews with insurers, some of the hospitals use an outside contracted company to do the challenges for them. These contracted physicians have remote access to the electronic medical records for review; they are not on-site at any of the facilities. A final limitation is the consistency with which the facilities are reporting their denials to be reviewed and challenged in the time frame allowed by the payer. All of these differences may make translation of the centralized denials management program in Hospital A difficult, requiring additional process changes. There is no standard or protocol across the hospital system for reviewing denials at this time.

The purpose of this developmental project was to determine whether implementing a centralized denials management program that has consistent and uniform processes will provide better results in the handling of denials. It was assumed no changes were made to how hospitals functioned, and physicians' practice.to change.

Each facility maintained its current standards of practice and leadership styles during the pilot. It is further assumed that denials data collection was consistent and that each team

member input the information the same way. It was also assumed that the centralized

denials management team promoted partnerships to be made between the denials

coordinator and the nurse reviewer with the payer to aid in negotiating denials.

Summary

Health care delivery is changing and so is the way hospitals are compensated for

the care they deliver. Addressing the clinical practice problem of insurance denials and

lost hospital revenue, a team was implemented to focus on concurrent denials. The

purpose of this project was to evaluate whether a pilot hospital denials management team

to focus on current denials decreased lost revenue compared to the hospital-based case

manager and utilization reviewer model alone. The evaluation of this developmental

project will show whether the centralized denials management program should become

the best practice corporate wide.

Section 2: Background and Context

Review of Scholarly Evidence

Healthcare delivery and reimbursement have changed throughout the years. This has led to the implementation case management teams of nurses and others with specialized skills to focus on lengths of stay and hospital care reimbursement from payers (Thomas, 2009). Case management was created due to increases in managed care, third-party payers, and a changing reimbursement system. Case managers are now used to help with financial reimbursement (e.g., using care coordination team meetings with floor nurses to aid in triaging patients for discharge). Case manager are the frontline defense in attempting to have a discharge plan in place in a timely manner, working hand-in-hand with the utilization reviewer in the prevention of denials. This has worked in the past; however, with changes in health care and implementation of the ACA, this is no longer an effective way to manage denials that are received by the hospital. The purpose of the proposed project was to evaluate a pilot centralized denial management team program's effects on number of denials, types of denials, overall lengths of stay, and hospital reimbursement revenue. The goal to achieve an increase of overturns of denials and a decrease in the length of stay should result in an increase in revenue.

Specific Literature

A review of literature sources was conducted in support of this project: the CINAHL and MEDLINE databases were searched for peer-reviewed literature, and the CMS websites were reviewed from 2000 to 2015 for current and changing policies and procedures related to Medicare reimbursement. Articles were retrieved if they met the

following inclusion criteria: hospital setting with a bed capacity of over 100 and presence

of a utilization review team. The articles were all reviewed for applicability to the current

project. All articles reviewed were used in support of this project and are discussed

below.

Research done by Thomas (2009) looked at two delivery models of case

management that dealt with payment denials and length of stay, comparing them to the

traditional role of case management. The data collected during the care coordination

process were from patients who were admitted and discharged from medical, surgical,

cardiology, and neurological units. The causal-comparative design used base-line data

collected from the prior year for comparison with data collected after project

implementation. A regression analysis was used to determine the number of utilization

reviews that were being conducted by the care coordinators of each inpatient unit.

Utilization reviewers reviewed payment denials and length of stay. The goal was to

decrease length of stay by doing daily reviews. The reviewers were able to decrease

denials and length of stay within the first year.

Analysis of variance (ANOVA) was used to look at payment denials in a study

done by the same author (Thomas, 2009). The author reported on the traditional model

where care coordinators reviewed charts every 3 days for contract payers and once every

day for patients who were insured through Medicare and Medicaid. Using this model,

only 80% of the reviews were completed 15% of the time. In comparison, using the full

immersion model, the care coordinators completed daily chart reviews and documented

them in the utilization review database and the electronic medical record for all patients regardless of payer.

The results suggest that there was a need to change the management and processing of denials. The full immersion model decreased the overall length of stay by 1.57 days. It was necessary to do daily reviews in order to manage patients' level of care correctly and determine accurately whether patients met criteria to be in the hospital or could be cared for in a less acute setting. In addition to the findings that there was a reduction in length of stay, it was also found that physician practice, nursing experience, payer reimbursements, organizational culture and practices, and timing of the admission all influenced denials. In addition, multidisciplinary team participation played a role in decreasing length of stay and was a contributing factor in decreasing denials. This study provided lessons that may be used to change how denials are managed and processed.

Darmody et al. (2007) reviewed hospital spending, which grew by appropriately 10.1% and saw growth in spending in outpatient as well as inpatient care that accounted for approximately 54% of the increase within the first year. Overall, hospital care represented a large portion of the spending, and third-party payers often focused on the management of these services. According to Darmody et al. (2007), payers practiced three areas of management: utilization review, physician gate keeping, and case management.

The purpose of the Darmody et al. (2007) study was to determine whether hospital employees with different job classifications created the same financial outcomes as concurrent utilization reviewers. A microeconomic theory of production was used for

this research. Microeconomic theory hypothesizes the relationships between a given quantity of inputs and the outputs that are needed to produce them. The inputs can be substituted for one another and have the ability to reduce cost. Even though substitutions exist in the hospital setting, they may impact the delivery of care and may not deliver the desired outcome. The study found that the individuals best suited for the position of concurrent utilization reviewer in the hospital were the registered nurses who understood the delivery of health care and what it takes to produce the desired outcome for the patients.

The researchers used a retrospective study approach. The study was conducted at a hospital in the Midwest with 500 beds and was conducted over two years. The objective of the study was to see what combination of inputs produced the lowest cost outcome combinations. It was based on skill mix in the concurrent review, such as a social worker, a case manager, and a registered nurse. Other impacts on denials outcomes were the education, training, and orientation of those managing the denials. The conclusion of the authors was that there was no significant savings in substituting less costly trained individuals such as unit secretaries, licensed practical nurses, or other types of ancillary individuals with little to no medical background for registered nurses in concurrent utilization review.

A study conducted by Murray (2001), using a descriptive analysis of over 27,000 concurrent reviews from a 500-bed hospital over a two-year period, reviewed the process that was used by the managed care industry to monitor length of stay and use of ancillary services by hospital patients. The purpose of this study was to assess the effectiveness of

the process in controlling costs and the facility's legal obligations. The research found

that an effective utilization review department could decrease admissions by 13%,

inpatient days by approximately 11%, and inpatient expenditures by 7% (Murray, 2007).

An effective utilization review process can aid in the reduction of inpatient expenditures.

A study done in Mercy Hospital in Chicago looked at which payers were not

paying claims. The hospital had a revenue loss of $13.3 million over several years, which

amounted to a 25.4% loss in their managed care population (Baumel & Corrato, 2003).

Mercy Hospital implemented a denials management program at three of its hospitals. In

the first year, the physician advisor reviewed all concurrent denials and was able to

overturn inappropriate denials, get patients downgraded to less intensive care more

quickly, and discharged patients sooner. Mercy Hospital appealed approximately 75% of

days denied and was able to get 40% of them overturned. It was also able to decrease its

denials by 18% annually thereby saving $2.2 million (Baumel & Corrato, 2003). The

hospital then started to look at its lengths of stay and medical necessity. It recognized that

when it had a patient denial which was an appropriate denial, the patient no longer

needed to be in the hospital. The physician advisor worked to educate his peers on the

fact that the patient no longer met medical necessity and needed to be discharged. This

research showed the impact a physician advisor can have decreasing overall length of

stay.

Research conducted by Jaques (2002) showed that hospitals with a Chief Medical

Officer (CMO) can have an impact on payer denial rate and length of stay. A 310-bed

hospital in San Antonio, Texas developed a team that included a social worker case

manager, a utilization reviewer, and the CMO. The team looked at the top three commercial managed care payers to identify trends as to why they were not being paid for hospitalizations. They identified the root causes as delays in procedures, differing physician practices, differing attending judgment, and payer. In identifying these issues and beginning to address them, they were able to decrease the number of denials in the first fiscal year by 25%. They were able to decrease their length of stay from 5.6 days to 5.0 in the first year.

According to Jaques (2002), Johns Hopkins implemented a multiphase program to examine the different reasons for denials. They looked at such things as relationships with payers, inaccuracies with registration, poor coding, and poor clinical documentation. They had noticed their denial rates increasing; every 0.1% increase in denials was the equivalent to appropriately $340,000; therefore, decreasing the denials rate by 0.3% was worth about $1 million. They enlisted case managers, social workers, and utilization reviewers who would follow the patients from time of admission to discharge. In doing this, they were able to recover $2.6 million in denials.

In a study done by Wickizer (1992), utilization review was found to be one of the major cost containment programs being used by hospitals. The study showed that approximately 20% of hospital admissions and approximately 35% of inpatient admissions were inappropriate. This study demonstrated that use of the utilization review department reduced hospital admissions between 10% and 15% and inpatient expenditures by about 5% to 10%. The study included 223 patients who met the criterion of having an active insurance policy. A cross-sectional study design was used and the

results showed that utilization review decreased admissions by approximately 11.5%. The study author's conclusion was that having an effective utilization review department has an effect on the hospital's budget by decreasing cost and unnecessary admissions (Wickizer, 1992). Even though this article is dated, it shows the importance of having a utilization team that can follow the patients and determine if they meet medical necessity.

What was evident from the literature review was the importance of having a team of experts, including case managers who work on the hospital units to anticipate patient needs at the time of discharge; the utilization reviewers who make sure patients are meeting medical necessity; and the coders who notify insurance companies of patient admissions and apply the proper code for billing. The CMO helps by reviewing charts and doing peer-to-peer reviews with the insurance company or payers' medical directors when warranted. The denials mangers assist with reviewing patients' charts to identify other causes for the denials and attempt to negotiate with the nurse reviewer to overturn the denials from the payer. It is through the expertise and efforts of all these individuals that hospital reimbursement can be maximized.

General Literature

Denials Management

There are two types of denials. The first type is considered a hard denial. These are denials due to a lack of pre-authorization for an elective procedure, lack of coverage for the service provided, or lack of insurer financial responsibility for the patient (Tienken & Clayton, 2010). The second type of denial is a soft denial. Soft denials are due to coding errors, inaccurate patient information collected upon arrival to the hospital,

denied drug reimbursement, or denied level of care (Tienken & Clayton, 2010). Disputed medical necessity is considered one of the leading causes of denials (Eramo, 2010).

Denials can be complete or partial. A complete denial is based on the payer's determination that an acute setting was not needed or appropriate. A partial denial is based on a payer's determination that treatment delays occurred in the organization's processes, resulting in denied payment for inpatient days (Thomas, 2009). The organization has the right to challenge the denial for total reimbursement if it believes the patient met medical necessity. Each insurer or third-party payer employs nurses, physicians, and other professionals to perform utilization review. Utilization management is an area of case management that has been accepted by health plans. According to Koike, Klap, and Unutzer (2000), a utilization review is "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriate care prior to its provision" (p. 621). Utilization review affects nearly all Americans who are covered by health insurance. Both hospitals and payers have utilization reviewers who are constantly reviewing inpatient records to make sure patients still need hospital care. These reviewers can be on-site or have remote access to clients who are in the hospital or in the health care system. The insurance reviewers communicate to the case managers and utilization reviewers regarding whether patients meet inpatient criteria or not.

In these organizations, there are usually three sub-areas of utilization review: pre-admission review, outpatient review, and concurrent review (CUR). Reviewers in CUR deny or approve authorizations for continued stay in the hospital. "Concurrent utilization

review is a process that payers may use to evaluate a hospital provider's plan of care against the payer's criteria of medical necessity, appropriateness and contract terms" (Darmody et al., 2007, p. 239). A hospital utilization reviewer is the liaison between the hospital and the payer's utilization reviewers. Experienced nurse utilization reviewers know when to challenge insurance companies and when to include physician advisors to conduct peer-to-peer negotiations with the insurance company's physician in order to overturn a denial.

Concurrent denials have an effect on hospital length of stay. If a denial is a true denial and a patient no longer meets medical necessity, he can no longer remain in the hospital. Identifying these patients before a denial is received by the hospital will decrease unreimbursed lengths of stay and decrease overall denials.

Because hospital denials can cost an organization approximately 3% of its net revenue (Pelaia, 2013), centralized denials management teams are expected to improve hospital revenue. According to University of Texas Southwestern Medical Center (2014), the denials management team reviewed the process of collecting, tracking, reporting, trending, forecasting, and measuring denials. These processes allowed hospitals to see where they need to make improvements to handle denials, such as trends and opportunities to restructure insurance contracts when they are up for negotiation.

One of the initial ways of controlling denial costs has been the implementation of case management. Case management was introduced in the 1980s as a means of controlling cost through ensuring that patients received the appropriate resources (Baguhn, 2011). As health care evolved and cutbacks were made, case managers started

working in utilization review and discharge planning. It was recognized in the 1990s that there was a financial connection between case managers, utilization review, and the management of patient length of stay (Baguhn, 2011). Case managers and utilization reviewers have provided important services across the health care continuum by improving the delivery of care and how hospitals get reimbursed for the care delivered. Case managers ensured that patients have the appropriate discharge plan in place from the time of admission, and utilization reviewers focused on ensuring the patients met medical necessity criteria for being in the hospital.

Denials management teams working closely with case managers can have an impact on hospital revenue. Denials management teams work on concurrent denials and communicate with case managers who make them aware that the insurance company is denying all or part of the inpatient stay. The case manager can then speak with the patient's primary physician to identify any further needs for hospital care. Case managers work to keep the lengths of stay down by making sure patients' needs are met post discharge, such as having appropriate home health care and durable medical equipment, or a short-term skilled nursing stay arranged before the patient returns home. Case managers identify patients' needs upon admission to prevent delays in discharge that could cost the hospital money for additional medically unnecessary days of care (Miodonski, 2011).

Summary

It was evident through the literature review that having a physician advisor or a dedicated team can help overturn denials and decrease the length of stay in hospitals.

However, having a centralized denials management team focusing on concurrent denials can impact denials rates proactively, decrease overall lengths of stay, and identify denial trends of insurers and payers. The literature review demonstrated that there is a reduction in overall length of stay, an increase in hospital revenue, and an increase in overturned denials when a team is employed to manage denials. The literature review also has shown that a collaborative team of case managers, utilization reviewers, and CMOs can have an impact on decreasing the number of denials and increasing revenue. The next section of the paper presents the proposed methods to carry out the evaluation of the pilot centralized denials management program.

Section 3: Collection and Analysis of Evidence

Project Methodology

The purpose of this project was to determine whether a pilot centralized denials management unit had a more significant impact on overturning denials and increasing hospital reimbursement than a hospital-based review team. The unit was developed to decrease hospital denials, monitor trends in denials, and increase revenue though implementation of a denials management team.

In this section, I discuss the data collection plan and the analysis methods for the proposed pilot program evaluation. The goal of this project was to propose an evaluation and data analysis plan to determine whether a centralized denials management team decreased concurrent denials and managed them in a timely manner, increased the number of overturned denials, and efficiently managed the level of care status of patients. Development of the pilot centralized denials management team was expected to show decreased costs to the hospital through overturning denials in comparison to the current hospital-based review team. In my analysis, I identified trends useful in future contract negations with insurance plans.

Project Design and Method

The Six Sigma methodology was used to manage the change necessary to reduce denials and aid in the financial recovery of payment to hospital. Six Sigma focuses on incremental process improvements (Waymack, 2004). The first step in this project was to identify the problem, which is lost revenue due to insurance denials. The centralized denials management unit was implemented to address the problem. The second step is to

measure the denials to quantify the extent of the problem. Denials are currently recorded in a corporate denial log. Comparison of denials numbers and types of denials before (2014 data) and after (2015 data) the centralized denials management team was implemented use the denial log for project Hospital A. The third step is to analyze the data. The analysis of the data compares the previous year's data to see whether there is a significant decline in denials of at least 5% and an increase in revenue after implementation of the centralized denials management pilot program.

Data from the denial log will be useful in identifying which insurance carriers disperse the most denials and the reasons for these denials. The denial log in Appendix C Figure 1 shows the format of the log from which the data will be collected by the denial market coordinators. The data will be categorized to determine the insurance carriers with the most denials and the causes of denials (medical necessity, level of care, admission denial, contractual denial, or delay in procedure). This analysis will be displayed using a pivot table to itemize the insurance carrier that issued the denial and the denial type. From these data, I will be able to track and trend payer behavior. The fourth step will recommend how the denials management team can improve its effectiveness in handling denials. Processes will be reviewed and changes explored. The fifth and final step is to make sure the process is working and sustaining improvements. If the data reviewed demonstrate that the centralized denials management team is cost effective, has managed to identify trends and denial types among payers, and has recouped revenue for the hospital, this program will be considered for expansion across the hospitals in the health care corporation.

The DNP project encompassed Six Sigma Steps 1 and 2. Step 1 was initiated by the organization in Hospital A in January 2015. Step 2 built on the current data collection process to propose an evaluation plan. Due to the proprietary nature of the resulting information, Steps 3 through 5 are planned to occur after the DNP project ends.

The cost-effectiveness analysis will be done at the corporate level, where they can identify hospital-wide losses on concurrent denials. A pilot program was implemented to determine whether a centralized denials management team would be effective in controlling money lost through concurrent denials as opposed to individual hospital-based denials management. The data for the evaluation will come from Hospital A and will be compared to data for the same months in Hospital A 1 year prior to determine whether there was a decrease in denials and an increase in revenue. The data will be retrieved from the denial log and, with the use of the pivot table, will be presented by insurer and causes of denials.

Population and Sampling

This developmental project is for a for-profit facility that is part of the Eastern Florida Division of a large managed care system. There are a total of 13 hospitals in this division. When reviewing denials, we look to see if they are per diem, case rate, or diagnosis-related group (DRG). A DRG is a classification of all human diseases, and payment based on that classification is a set fee (Health Information Professionals, 2012). Per diem rate is a fixed amount per inpatient day, and case rate is based by case; for example, a hip surgery would be paid as a flat rate case that has been agreed upon

between the hospital and insurance company (Johnson, 2009). Knowing the financial information tells us the type of payer if it is a case rate or per diem rate.

According to MacDonald (2005), pivot tables are useful in summarizing information and analyzing large quantities of data. The usage of a pivot table allows for summarizing long lists by calculating information and putting it into a graph or making it more specific to the needs of the project. The denials information identified as to what type of denial it is, such as a continued stay denial, an admission denial, or a carve-out that can be from a delay in discharge or a family delay in refusing testing. The time of the denial received and the number of days denied are noted. The information will be entered into the denial log. The information is downloaded into a pivot table (see Appendix B for an example) and classified into the appropriate category. The data that are obtained from the pivot tables are length of stay, insurance denials by payer, number of denials overturned, number of patients converted from observation to inpatient, and number of procedures and labs ordered by the physician and denied. The way in which the denials information is collected is the same manner across the 13 hospitals in the system. The data are transferred to the denial log and disseminated in the same manner. The denials management coordinators are all located in the same office and trained so that there are no differences in the processes for recording the data.

Data Collection

The data will be reviewed from the previous year's denial log (2014) and compared to the data that were gathered in 2015 after the project's implementation. Data on the following variables are already being collected and will be analyzed for the project

evaluation: continued stay denials; carve-out due to delay in physician, testing, nursing, or family issues; inappropriate status (inpatient versus observation); insurance plan coverage; wrong patient information; whether peer-to-peer review was done; and the outcome of the peer-to-peer review. It will be important to identify and compare the number of denials processed in a day, week, month, and year in order to compare financial outcomes accurately.

Appendix C Figure 1 is a copy of the denial log that would be used for each facility and from which data for steps three through five of the project will be taken. The denial log contains information on which payer is issuing the denial, payer type (Medicare or Medicaid, an HMO, or a PPO), and why the payer is denying payment (admission denial, continued stay, carve-out issue, not a covered benefit, physician delay, discharge delay, or care can be delivered at a lower level of care). This information will allow tracking and trending of the causes of denials and which payer(s) issued the denials. Payers will fax denials and authorizations to the hospital payer mailbox for which denials coordinators and utilization reviewers have access. The denials once read and printed by the denials management team will be marked as under review by the denials management market coordinator (DMC). The DMC is the one who monitors the plan payer mailbox marking it as "communication" if the utilization reviewer needs to look at it or as "under review" if it is a denial being worked by the DMC. The DMC then reviews the patient's chart to determine if it is a concurrent, continue stay, or inappropriate status denial. Once the determination is made, the DMC then works it accordingly. The hospital utilization reviewer will put the authorizations on the

certification line to show that the patient's stay has been approved by the insurance company. If it is not a denial but an authorization or payer log, the document will be marked as communication so the hospital will know it is for them to address.

Once the denials coordinator receives the denial, she will review it and manage it as needed. The information then will be entered into the denial log. This is the information that will be used to identify, track, and trend issues that need to be addressed either at the hospital level, contract level, or with the payer. These data will be useful for corporate management in decision-making about whether this project is worth making permanent.

The denials management teams must be knowledgeable and proficient in InterQual, which is the standard that is being used throughout the organization to determine medical necessity and appropriate level of care. A competency test with 90% or greater showing their understanding and knowledge of InterQual must be taken before a denials manager can work on denials. They also must have an understanding of the contract language and the guidelines that will enable the team to be able to overturn denials and track and trend payer reasons for denial. It is through having centralized denials teams that the organization can learn the contract language to know if the denial can be challenged based on contractual agreement. The contracts are the same for all 13 hospitals. InterQual is used for all 13 hospitals and is considered the "Gold Standard" that determines whether patients meet hospitalization criteria. This information then can be used in contract negations to set better standards for the patient and the hospital.

Robertson and Dore (2005) noted that denials management has become one of the hottest topics in health care today. It has been observed by many CFOs that implementing a denials program can have a major impact on the bottom line; it results in more revenue than any other cost reduction initiative or single revenue generator. Being able to identify the type of denial and the type of insurance product can lead to an even more effective way to deal with overturns of denials for better reimbursement. In order to meet the needs of patients and their families, hospitals must find ways to provide quality care and still afford to implement the latest advancements in medicine.

The ACA has had an impact on hospitals. It is estimated that 11.5 million people have enrolled in the Marketplace insurance ("Get the Facts on ACA Sign Ups"). According to Evans, Hollweck, and Sanderson (2014), with the increase in individuals having insurance and the increase in visits to the hospital, denials teams are getting prepared for an increase in denials through the health exchange. Having a team whose primary focus is denials will help hospitals to stay abreast of increased insurance enrollees and increased demands for hospital care.

Summary

As our country experiences changes in its health care policies, advances in technology, and the continuing demand for high quality of care, we must change how we deliver that care. New paradigms in the delivery of health care services are an organization's priority to maintain reimbursement and provide up-to-date care. Centralized denials management is one of the ways that hospitals can handle denials and decrease the lengths of stay while still delivering quality care. The centralized denials

management team would be able to aid in overturning denials, by placing patients in the right status and continuing to evaluate patients throughout their hospitalization. This will aid in the timely discharging of patients to prevent denials due to lack of medical necessity.

A comprehensive centralized denials management program will help hospitals decrease denials, decrease overall length of stay, and increase revenue. The goal of this developmental project was to show how implementing a centralized denials management team can impact the bottom line compared to the hospital-based denials management program. The denial log data collected during the project will be compared to the previous year's denial log data. This project would allow tracking and trending of these denials. Pivot tables, pie charts, and graphs will be used to present a breakdown of denials by insurance company and the denial reason(s) will be identified; the performance improvement of the health system will be analyzed.

In summary, the developmental project will be able to determine the impact the centralized denials management team can have on overall length of stay, number of denials issued by payers, and number of overturned denials. The data can be compared to data collected when denials management was done by each hospital in the corporation. The data will be compared to determine whether the centralized denials management team approach is cost effective and the practice should be expanded corporate-wide.

Section 4: Findings and Recommendations

The purpose of this developmental project was to develop an evaluation plan to determine whether a centralized denials management unit helped in overturning denials and increasing reimbursement compared with the hospital-based review teams currently used. The gap in practice acknowledged opportunities to determine how denials operations could be improved in the corporation. Researchers will be able examine the gap to determine payer trends and provide areas of improvement and prevention of denials.

Findings and Implications

The proposed process for centralized denials management can be detailed as part of the findings and implications of the project. Once the denial outcome of each case has been made, the information will be inputted into the denial log (see Appendix C Figure 1). This information is then aggregated into a pivot table to show month-to-month progress. These data will show whether the pilot centralized denials management program is more effective than a hospital-based approach. Using the pivot tables, the corporation can track and trend from month-to-month to see whether denials are trending upward or downward.

At this time, the four payers with the highest denial rates have been identified. Weekly meetings have been put into place with supervisors from these companies to discuss means to decrease denials. Payers who are not abiding by contracts are also discussed in these meetings, so that payers may review contract guidelines with their reviewers. It is important to maintain working partnerships with payers to help identify

issues that can be addressed at the local level before having to escalate to legal intervention. Since the implementation of the denials management team last year, approximately 40% of denials have been overturned.

The current trend in denials review is to have a utilization team within the hospital setting to focus on denials, along with making sure patients are meeting criteria for being in the hospital. One of the major concerns of hospitals today is the loss of revenue to claims denials and not being able to reclaim some of those denials in a timely manner. According to Healthcare Reports (2011), it is estimated that 25% to 30% of denied or rejected claims result in millions of dollars in lost revenue for hospitals. They recommend employing trained individuals who are able to focus solely on denials management. Implementing a denials management team across the organization would impact retrieving lost revenue. Although the organization has projected a 5% reduction in denials, I believe that on final analysis, the denials management team may have recovered at least 25% of the revenue lost to denials within the first year of its inception.

Theoretical and Methodologic Foundations

The Six Sigma change method is the performance improvement model used to guide this DNP project. Six Sigma guides organizations as they focus on process improvements (Waymack, 2004). The use of Six Sigma allowed me to identify areas in the denials review process that need to be improved and how to solve them through a pilot centralized denials management team. Using the Six Sigma method will allow continuous rapid change in the denials management processes in response to changing national mandates. Evaluation of the denials team outcomes will provide information on

the numbers of concurrent denials and how much they have been reduced in the effort to increase hospital revenue.

The model for mprovement is the theoretical framework that will aide in the optimization the revenue cycle by using the Plan-Do-Study-Act (PDSA) cycles. This model is able to be applied to quality improvement activities, allow for changes within the organization, and measure the success of the program (Crowl, Sharma, Sorge, & Sorensen, 2015). Enhancing the revenue cycle will allow improving services that are offered to the community. This would include expanding maternity, expanding the emergency room, and obtaining high technological equipment.

In addition to decreasing the number of denials, the denials coordinators will be able to help with decreasing the hospital length of stay. They will be able to track and trend which physicians have the highest length of stay and the reasons behind it. Some reasons are not getting the test they ordered done in a timely manner, lack of direction from the physician, and delay by the emergency department in contacting the primary physician thereby making the patient wait to be seen until the next day (Ali, 2010). The denial coordinators are able to identify these trends. They are then able to send a correspondence to the appropriate case management director, who along with the CFO can sit down with the primary care physician and review these data to find out what can be done to assist the physician in decreasing the patient's length of stay.

According to The University of Texas (2014), having a denials management program in place aides in the improvement of the revenue process, that for some institutions it can save them as much as 25% on their claims. It improves communication

among internal departments identifying issues to reduce the volume of denials and keeping cost down to their patients.

Recommendations

The goal is to implement an organization-wide team of five denials coordinators. The director of operations will ensure that everyone is doing the same process and setting up calls with payers once trends have been established or if payers are not abiding by their contracts. The director will challenge denials reviewed by payer supervisors to show how the patient met medical necessity and needed to be in the hospital. The director also will speak with the payer supervisor and contracting supervisor regarding contract issues or interpretation of why denials reasons cannot occur based on contractual agreements. If this conversation is ineffective, the denial will go to the corporate legal department for review and further negotiation. The director is a liaison between the denial coordinators and facilities they manage. The director has made a visit to the facilities to help them identify ways that denials can be averted, such as speaking with physicians before the patient is discharged to ensure appropriate status, such as observation or outpatient if, for example, the patient had a minor surgery. This process could avoid denials before the patient is discharged from the hospital.

The four denials management market managers will each have his or her own territory of hospitals and will manage those hospitals' payer mailboxes. They will mark each denial as under review to show the hospital that they have seen the denial and are working on it. The denial market coordinators then will review the denial and the patient's record to see if the denial was for medical necessity or had an incorrect status

claimed at the facility. The denial coordinator would do an InterQual analysis on the

denial to see if it met criteria for an inpatient or observation setting. If the patient

InterQual evaluation met criteria, the denial will need to be sent to the CMO to see if he

or she agrees that inpatient criteria were met. The CMO can decide to challenge the

denial with a peer-to-peer contact with the medical director of the payer. Appendix B

Figures 1 is an example of a pivot table that shows the four payers with the highest

denials. The figure gives data from 2015 to current. Other break downs will include

physicians with the highest number denials, causes for denials, number of days denied,

and percentage of denials overturned. Each table will show month-to-month and year-to-

date breakdown on how the denial managers are impacting the denials. This information

will be given to the director of case management and the CFO. This lets them put

processes into place that will assist in averting denials and speak with physicians to

educate them on the reasons their inpatients' care is being denied. The goal is to see a

decrease in concurrent denials. The denial log is a tool that is useful in tracking and

trending from month-to-month and year-to-date. It will show the progress being made by

each of the hospitals and by the organization as a whole.

Strengths and Limitations

The strength of this developmental project is that if implemented corporate-wide,

all the denials coordinators would be in one room together. They would be able to discuss

issues that arise during their day and process denials in the same manner. If there were a

process that was not working, denials coordinators would be able to discuss the issue and

make changes accordingly. Having the denial coordinators in one centralized area lets them gain competency based on experiences of the team.

Denial coordinators will have the ability to track and trend payer habits. They will then be able to communicate with case managers and utilization reviewers at the hospital base level, to inform them of these trends, so they may collaborate with team members in their facility to reduce concurrent denials, decrease the length of stay by identifying issues and prevent unnecessary additional hospital days (Harrison, Nolin, & Suero, 2004). This is just another means of collaborating between denials coordinator and the hospital based case managers and utilization reviewers to increase hospital revenue, decrease length of stay and reduce additional patient days.

The limitations to this developmental project are that each hospital does not have the same bed capacity nor have an on-site CMO. Not all insurance carriers are covering the same territory, and each has its own unique requirements.

The recommendation is to maintain the centralized denials managers and to allow them to track and trend payer issues that may be occurring globally. Preliminary outcomes data indicate that the denials coordinators have been effective over the last year in getting concurrent denials overturned. They have been effective in educating facility utilization reviewers at the hospital level on how to avoid denials. The facilities are now consistently conducting InterQual evaluations and recognizing when a patient does not meet medical necessity. They have been instrumental in getting physicians to discharge patients or move them to the appropriate care status level. In doing this, the data have shown that there has been a reduction in denials, an increase in revenue, and a decrease in

length of stay. If these preliminary data findings are upheld on detailed review, the recommendation to management will be to make this process for denial reviews and evaluation the "Gold Standard" for the corporation.

Summary

It is evident that having a centralized denials team can be effective. Teams focus solely on the various types of denials (concurrent, continued stay, or contractual) and work them appropriately. Health care is continually changing. Hospitals need to find a way to keep their doors open to the community, while continuing to provide high quality care. They need to have a centralized denials management team that will be part of the solution in aiding financial recovery from insurance companies that do not want to pay for services that are being rendered or have been rendered for their clients. It is important to keep the lines of communication open between payers' reviewers and the denials managers to try to avert denials up front. Keeping a hospital stay or procedure from becoming a denial in the first place is the ultimate goal of the proposed process and evaluation plan.

Section 5: Dissemination Plan

The purpose of this project was to evaluate whether a centralized denials management team approach was more effective than the previous hospital-based approach. Review of information from the past year has shown that there has been an increase in overturned denials and a decrease in concurrent denials, compared to the hospital-based approach. Corporate headquarters has recognized the impact that the centralized denials management unit has had on decreasing concurrent denials, increasing revenue and decreasing length of stay. The initial expectation was to increase revenue by 5% since the start of the program. The team has exceeded this goal.

Dissemination Plan

Implementing an effective denials management team could help provide appropriate care while keeping costs down. There a large number of patients' days that do not meet acute level of care due to inefficiencies in care processes (Poulos, Magee, Bashford, and Eager, 2011). This project was implemented to plan an evaluation for a year-old pilot denials management team. The proposed evaluation plan will be given to the CFO of the division and the director of case management for the division. Case management for the hospital system falls under the CFO's administrative duties. The CFO and director of case management will review the results of the proposed data analysis plan. If the numbers are consistent with the projection or are better than projected, the proposal would then be presented to management at corporate headquarters for consideration to be rolled out nationally to all hospitals within the corporation. The executive summary has been developed for communication to corporate management.

Executive Summary

Our health care system is constantly changing with the implementation of electronic health records, electronic medication management, meaningful use, and improvements made to equipment. Hospitals need to find a way to put money back into the system so they can offer the latest in technology and quality of care at an affordable price. According to Pelaia (2013), hospitals are losing approximately $261 million a year. This number will only rise as health care continues to change. The Six Sigma model can identify areas in which hospitals can improve processes to decrease costs. Hospitals currently use utilization departments to review denials, make sure patients' admission statuses are correct, and ensure the hospital is following national regulations and guidelines. It is estimated that 67% of denials are appealable (Pelaia, 2013).

The purpose of this project was to compare the current hospital-based utilization review to a pilot centralized denials management team program to see if the centralized denials team was more effective than the hospital-based approach in getting concurrent denials overturned and recouping money for care delivered. An implementation of a pilot denials management unit was put into place February 2015. Hospital A was the first hospital to go live March 2015. A comparison of outcomes from this unit and the hospital-based denials approach is proposed to determine whether there was an effect on decreasing denials and increasing revenue. The denials management team consisted of a director and four denials market coordinators (DMCs). Hospital A was the first to go live, and data from this hospital will be reviewed and compared with previous data from the

hospital-based approach. The goal of this project was to demonstrate a reduction in concurrent denials by 5% and increase hospital revenue.

The DMCs had remote access to the hospital's insurance payer mailbox and were able to review all the denials the hospital received from insurance companies. The DMC then logged this information into the denial log. The information was tracked and trended for payer habits, denial reasons, physician, and the number of denials overturned. This information can be disseminated using pivot tables. The information can be given to the director of case management, the CFO, and the CEO to review, and the hospital can use the data to put together an action plan for addressing issues. The hospital's director of case management, CFO, and CEO may want to meet with physicians who have the highest denial rates and provide them with information on the causes of the denials and what they need to focus on to prevent future denials.

The literature review showed that case management, utilization review, and denials management departments need to work together in the reduction of concurrent denials. Case managers work at discharge planning to help facilitate discharges in a timely manner. Utilization reviewers at the hospital level work on making sure patients meet medical necessity and communicate with physicians when they do not. The utilization reviews focus on discharge of the patient or documentation of the reason(s) the patient needs continued hospital care. It is through the use of Milliman or InterQual guidelines—the national standards for admission criteria, level of care, and length of stay—that utilization reviewers identify whether the patient meets inpatient or observation status. Prior to the implementation of the pilot centralized denials

management unit, Hospital A was not able to dedicate the time needed to get denials

overturned. Since the implementation of the denials management program, Hospital A

has seen a decrease in concurrent denials. In the first quarter of 2015, there was little

improvement in concurrent denials. The second quarter started to show some

improvement, but it was not until the third quarter that there was a 3% decrease in denials

and a reduction of $632,000 lost to denials. In the fourth quarter, the denials management

program met its goal of decreasing denials by 5% or $1.2 million. In reviewing this

program, the team dedicated to just managing denials has made an impact on concurrent

denials and has increased hospital revenue.

As our health care system has continued to change, there has been a paradigm

shift in how we manage patient care. It is now the organization's responsibility to provide

its community with quality of care and state-of-the-art technology. To achieve its

community mission, it must find a different means for obtaining revenue. Implementing a

centralized denials management unit is one way to focus on getting payers to pay for the

service that the hospital provides to their patients. It is evident from the pilot that a

centralized denials management program is a way to ensure future financial strength of

hospitals within the corporation.

Analysis of Self

As a Scholar

There are many facets to being a nursing scholar. Being a nursing scholar comes with many component virtues, roles, and responsibilities to put into practice what we have learned and to be an example for others to follow (Conard & Pape, 2014). It is essential that we do not settle for the status quo, but rather ask how we can make a difference in what we do. It is evident that there are many changes coming in health care. As a nursing scholar, I know it is important to identify hospital and corporate readiness for the changes to come. As the changes that are occurring are impacting reimbursement, I must understand not only the care of patients, but also health care finances. I must continue to learn, using my evidence retrieval skills to ensure current knowledge and predictions for hospital finance.

As a Practitioner

My development as a practitioner has allowed me to perceive this project from many views. I have looked at this project as a denials market coordinator, a director, and a CFO. In considering this like a CFO, I must begin by looking at my own budget. How do we stretch what we make to get what we need? The CFO of the hospital has to do the same. He must look at what the hospital needs and what he needs to do to get it. In the process, it may have to be denial of a nurse manager's request for a new piece of equipment in order to get another piece of equipment that will help bring in more revenue. I have had to look at the clinical practice problem addressed by this project from every angle to see if this project is worth continuing. Being in the DNP program has

helped me grow as a practitioner as well as a nursing leader. It is through this process that I have gained the skills required to develop this program at the corporate level with the expectation of extending it corporate wide.

As a Project Manager

As a project manager, I see that DNP-prepared nurses must be willing to look at new options and initiatives that are being introduced, such as the Bundled Payments for Care Improvement initiative. This is another performance accountability for patient care (Centers for Medicare & Medicaid Services, n. d.) that is affecting plans for hospital revenue. In knowing that such changes are coming, it is important to be able to identify a means of being able to track and trend how changes may affect payer outcomes. As a DNP, I use my educational background to help put together a team of denials coordinators who will be able to react quickly and effectively to regulatory changes. In doing research for this developmental project and presenting it to the corporate leadership, I may have benefitted financial growth within the organization and at the local hospital and national corporate levels.

<div align="center">

Summary

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In conclusion, the purpose of this developmental project plan was to demonstrate whether the pilot centralized denials management team was able to identify causes of denials and how to address them in order to improve the hospital's reimbursement. It is evident through the literature review, that a centralized denials management team should be effective in increasing revenue, identifying payer trends for denials, and decreasing length of stay. I believe that once the corporate administration reviews the outcomes, the

centralized denials management team will become the "Gold Standard" for the

organization nationwide.

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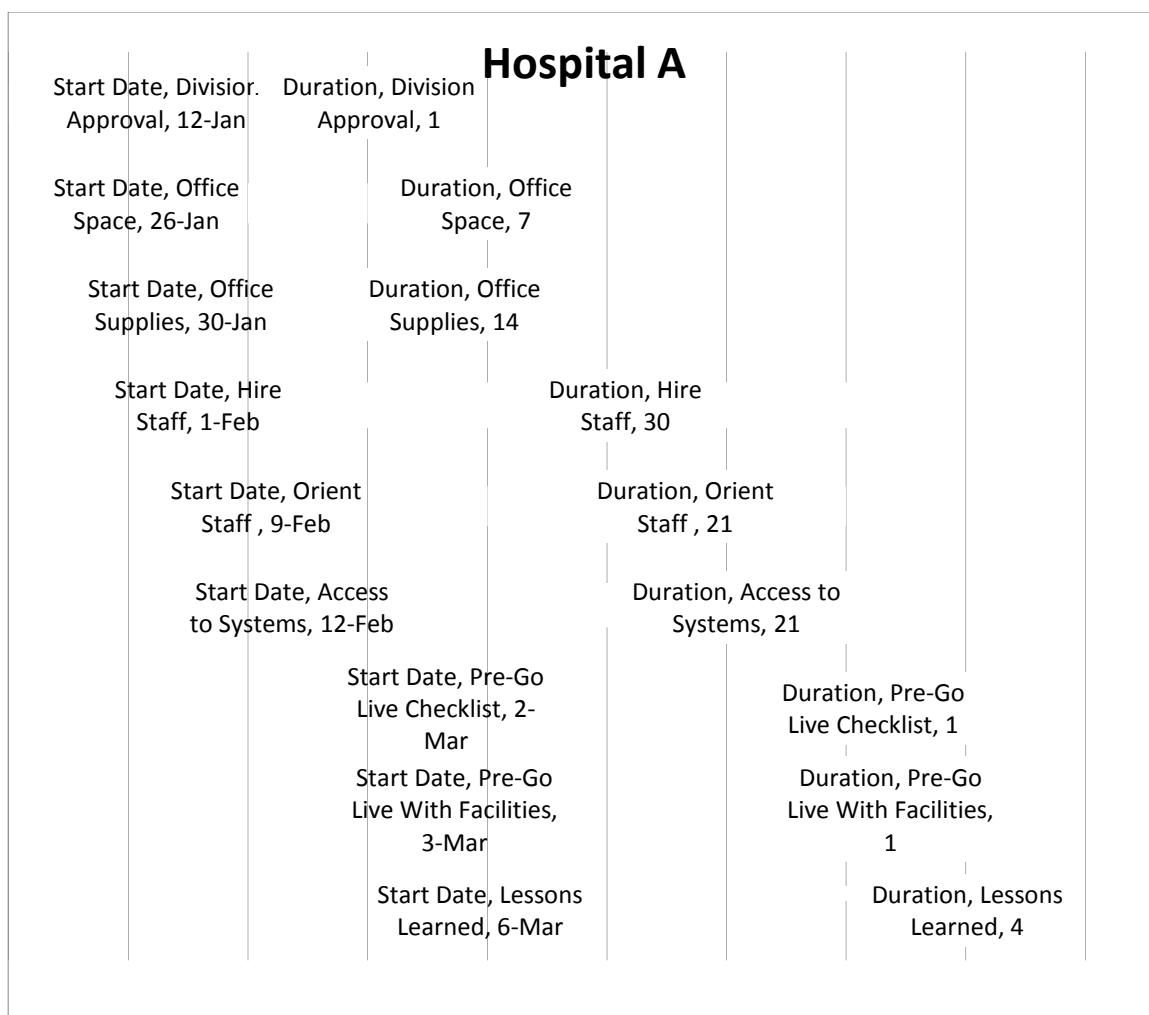
Appendix A: Gnatt Chart

Hospital A

Start Date, Division. Duration, Division
Approval, 12-Jan Approval, 1

Start Date, Office Duration, Office
Space, 26-Jan Space, 7

Start Date, Office Duration, Office
Supplies, 30-Jan Supplies, 14

Start Date, Hire Duration, Hire
Staff, 1-Feb Staff, 30

Start Date, Orient Duration, Orient
Staff , 9-Feb Staff , 21

Start Date, Access Duration, Access to
to Systems, 12-Feb Systems, 21

Start Date, Pre-Go Duration, Pre-Go
Live Checklist, 2- Live Checklist, 1
Mar

Start Date, Pre-Go Duration, Pre-Go
Live With Facilities, Live With Facilities,
3-Mar 1

Start Date, Lessons Duration, Lessons
Learned, 6-Mar Learned, 4

Figure A1

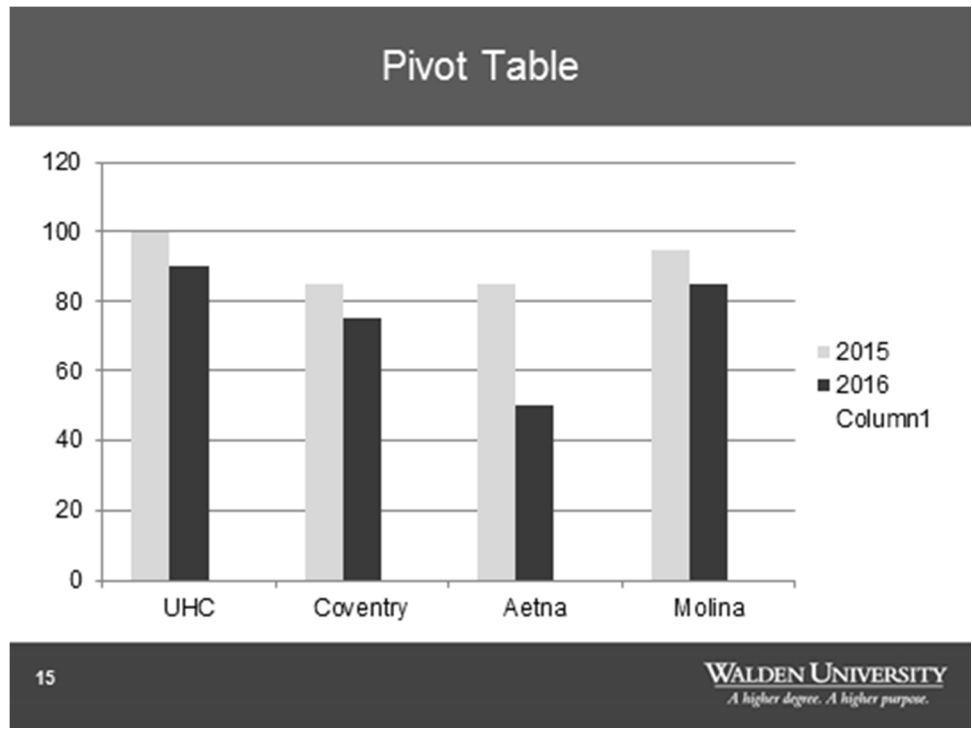Appendix B: Sample Pivot Table

Figure B1

Appendix C: Sample Denial Log

Date	Admit date	discharge	reason for denial	first day denied	last day denied	phyiscian	peer to peer	outcome

Denial Log

Figure C1

INTERQUAL® ACUTE CRITERIA
REVIEW PROCESS

InterQual Acute Level of Care Criteria provide support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Acute Criteria address the Observation, Acute, Intermediate, and Critical levels of care. Pediatric criteria include four additional levels of nursery care (NICU, Special Care, Newborn, and Transitional Care). Adult criteria are for review of patients ≥ 18 years of age and pediatric criteria are for review of patients < 18 years of age.

2013 InterQual Acute Criteria include condition-specific, general and extended stay subsets. If a patient's primary condition or diagnosis matches one of the following condition-specific subsets then refer to the appropriate subset:

Condition-specific subsets	
Acute Adult	**Acute Pediatric**
Medical	**Medical**
• Acetaminophen Overdose	• Acetaminophen Overdose
• Acute Coronary Syndrome (ACS)	• Anemia/Bleeding
• Anemia/Bleeding	• Asthma
• Arrhythmia	• Bronchiolitis
• Asthma	• Carbon Monoxide Poisoning
• Carbon Monoxide Poisoning	• Cellulitis
• Cholecystitis	• Croup
• COPD	• Cystic Fibrosis
• Cystic Fibrosis	• Epilepsy
• Diabetes Mellitus	• Diabetes Mellitus
• Diabetic Ketoacidosis	• Diabetic Ketoacidosis
• Deep Vein Thrombosis	• Failure to Thrive
• Epilepsy	• Gastroenteritis

Figure C2

Figure C3