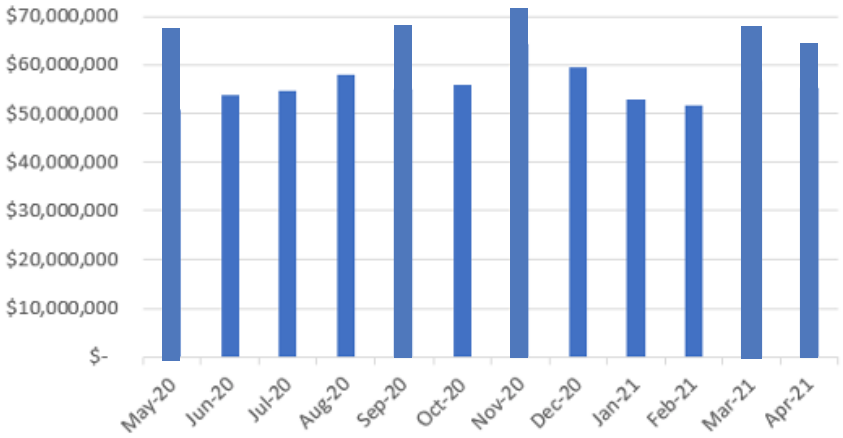
Rev/Track Insights Report

ABC Healthcare Denials Analysis
Month Ending: April 2021

Summary

April's payments are consistent but are below baseline.
In April 2021, your EDI payments ($64.5mm) remained consistent with March's total payments ($64.9mm) but are 14% below your Nov 2020 totals ($73.5mm), which marked your 12-month high.



Both denials and overturns are declining.
Total and Original denials declined in April compared to March, but so did overturned dollars. Overturned dollars in April decreased across all major payor groups in April.

Medicare continues to be a key driver of denials.
The largest increase in denials over a 6-month period between Dec 2020 and April 2021 was associated with Medicare outpatient institutional claims. These contributed $9.7M denied claim dollars to a peak denied claim dollars amount of $19.6M in March 2021. Additionally, PGS Medicare remitted significantly greater original denied dollars in April, $1.6M more than their rolling monthly

Denial rate is above average, denials likely being missed.
April 2021's 19.7% original denial rate a higher denial rate than typical best practice for secondary outpatient institutional claims. Claims remitted with a CO16 ("Additional info requested") contribute most to this higher rate. It is likely that these denials are not present in Epic workqueues because the secondary payment amount is equal to the primary payer's PR amount. Recoverable secondary denials can often be hidden in Epic due to denial (BDC) suppression logic, based on expected allowed amounts.

Strongest predictors of denial overturn likelihood for submitted claims:

- 'Documentation Issues' denial category (11.9 avg model score)
- Medicaid payer class (2.1 avg model score)
- Institutional - External injury/poisoning/other consequences principal diagnosis category (2.9 avg model score)
- Professional – Congenital malformations/abnormalities principal diagnosis category (4.7 avg model score)

QUICK LOOK: METRICS

EDI Payments
$64.5mm recorded in April 2021

- -4% vs prior month
- +9% vs prior year
- -12% vs rolling 12-month average of $72.2mm
- -14% vs 12-month high of $73.5mm recorded in Nov 2020

Denials
19.7% Original Denial Rate in April 2021

Original Denials: $15.35mm

- +2% vs prior month
- -5% vs prior year
- +6% vs 12-mo avg ($16.3mm)
- -1% vs 12-mo high ($15.2mm-Jan21)

Total Denials: $21.1mm

- +7% vs prior month
- -5% vs prior year
- +7% vs 12-mo avg ($19.6mm)
- +3% vs 12-mo high ($20.5mm-Jan21)

Medicare Denials: $9.1mm

- +3% vs prior month
- +4% vs prior year
- +2% vs 12-mo avg ($8.9mm)
- +3% vs 12-mo high ($8.8mm-Jan21)

Overturn Dollars
$3.7mm recorded in April 2021

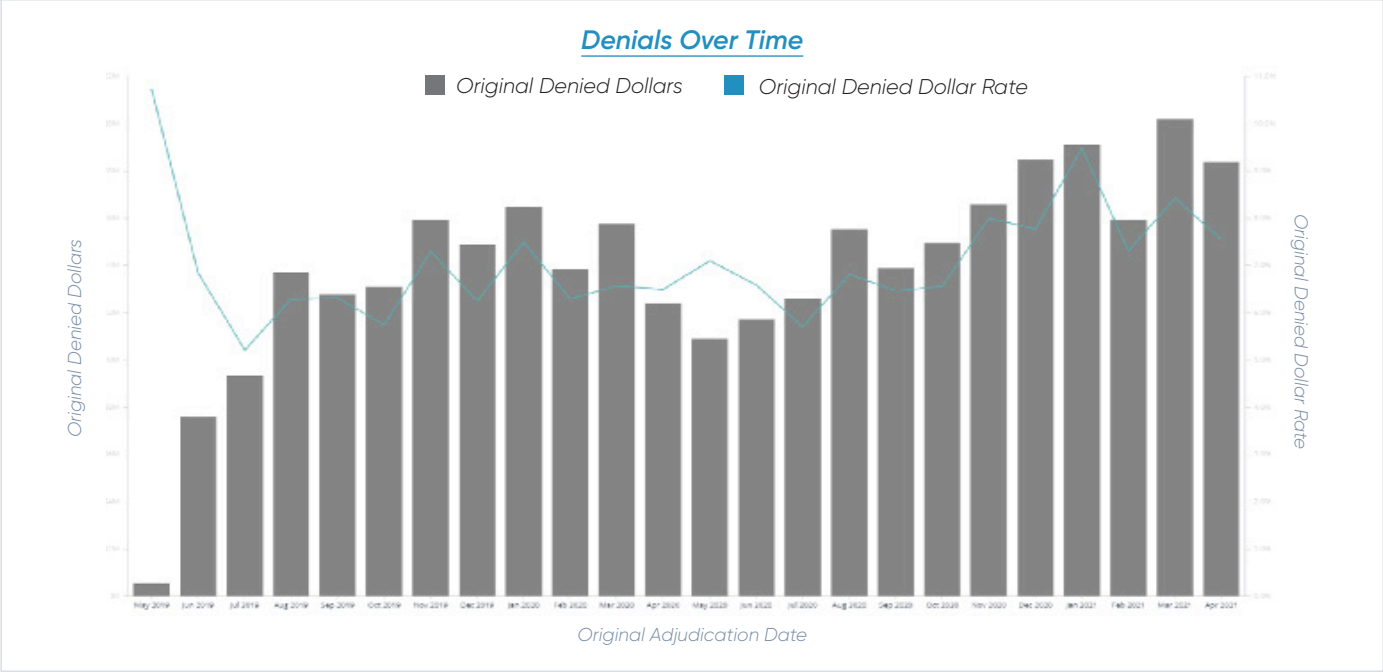
- -9% vs prior month
- +6% vs prior year
- -11% vs rolling 12-month average of $4.1mm
- -13% vs 12-month high of $4.2mm recorded in Sep 2020

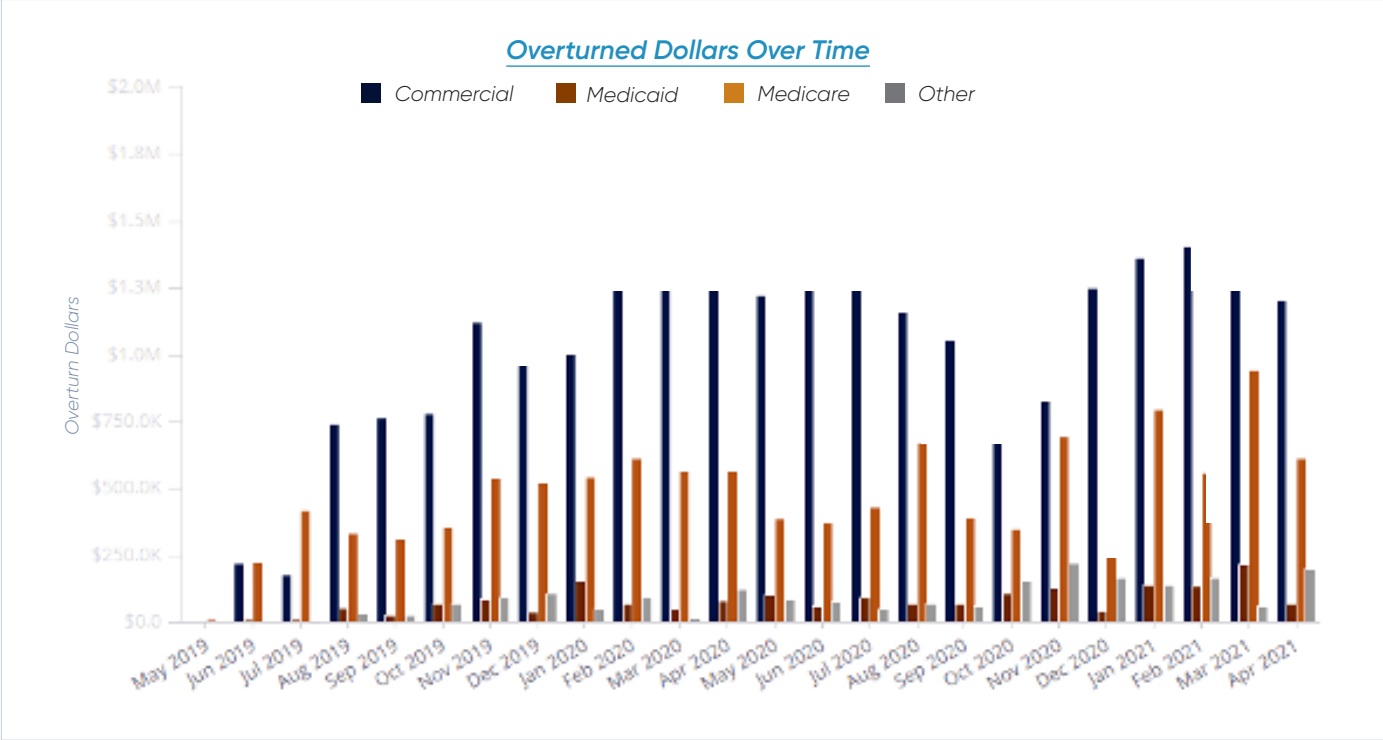
Collection Ratio, By Payer Class

- Medicaid: 16.8%
- Medicare: 25%
- Commercial: 48.6%
- Other: 50.8%

Denials

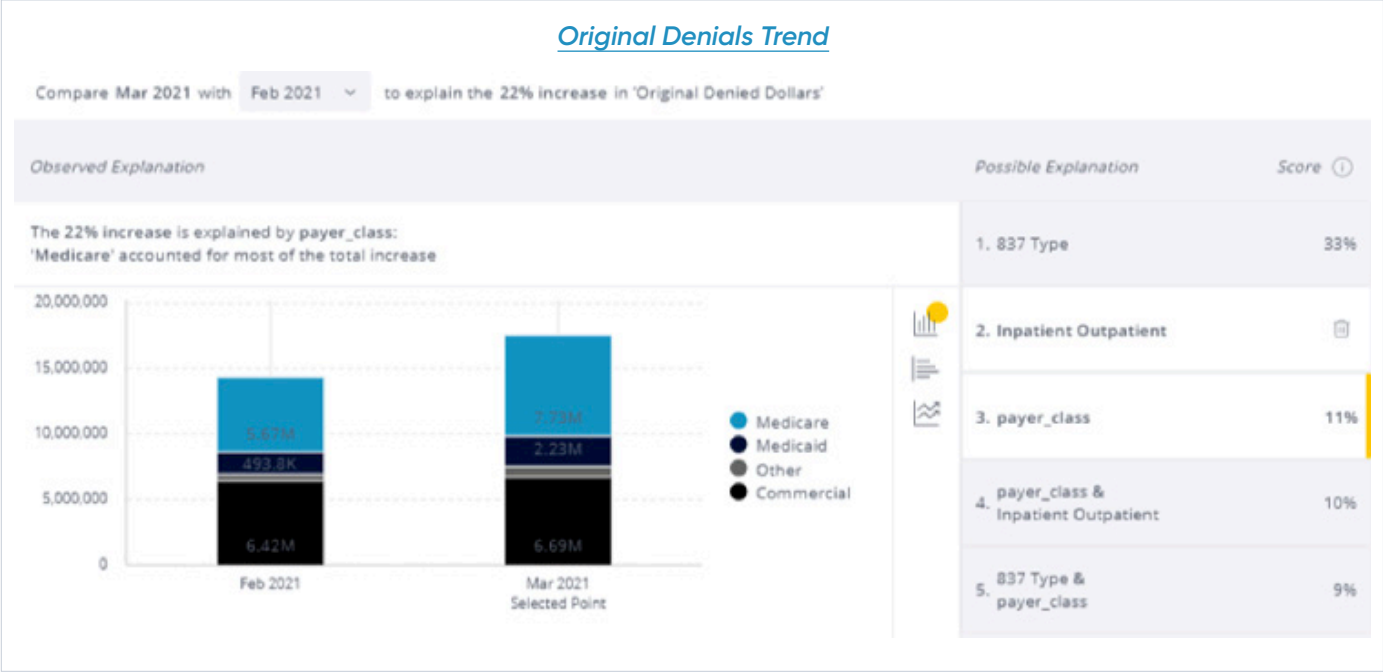
12-month trending of Original Denial Dollars and Rate Over Time shows a peak denials volume in March 2021 at $15.35mm, representing a 2% increase from February claim dollars denied ($15.7mm). However, the most recent month (April) indicates a positive downward trend.





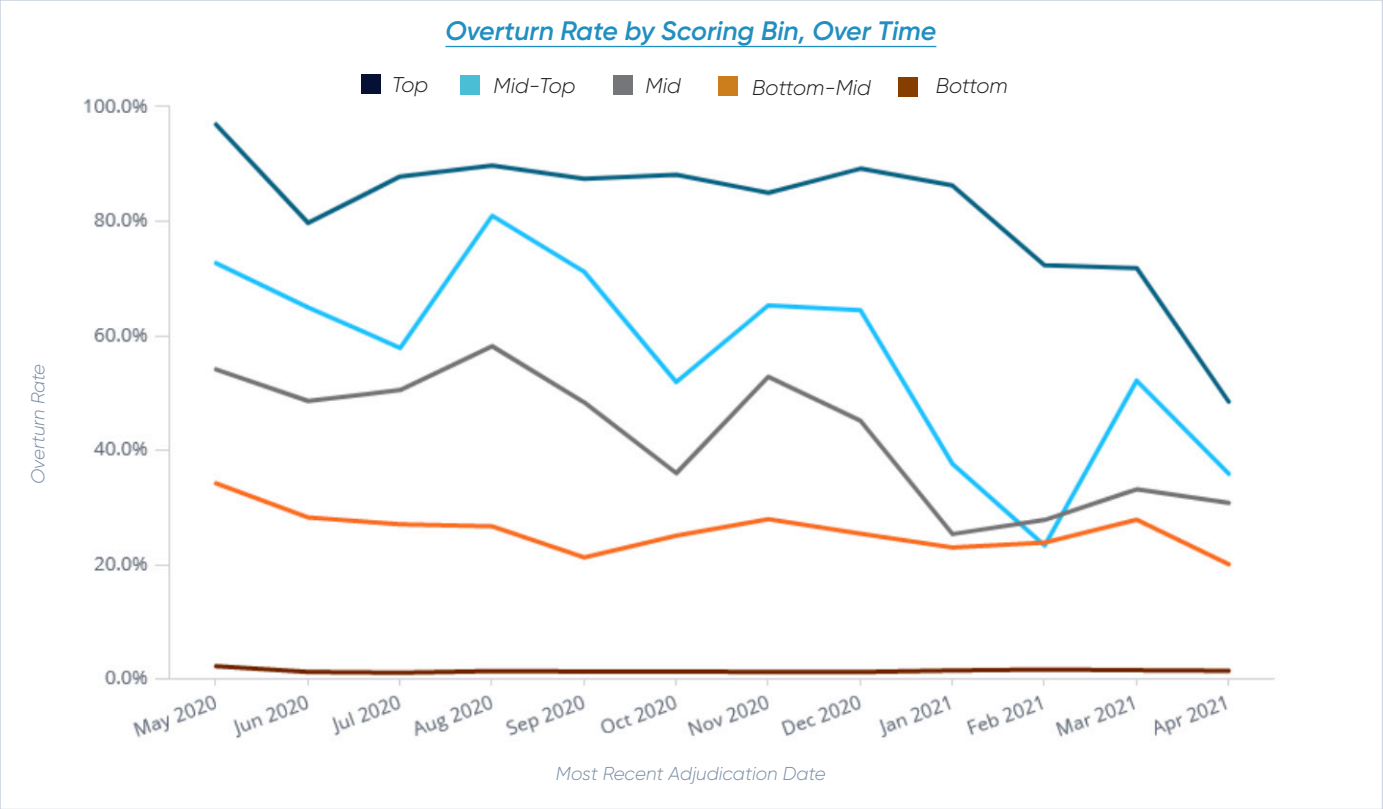
Medicare Impact
Contributing to the peak in March 2021 is a 120% growth in Medicare outpatient denials and a 49% growth in Medicaid inpatient denials. These denials are uniquely attributable to institutional claims only, as professional claim denial volumes remained relatively flat from February to March.

In April, Medicare Outpatient monthly claim dollars denied declined significantly compared to peak in March (700k reduction), but Medicaid inpatient denials continued to increase from March ($2.17mm) to April ($2.51mm).



Overturn Rates
Denial overturn rate across all scored performance bins and payer classes declined from March to April. Declines in top-scoring bins but increases in lower-scoring bins typically indicate sub-optimal prioritization of denied accounts for appeal, but declines in all performance bin categories indicate delays in appeal efforts, especially since median payer response days remained consistent in April.

Also contributing to the decline in overturn rate is that Medicare remitted an additional $1.1 million in denied claim dollars compared to the previous 180-day average.



Payer Performance

Payer Class Performance (averages)

Payer Class	Avg Lag Days	Overturn Rate	Collection Ratio	Adjudications
Commercial	15.4	6.2%	49.1%	1,254,102
Medicare	16.7	1.9%	22.0%	719,600
Medicaid	12.4	8.9%	17.8%	416,220
Other	14.7	6.0%	51.2%	90,054
Grand Total	**14.8**	**5.75%**	**35.0%**	**2,064,392**

UHC Denials
Drilling into your Average Per Payer Class, filtering by detailed payer names and claim type reveals that UHC adjudicated the largest number of claims within the Commercial payer class.

UHC Adjudications

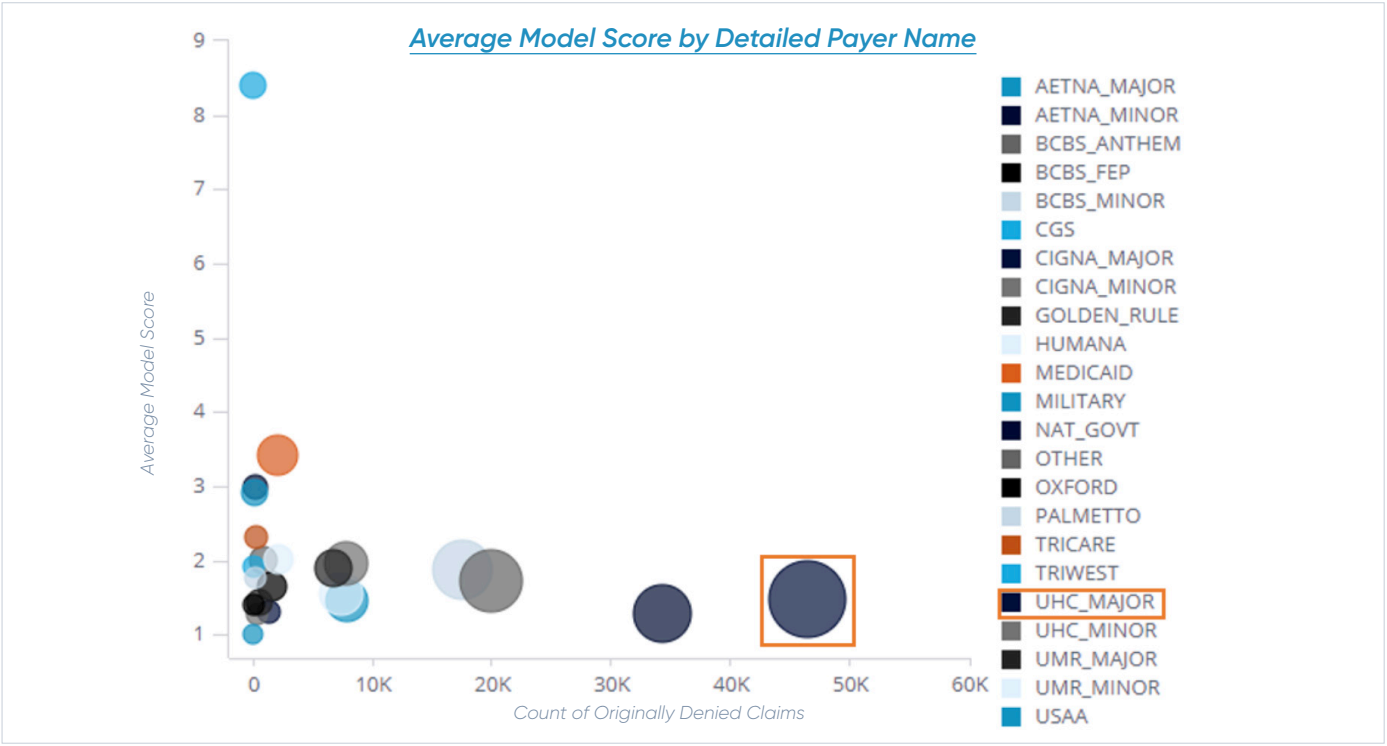
UHC > 99000 > svc_carc_code (All)

Payer Class	svc_carc_code	Avg Lag Days	Overturn Rate	Collection Ratio	Adjudications
Commercial	"234"	8.6	0.0%	99%	52,785
	"45"	14.2	27.5%	5.1%	2,397
	"18"	8.8	0.00%	100.0%	1,638
	"27"	8.5	0.0%	0.0%	505
	"97"	14.1	0.0%	4.9%	321
	"227"	13.9	0.0%	0.0%	297

Of your 526,822 adjudications, 40,258 (9%) are denied due to claims with CPT 99000 [Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory]. 38,878 of those claims (97%) are denied for CARC 234 [Px not paid separately]. It will be necessary to explore two things to ascertain appropriateness for charging for the service and receiving reimbursement from UHC: Do the physician practices billing for this service employ a messenger service at their own expense to transport specimens (vs. send-out labs incurring this cost), and is the code being used to report the procurement of a specimen, rather than the transport of it?

UHC Overturns

UHC_Major was both your largest denial volume payer and one of the lower scoring detailed payer names for adjudications posted in April 2021, consisting of an average model score of 1.49 and an overturn rate of 3.0% across 51,434 adjudications in April.



Invoice Details

Claim & Service Line CARC Dollars, Combined

837 Type	Inpatient Outpatient	Payer Hierarchy	Claim Count	Initial Denied Claim Count	Original Denial Rate	Original Denied Dollars	Original Dollar Denial Rate	Average Denied Dollars (Original)	Latest Denied Claim Count	Latest Denial Rate	Latest Denied Dollars	Latest Dollar Denial Rate	Average Denied Dollars (Latest)	Denied Overtu
Institutional	HH/Hospice	Primary	19,505	649	3.3%	$1,036,497	2.7%	$1,597	587	3.0%	$863,242	2.3%	$1,471	
		Secondary	354	29	8.2%	$60,456	6.9%	$2,085	29	8.2%	$60,367	6.9%	$2,082	
	Inpatient	Primary	30,345	3,997	13.2%	$144,158,584	11.4%	$36,067	2,056	6.8%	$66,609,140	5.6%	$32,397	
		Secondary	5,559	446	8.0%	$7,076,521	2.7%	$15,867	481	8.7%	$9,851,194	3.8%	$20,481	
		Tertiary	7	4	57.1%	$9,328	2.4%	$1,332	4	57.1%	$9,328	2.4%	$1,332	
	Outpatient	Primary	843,591	76,717	9.1%	$105,677,540	4.9%	$1,378	69,668	8.3%	$78,081,142	3.7%	$1,121	
		Secondary	91,768	16,902	18.4%	$28,396,800	6.4%	$1,680	17,277	18.8%	$34,414,382	7.8%	$1,992	
		Tertiary	127	78	61.4%	$137,203	31.3%	$1,759	77	60.6%	$176,265	37.4%	$2,289	
Professional	Not Applicable	Primary	2,023,129	313,389	15.5%	$43,397,459	7.0%	$138	292,211	14.4%	$36,100,239	5.9%	$124	
		Secondary	194,957	24,503	12.6%	$4,922,775	6.8%	$201	24,023	12.3%	$4,616,480	6.4%	$192	
		Tertiary	398	253	63.6%	$58,155	42.6%	$230	243	61.1%	$58,047	49.5%	$239	

Denial Rate

You are experiencing a higher denial rate (19.7% original denial rate) than typical best practice for secondary outpatient institutional claims and claims remitted with a CO16 (additional info requested) appear to be mostly contributing to the higher rate. It is likely that these denials are not present in Epic workqueues because the secondary payment amount is equal to the primary payer's PR amount; recoverable secondary denials can often be hidden in Epic due to denial (BDC) suppression logic if the account is over-contractualized or zero balance due to system adjustments taken during primary remittance processing or automatic adjustments posted based on the expected primary payment amount calculated by Epic contracts at the time of billing.

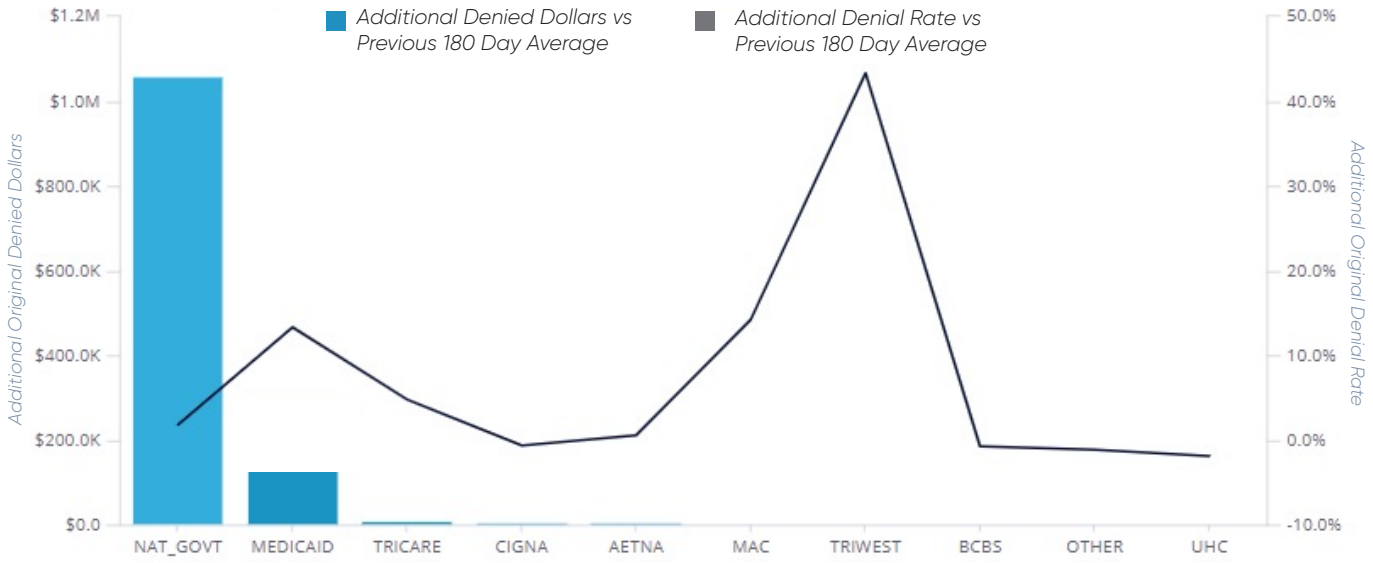
Secondary Outpatient Institutional Denials

837 Type	Inpatient Outpatient	svc_carc_code	Claim Count	Initial Denied Claim Count	Original Denial Rate	Original Denied Dollars	Original Dollar Denial Rate	Average Denied Dollars (Original)
Institutional	Outpatient	"45"	24,186	7,142	29.5%	$61,928,988	3.5%	$8,671
		"16"	6,458	6,376	98.7%	$217,072,250	43.2%	$34,045
		"23"	42,530	2,070	4.9%	$29,143,872	1.0%	$14,079
		"96"	1,880	1,849	98.4%	$5,241,638	11.2%	$2,835
		"23","45"	6,739	1,057	15.7%	$3,236,089	3.6%	$3,062
		"97"	2,603	650	25.0%	$3,180,158	1.4%	$4,893
		"276"	631	629	99.7%	$368,732	1.8%	$586
		"18"	1,082	482	44.5%	$42,832,874	21.7%	$88,865
		"3","45"	1,407	432	30.7%	$1,072,929	8.8%	$2,484
		"252"	286	282	98.6%	$7,670,431	86.6%	$27,200
		"16","45"	280	279	99.6%	$60,837	12.5%	$218
		N/A	1,972	245	12.4%	$406,421	1.1%	$1,659
		"24"	227	201	88.5%	$3,327,798	65.9%	$16,556
		"94","97"	1,516	197	13.0%	$880,118	0.9%	$4,468
		"23","96"	270	192	71.1%	$296,848	16.6%	$1,546
		"177"	187	187	100.0%	$15,124,085	97.7%	$80,877
		"22","45"	168	166	98.8%	$439,417	26.6%	$2,647
		"4"	133	128	96.2%	$1,242,499	94.6%	$9,707

Sift recommends performing a zero-balance scrub on a representative sample of secondary buckets with a posted CO16 and/or CO197 to confirm that there are no missed payment opportunities.

Details: Claims, Service Lines, Denials

Top 10 Broad Payers by Initial Denial Rate Shifts, Last 30 Days



PGS Medicare and Medicaid

PGS Medicare remitted significantly greater original denied dollars in April, $1.1M more than their rolling monthly average. 59 [Multiple/concurrent procedures for physical therapy] denied institutional claims (CPTs 97530, 97140, 97110, 97112) was the largest contributing cohort of claims for this claim population.

PGS Medicare: Top 10 Denials

CARC Code	CARC Description	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
256	Srvc non pybl under mgd care	$46,983,262	1,039	$41,624,687	928	89.3%	$44,854
59	Multiple/concurrent procedures	$15,654,427	62,492	$120,062	534	0.9%	$225
96	Non-Covered Charges	$4,216,745	16,101	$499,979	514	3.2%	$973
50	Non Cvd medical necessity	$2,901,793	982	$1,248,833	184	18.7%	$6,787
272	Cvg/program guide not met	$2,668,176	398	$1,904,555	71	17.8%	$26,825
16	Lacks Info Needed For Adjudication	$2,466,074	1,430	$1,643,712	718	50.2%	$2,289
18	Exact Duplicate Claim/Service	$2,092,732	5,294	$607,698	766	14.5%	$793
22	Dnied/Rdcd May Be Cvd By Othr Payor	$1,652,129	2,254	$854,543	859	38.1%	$995
24	Chgs Cvd Under Capit Agrmt/Mgd Care	$1,605,338	2,651	$1,201,003	2,011	75.9%	$597
13	Date Of Death Precedes Date Of Svc	$1,461,085	25	$1,155,800	18	72.0%	$64,211
Grand Total		$81,701,760	92,666	$50,860,872	6,603	7.1%	$7,703

Top 10 Denials and Top 10 Procedure Codes

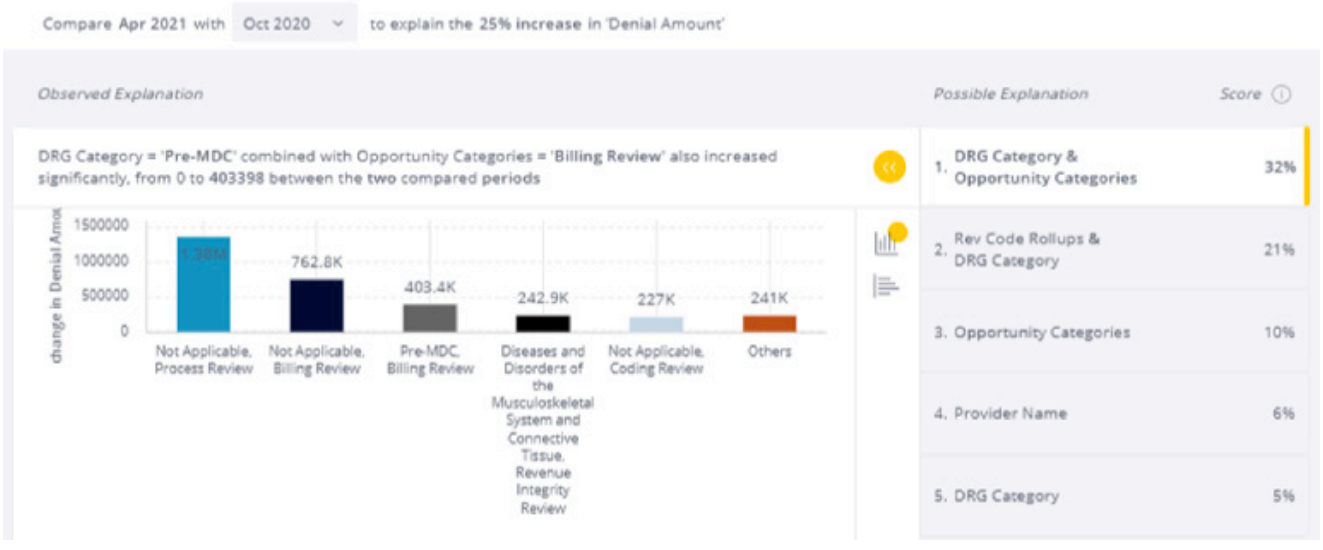
CARC Code	CARC Description	Denied Amount	Denied Cour
256	Srvc non pybl under mgd care	$46,983,262	
59	Multiple/concurrent procedures	$15,654,427	
96	Non-Covered Charges	$4,216,745	
50	Non Cvd medical necessity	$2,901,793	
272	Cvg/program guide not met	$2,668,176	
16	Lacks Info Needed For Adjudication	$2,466,074	
18	Exact Duplicate Claim/Service	$2,092,732	
22	Dnied/Rdcd May Be Cvd By Othr Payor	$1,652,129	
24	Chgs Cvd Under Capit Agrmt/Mgd Care	$1,605,338	
13	Date Of Death Precedes Date Of Svc	$1,461,085	
Grand Total		$81,701,760	

Proc Code	Denied Amount	Denied Count
97140	$4,975,090	22,671
97530	$4,094,560	11,223
97112	$2,671,634	7,979
97110	$2,581,187	10,910
97113	$213,033	356
97035	$143,625	2,121
97162	$120,469	488
97116	$77,528	640
97161	$64,228	321
17311	$53,491	155
Grand Total	$14,994,846	56,864

Medicaid's original denial rate in April was 13.3% higher than the prior 180-day average denial rate. This is the result of Compcare Health Services (Medicaid), which has shown increased process review-related denials compared to October 2020 (6 months ago).

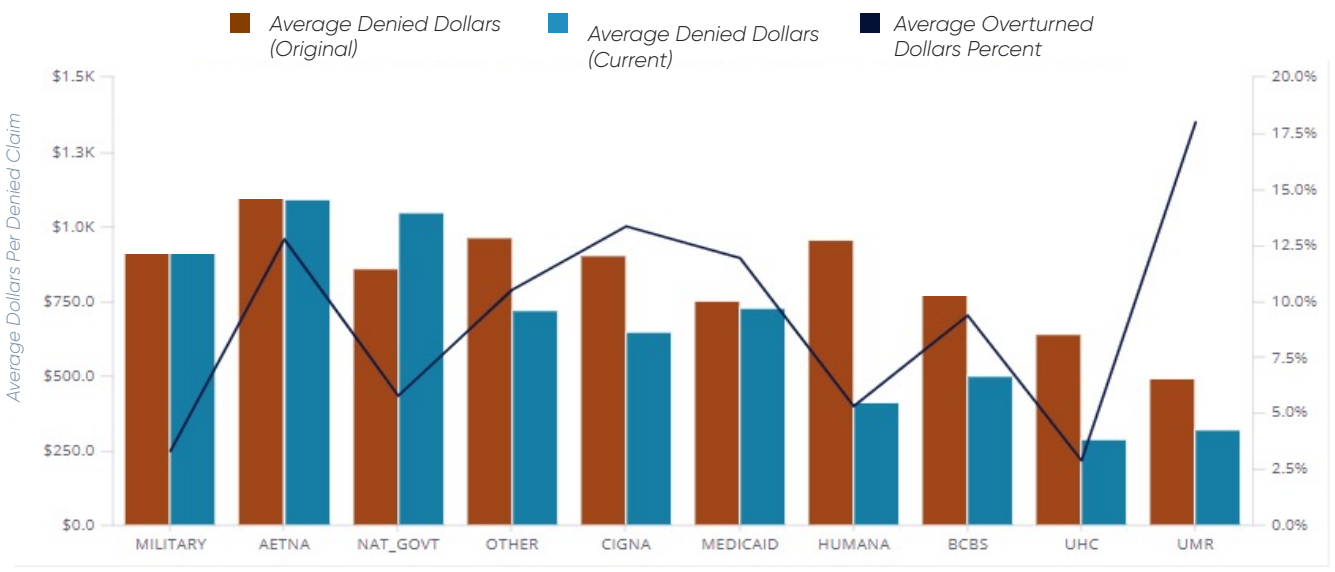
This increase in process review-related denials accounted for $676,000 more in CARC 252 denials in April as part of an ongoing trend compared to its low point of $2,000 CARC 252 denials in October 2020. Of the $676k total, $647k is for N26-Missing itemized bill/statement and N479-Missing EOB.

Compcare Health Services Impact



Additionally, pre-MDC DRG claims with 'Billing Review' categorized denials increased significantly from $0 to $403k between the two time periods (October 2020, April 2021). This is the result of one liver transplant surgery claim (DRG 005) at Waukesha Memorial Hospital, totaling $403,398 in denied amounts for 16-Lacks Info Needed for Adjudication (M50-Revenue Code mssng/incomp/inval).

Top 10 Broad Payers by Initial Denial Rate Shifts, Last 30 Days



Cigna Overturns

Cigna has a higher-than-average overturn rate (17%) compared to the rest of your high-volume denial payers. Utilizing the Rev/Track's Denials Details Dashboard's "Top 10 Denials", filtered for payer name "Cigna", we can observe four (4) documentation-related denial CARCs (A1, 252, 11, 96) which are commonly overturned, indicating inappropriate payer delay in payment and additional rework of internal staff resources for claims ultimately paid.

Cigna: Top 10 Denials

CARC Code	CARC Description	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
256	Srvc non pybl under mgd care	$46,983,262	1,039	$41,624,687	928	89.3%	$44,854
59	Multiple/concurrent procedures	$15,654,427	62,492	$120,062	534	0.9%	$225
96	Non-Covered Charges	$4,216,745	16,101	$499,979	514	3.2%	$973
50	Non Cvd medical necessity	$2,901,793	982	$1,248,833	184	18.7%	$6,787
272	Cvg/program guide not met	$2,668,176	398	$1,904,555	71	17.8%	$26,825
16	Lacks Info Needed For Adjudication	$2,466,074	1,430	$1,643,712	718	50.2%	$2,289
18	Exact Duplicate Claim/Service	$2,092,732	5,294	$607,698	766	14.5%	$793
22	Dnied/Rdcd May Be Cvd By Othr Payor	$1,652,129	2,254	$854,543	859	38.1%	$995
24	Chgs Cvd Under Capit Agrmt/Mgd Care	$1,605,338	2,651	$1,201,003	2,011	75.9%	$597
13	Date Of Death Precedes Date Of Svc	$1,461,085	25	$1,155,800	18	72.0%	$64,211
Grand Total		$81,701,760	92,666	$50,860,872	6,603	7.1%	$7,703

CARC A1-Claim/Svc Denied is overturned 79.9% of the time. Of the A1 denials from Cigna, 90% have RARC M127-Medical Records Missing. Rev Code Rollup categories indicate these soft denials impact mostly surgery, rad/onc, physical therapy and therapeutic radiology institutional claims.

Cigna: Rev Code Roll-up Categories

Rev Code Rollups	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
Surgery	$467,088	833	$329,284	598	71.8%	$551
NA	$61,566	709	$45,164	539	76.0%	$84
Treatment Room	$213,086	364	$213,086	364	100.0%	$585
Physical Therapy	$62,235	436	$46,148	321	73.6%	$144
Therapeutic Radiology	$658,827	260	$640,000	252	96.9%	$2,540
Radiation Therapy	$63,989	75	$63,989	75	100.0%	$853
Observation	$33,811	91	$9,183	74	81.3%	$124
CAT Scan	$40,878	57	$39,461	52	91.2%	$759
EEG	$44,996	15	$44,996	15	100.0%	$3,000
Cath Lab	$168,655	1	$168,655	1	100.0%	$168,655
Grand Total	$1,815,130	2,841	$1,599,966	2,291	80.6%	$698

CARC 252-Docs needed to process claim is overturned 52.6% of the time. Of the 252 denials from Cigna, 89% have RARC M127-Medical Records Missing. Rev Code Roll-up categories indicate these soft denials impact mostly surgery institutional claims and related professional claims.

Cigna: Rev Code Roll-up Categories #2

Rev Code Rollups	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
Surgery	$145,619	177	$61,721	65	36.7%	$950
NA	$16,105	147	$10,328	109	74.1%	$95
Treatment Room	$54,604	66	$33,603	40	60.6%	$840
Labs	$3,668	52	$2,802	39	75.0%	$72
Radiation Therapy	$37,207	44	$0	0	0.0%	
Physical Therapy	$2,393	20	$1,386	12	60.0%	$116
Therapeutic Radiology	$101,971	11	$101,971	11	100.0%	$9,270
EKG	$915	8	$0	0	0.0%	
Cardiology	$2,042	2	$2,042	2	100.0%	$1,021
EEG	$4,167	1	$4,167	1	100.0%	$4,167
Grand Total	$368,690	528	$218,020	279	52.8%	$781

CARC 11-Dx Incons w/ Px denials is overturned 52.6% of the time. Cigna is getting overturned on common outpatient levels of service (99213) 79.5% of the time. Also, rehab codes 97110 and 97530, testosterone code 84402, and in-office skin procedure code 17110 are overturned 50-60% of the time.

Cigna: Top 10 Procedure Codes

Proc Code	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
99213	$9,058	44	$7,139	35	79.5%	$204
84403	$7,933	38	$3,304	16	42.1%	$207
97110	$7,762	34	$4,628	21	61.8%	$220
97530	$9,818	31	$5,381	16	51.6%	$336
17110	$7,184	21	$3,374	10	47.6%	$337
84402	$5,210	20	$2,580	10	50.0%	$258
97112	$5,763	17	$1,964	6	35.3%	$327
77049	$37,252	7	$15,967	3	42.9%	$5,322
70544	$5,298	2	$0	0	0.0%	
72141	$8,544	2	$8,544	2	100.0%	$4,272
Grand Total	**$103,822**	**216**	**$52,882**	**119**	**55.1%**	**$444**

CARC 96-Non-covered charges mostly impacts professional claims and is overturned 30.1% of the time, indicating inappropriate payer delay in payment and additional rework of internal staff resources for claims ultimately paid. One highly denied CPT, SLP treatment code 92507, is overturned 93% of the time.

Cigna: Top 10 Procedure Codes #2

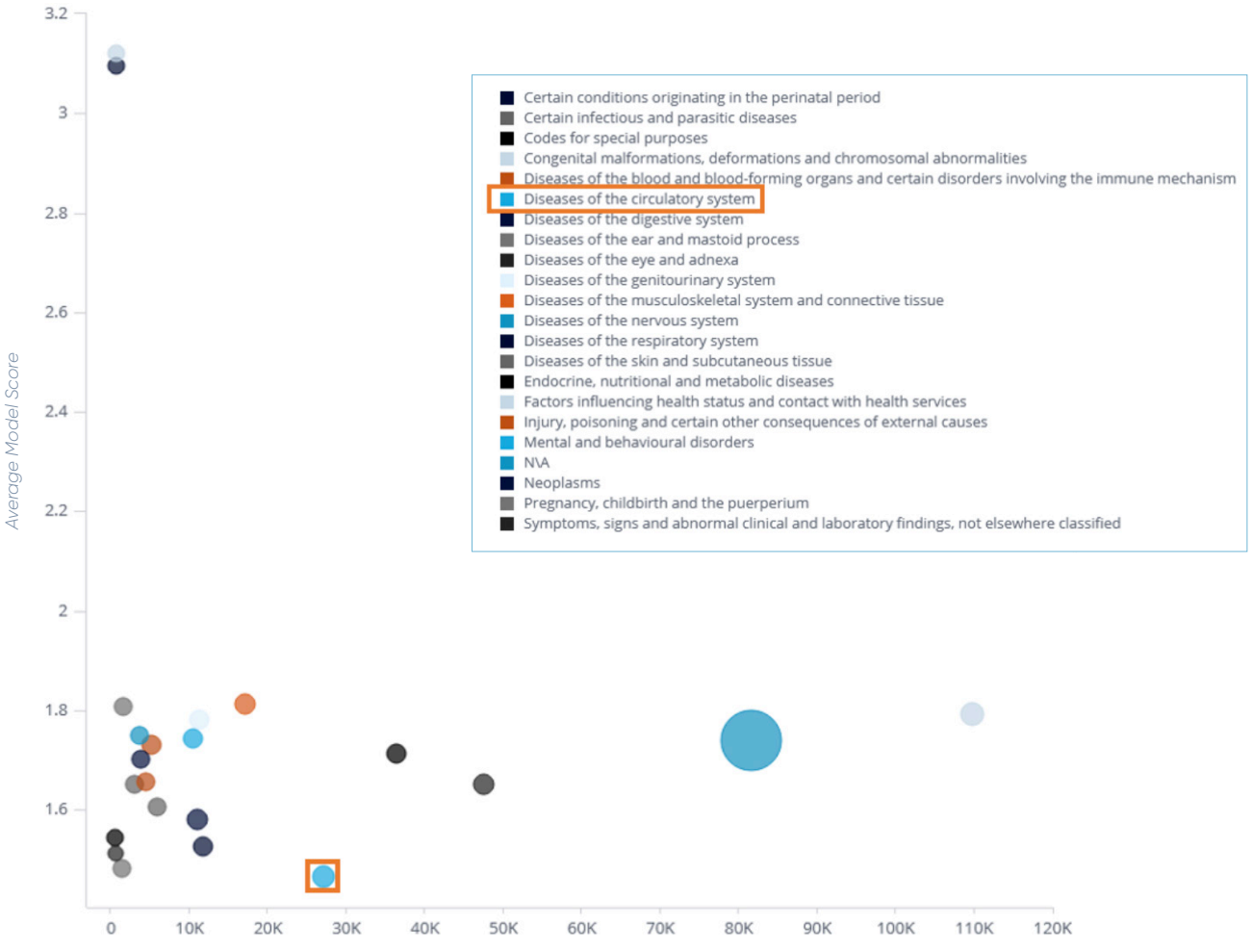
Proc Code	Denied Amount	Denied Count	Denied Amount Overturned	Denials Overturned	Overturned Volume Rate	Average Overturned Amount
99213	$16,421	79	$3,462	17	21.5%	$204
99214	$15,946	55	$5,648	19	34.5%	$297
92507	$16,672	51	$15,658	47	92.2%	$333
76821	$16,404	51	$0	0	0.0%	
76819	$26,150	51	$0	0	0.0%	
76816	$16,446	40	$1,134	2	5.0%	$567
74177	$20,012	3	$13,440	2	66.7%	$6,720
J2350	$132,075	2	$132,075	2	100.0%	$66,037
J9306	$26,182	1	$0	0	0.0%	
J9354	$25,418	1	$25,418	1	100.0%	$25,418
Grand Total	**$311,725**	**334**	**$196,835**	**90**	**26.9%**	**$2,187**

Sift recommends evaluating your EMR's electronic claim attachment workflows for possible denial prevention tactics to reduce the frequency of Cigna documentation-related soft denials. Additionally, your managed payer contracting department could discuss the high overturn frequency of clinically relevant and medically necessary claims being unnecessarily denied and payment unduly withheld by Cigna.

Clinical Overturn Performance

Professional invoice denials with the lowest likelihood to overturn are for claims where the principal diagnosis category is 'Diseases of the circulatory system', resulting in an average model score of 1.6 and claim overturn rate of 2.6%. These claims typically bill from the ABC Medical Group and get denied for bundling/inclusive denials.

Average Model Score by Principal Diagnosis Category (Professional)



Zero-Balance Scrub

To determine if denials are being missed as a result of Epic denial (BDC) suppression logic, Sift recommends performing a zero-balance scrub on a representative sample of secondary buckets with a posted CO16 denials is advised to confirm that there are no missed payment opportunities.

CPT 99000, CARC 234 Investigation

To address denials the 91% of denied claims with CTP 99000 [Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory] that are denied for CARC 234, it should be determined if the physician practices that are billing for this service are utilizing a messenger service to transport specimens and if coding for transport and procurement is being done properly.

Review Claim Attachment Workflows

Cigna has a persistent level of documentation-related soft denials. Electronic claim attachment workflows should be reviewed to determine if optimizations can be made to reduce Cigna documentation issues.

Contact Cigna Regarding Unnecessary Denials

Sift recommends that the Managed Payer Contracting Department discuss the high overturn frequency of clinically relevant and medically necessary claims that are being unnecessarily denied and payment unduly withheld by Cigna.