LATEST TRENDS IN MANAGING DENIALS AND APPEALS OF CLINICAL LAB, MOLECULAR, AND PATHOLOGY CLAIMS

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Presenter Introductions

Diana Richard, AVP, National Accounts, Path/Rad/Hospital Systems, XiFin Inc.

- Over 20 years of experience in diagnostic provider billing
- Anatomic Pathology Subject matter expert
- Maintains strategic support role for XiFin's diagnostic customers
- Facilitates routine data studies of reimbursement trends, publishing outcomes through presentations, webinars, blogs, and conference posters

Stephanie Denham, AVP, RCM Systems and Analytics, XiFin, Inc.

- Over 20 years of experience in finance and revenue cycle management
- System, Reporting, and Analytics expert
- Facilitates cross-customer analyses on productivity metrics, and utilization of system functionalities, to help drive opportunities in product development and functionalized workflow.

Learning Objectives

Recent Payor Issues/Updates & Trends in Denials

Trends in Appeals

Strategic Appeal Processes

Monitoring Denials and Appeals

Data Mining: Value in the Numbers

XiFin Client Database

Anatomic Pathology, Molecular, and Clinical Transactions

More than 20 Million Claims Analyzed

2024 Study of 2023 Denial and Appeal Trends by:

- Payor Group
- Denial Reason
- Appeal Type
- Revenue Generated

25+

Over 25 publicly traded companies use XiFin

73%

73% of the largest laboratories utilize XiFin

RECENT PAYOR ISSUES/UPDATES & TRENDS IN DENIALS

Recent Payor Trends

	Commercial Adoption of G Code (HCPCS) Requirements
	Large Blue plan erroneously triggers OON on pathology practice, driving spike in PR1, PR2, PR3, PR100, CO131, and PR45 reason codes
	Cigna downgrading services: G0483 (Tox) down-coded to G0480
	BCBS Federal removes prior authorization requirement on medically necessary genetic testing
	Anthem Medicare Advantage clarifies on January 1st it is inappropriate to bill certain diagnosis codes as a primary or first listed diagnosis
	Effective March 9, 2024, MPFS increased and average 1.68% due to Consolidated Appropriations Act

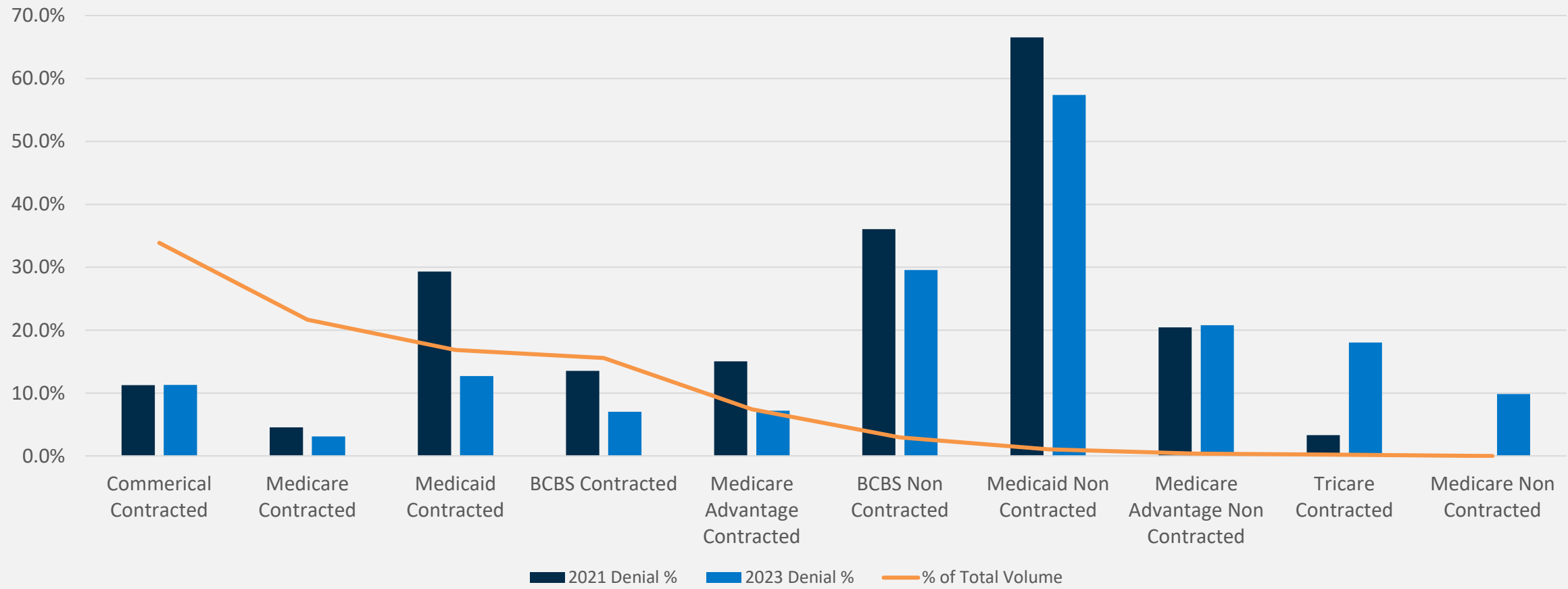
Top Denial Reasons

CO151	Payment adjusted because the payor deems the information submitted does not support this many/frequency of services
CO252	Claim will be reconsidered when additional claim information is received
CO96	Non-covered charges
CO50	Non-covered services because this is not deemed a 'medical necessity' by the payor
CO55	Experimental/Investigational, when a procedure code is billed with an incompatible diagnosis for payment purposes, and the ICD-10 code(s) submitted is/are not covered under an LCD or NCD

TRENDS IN APPEALS

Risk of Denial: Averages by Payor Group, All Segments

% Claims Denied by Payor Group in 2023, Compared to 2021

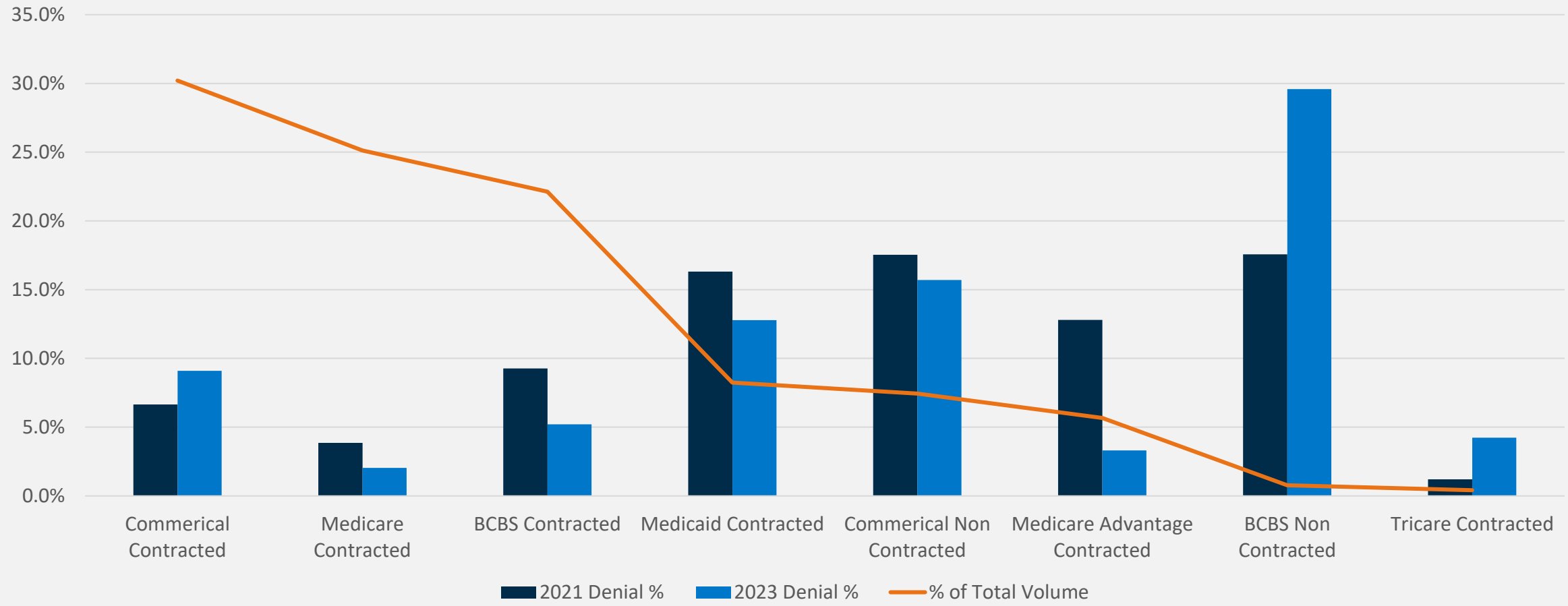


Revenue Impact of Appeals by Segment

	Appeal Payments as % of Total Insurance Payments Received		Average Payment Amount per Appeal	
Segment	**2023**	**2021**	**2023**	**2021**
Clinical	0.43%	0.11%	$96	$121
Molecular	11.17%	6.56%	$1,584	$1,420
Pathology	1.50%	1.12%	$249	$327
Overall Average	7.38%	**3.39%**	$541	**$623**

Risk of Denial: Averages by Payor Group, Anatomic Pathology

% Claims Denied by Payor Group in 2023, Compared to 2021

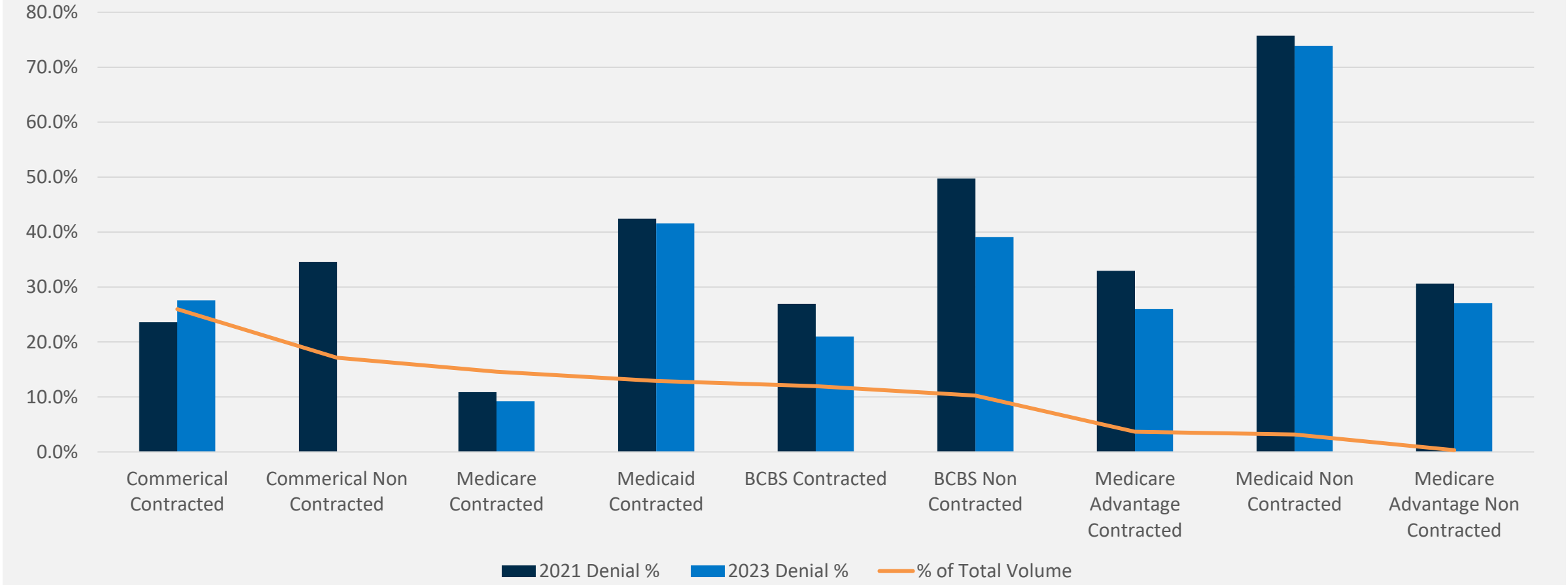


Appeal Trends and Successes: Anatomic Pathology

Appeal Type	% of Total Appeals Filed	% of Appeals Paid after 1st Attempt	% of Appeals Paid after 2nd Attempt	% of Appeals Paid after 3rd Attempt	Avg Payment per Appeal (Paid and Unpaid)	Avg Payment per Successful Appeal
Overall Averages		25.1%	2.5%	0.5%	$69.82	$248.69
Additional Information	27.9%	23.3%	2.0%	0.2%	$68.71	$269.32
Medical Necessity	20.6%	25.9%	2.1%	0.5%	$50.42	$176.75
Out of Network	16.6%	25.0%	1.9%	0.5%	$64.15	$234.25
Prior Authorization	12.8%	18.2%	1.2%	0.0%	$53.70	$275.31
Other	8.8%	37.1%	4.8%	1.8%	$144.00	$329.42
Timely Filing	4.4%	13.5%	3.8%	0.5%	$31.42	$176.86
Duplicate	2.6%	22.2%	2.7%	0.1%	$80.62	$322.49
Bundling	2.0%	54.5%	9.4%	3.6%	$117.21	$173.86
Frequency	2.0%	16.8%	2.3%	0.5%	$90.04	$459.49
NonCovered	1.7%	39.7%	0.3%	0.0%	$42.17	$105.25
Maximum Benefits	0.6%	36.0%	13.1%	3.8%	$268.24	$507.01

Risk of Denial: Averages by Payor Group, Molecular

% Claims Denied by Payor Group in 2023, Compared to 2021

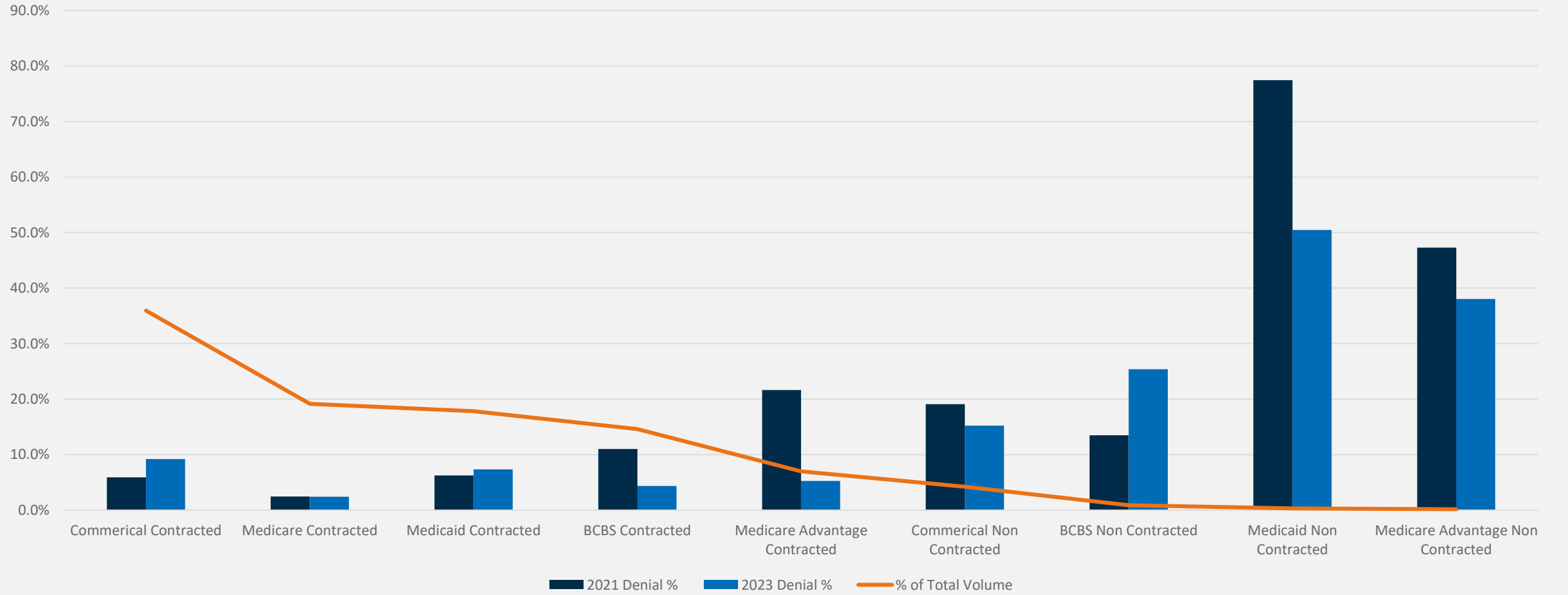


Appeal Trends and Successes: Molecular

Appeal Type	% of Total Appeals Filed	% of Appeals Paid after 1st Attempt	% of Appeals Paid after 2nd Attempt	% of Appeals Paid after 3rd Attempt	Avg Payment per Appeal (Paid and Unpaid)	Avg Payment per Successful Appeal
Overall Averages		15.5%	3.8%	1.0%	$320.84	$1,583.61
Medical Necessity	25.2%	10.2%	2.1%	0.5%	$175.81	$1,376.56
Additional Information	23.0%	25.3%	7.7%	2.4%	$696.63	$1,969.90
Other	22.6%	16.9%	4.2%	0.9%	$273.70	$1,245.57
Prior Authorization	11.3%	11.8%	2.8%	0.6%	$227.27	$1,496.10
Out of Network	7.4%	12.1%	1.8%	0.2%	$128.45	$910.32
Medical Records	4.4%	6.5%	0.3%	0.0%	$78.84	$1,155.03
Experimental/ Investigational	3.2%	7.2%	1.3%	0.2%	$233.43	$2,662.82
NonCovered	1.4%	14.6%	1.0%	0.1%	$237.62	$1,512.34
Low Payment	0.7%	12.8%	2.1%	0.9%	$169.17	$1,069.43
Timely Filing	0.3%	10.2%	0.6%	0.0%	$97.24	$896.01
Claim Review	0.3%	55.7%	7.7%	1.9%	$1,001.90	$1,532.80

Risk of Denial: Averages by Payor Group, Clinical

% Claims Denied by Payor Group in 2023, Compared to 2021



Appeal Trends and Successes: Clinical

Appeal Type	% of Total Appeals Filed	% of Appeals Paid after 1st Attempt	% of Appeals Paid after 2nd Attempt	% of Appeals Paid after 3rd Attempt	Avg Payment per Appeal (Paid and Unpaid)	Avg Payment per Successful Appeal
Overall Averages		30.9%	2.0%	0.5%	$32.13	$96.31
Additional Information	31.6%	40.9%	2.6%	0.9%	$60.58	$136.20
Other	21.3%	62.9%	2.2%	0.2%	$28.23	$43.22
Medical Necessity	15.6%	17.9%	3.6%	0.8%	$34.38	$154.42
Experimental/ Investigational	10.3%	7.0%	0.8%	0.4%	$4.25	$51.75
Prior Authorization	10.0%	3.1%	0.1%	0.0%	$2.88	$90.67
Out of Network	8.2%	5.1%	0.2%	0.0%	$5.82	$109.68
Timely Filing	3.1%	10.4%	0.6%	0.0%	$13.89	$126.34

Appeal Success Rates by Procedure Code

Procedure Code	Segment	Code Description	Appeal Success Rate	Avg Revenue Generated per Successful Appeal
80053	Clinical	Comprehensive Metabolic Panel	87%	$7.97
80061	Clinical	Lipid Panel	87%	$7.19
82306	Clinical	25 Hydroxy Includes Fractions if Performed	87%	$10.96
83036	Clinical	HGB Glycosylated	86%	$5.36
84443	Clinical	Assay of Thyroid Stimulating Hormone TSH	88%	$5.57
85025	Clinical	Blood Count Complete Auto&Auto Difrntl WBC	85%	$2.47
87491	Clinical	IADNA Chlamydia Trachomatis Amplified Probe TQ	58%	$23.21
87591	Clinical	IADNA Neisseria Gonorrhoeae Amplified Probe TQ	59%	$23.43
81162	Molecular	BRCA1 BRCA2 Gene Analysis Full Seq Full Dup/Del Alys	44%	$1,460.52
81220	Molecular	CFTR Gene Analysis Common Variants	35%	$360.59
81329	Molecular	SMN1 Gene Analysis DOSAGE/DELET Alys w/ SMN2 Alys	34%	$91.37
81404	Molecular	Molecular Pathology Procedure Level 5	25%	$208.25
81405	Molecular	Molecular Pathology Procedure Level 6	27%	$194.10
81406	Molecular	Molecular Pathology Procedure Level 7	25%	$178.76
81420	Molecular	Fetal Chromosomal Aneuploidy Genomic Seq Analysis	43%	$561.51
81432	Molecular	Hereditary Breast CA-Related Gen Seq Analysis 10 Gen	41%	$536.47
81433	Molecular	Hereditary Breast CA-Related Dup/Del Analysis	41%	$352.21
88305	Pathology	Level IV Surg Pathology Gross&Microscopic Exam	52%	$110.64
88307	Pathology	Level V Surg Pathology Gross&Microscopic Exam	57%	$80.10
88341	Pathology	Immunohistochemistry/Cytchm Ea Addl Antibody Slide	51%	$148.05
88342	Pathology	Immunohistochemistry Tissue Immunoproxidase Ea Antibody	49%	$72.65
88360	Pathology	M/PHMTRC Alys Tumor Imhchem Ea Antibody Manual	49%	$56.67

STRATEGIC APPEALS PROCESS

Golden Rule of Medical Billing

Report Documentation: ***If it wasn't documented, it wasn't performed***

Report documentation should clearly outline the services provided and the medical necessity of those services

- Ordered
- Performed
- Medically Necessary

The Golden Rule

Of Medical Billing

Payor Policies: Industry Edits

National Correct Coding Initiative (NCCI) Edits

- Example: CO97 - Procedure or Service Isn't Paid for Separately
- Unlikely Code Combinations
- Published CCI Edits as **Unbillable Errors**
- **Corrected Claims** with Modifiers for Denials

Local Coverage Determinations (LCD) / National Coverage Determinations (NCD)

- Procedure / Diagnosis Code Combinations, Frequency
- Maintained by XiFin – **Unbillable Errors**
- Advanced Beneficiary Notice (ABN) Required to Bill Patients

Payor Policies: Industry Edits (continued)

Medically Unlikely Edits (MUEs)

Units of Service

Updated Quarterly

Two edit categories

- Claim Line: Units evaluated on each line
  - **Consolidation Rules:** Separate Units and Append Modifier
- Date of Service: Units evaluated for entire DOS
  - Some cannot be overturned through appeal
  - **Automated Appeals** with medical records

3-Cycle Appeals Process

First Level

Submission of high-level appeal letter specific to the testing performed

May have letter written by genetic counselor and/or pathologist to define scientific methodology of the test as well as medical criteria

Generally, attachment of lab report and order is included

Separate Department at Payor, **typically RN**

First-level appeals may be sent more than once

3-Cycle Appeals Process (continued)

Second Level

Written appeal, includes cover letter specific to case

Genetic counselor and/or pathologist will provide evidence to support the patient has met specific criteria to meet the payor policy

Qualified independent contractor will review appeal and provider may submit additional medical records not submitted in first level appeal

Third Level

Resubmission of second appeal documentation for review by an **Administrative Law Judge**

In some cases, it may be strategic to request outside review of case

Process of outside review is not viewed favorably by most payors. Measure pros and cons of taking an aggressive approach

MONITORING DENIALS AND APPEALS

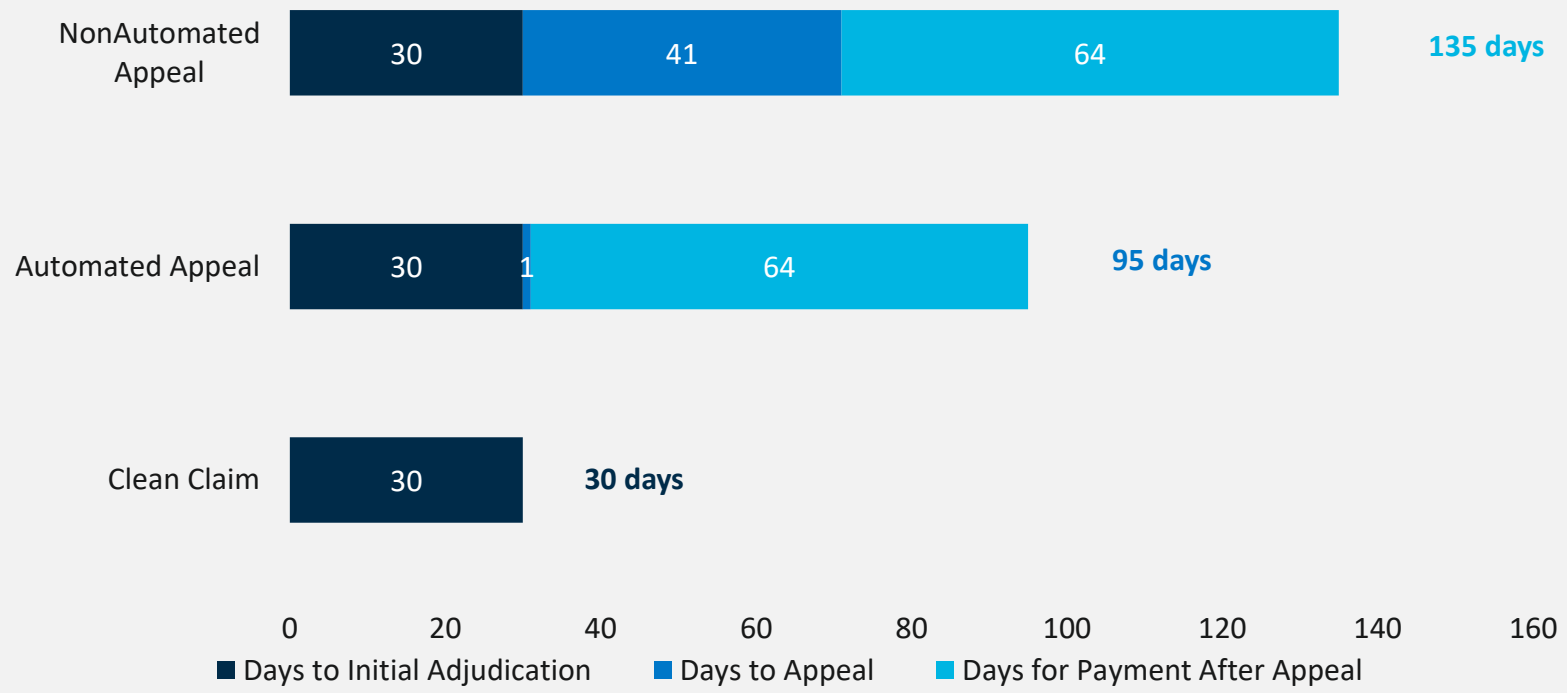
Speed of Adjudication

Good: Appeal claims to collect all available revenue

Better: Automate appeals to shorten time to collect

Best: Install front end edits for clean claims, attachments at time of submission.

Time for Full Adjudication

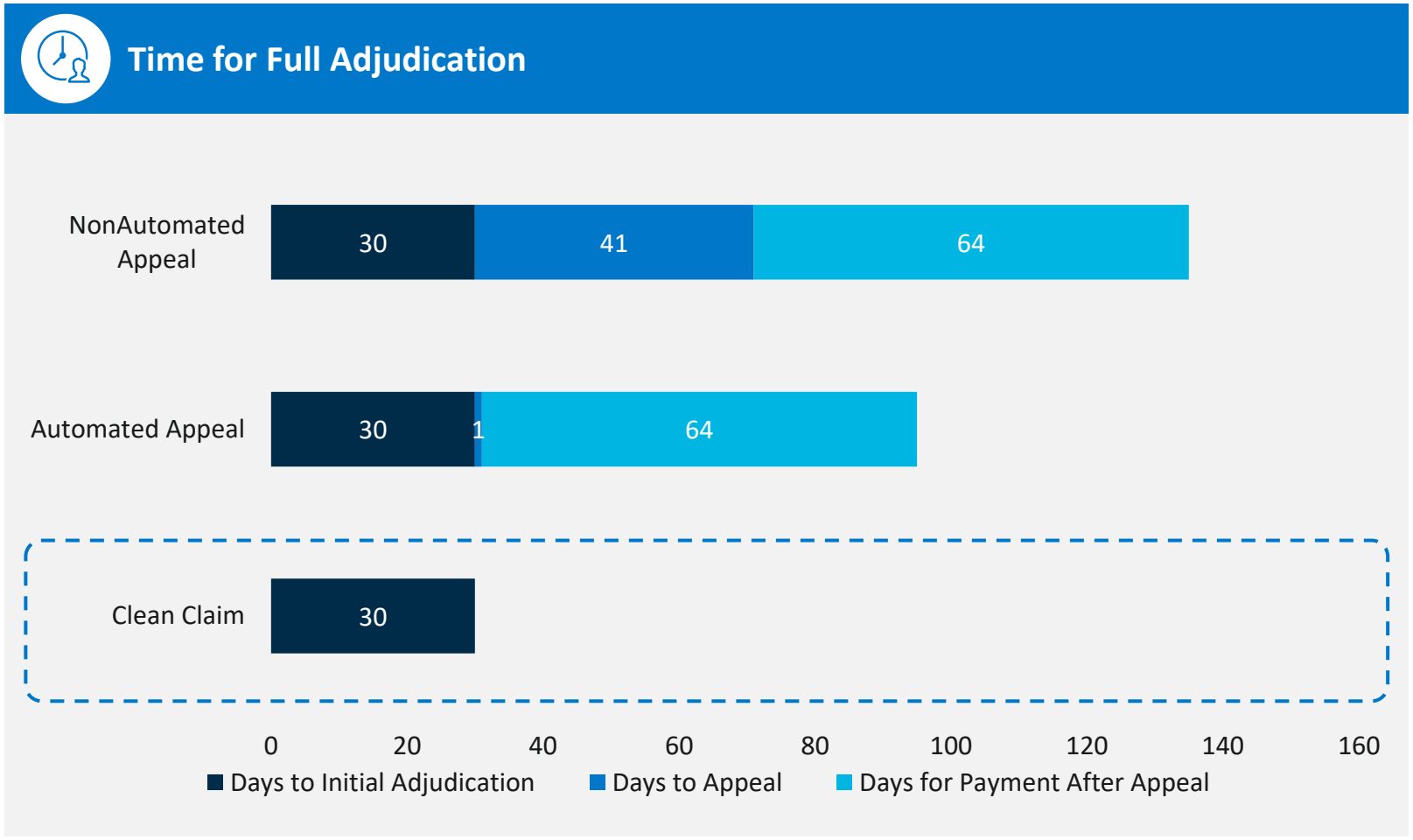


Clean Claims with Front End Editing

Published Payor Policies

Non-Published Payor Policies

Corrected Claims



Automated Appeals

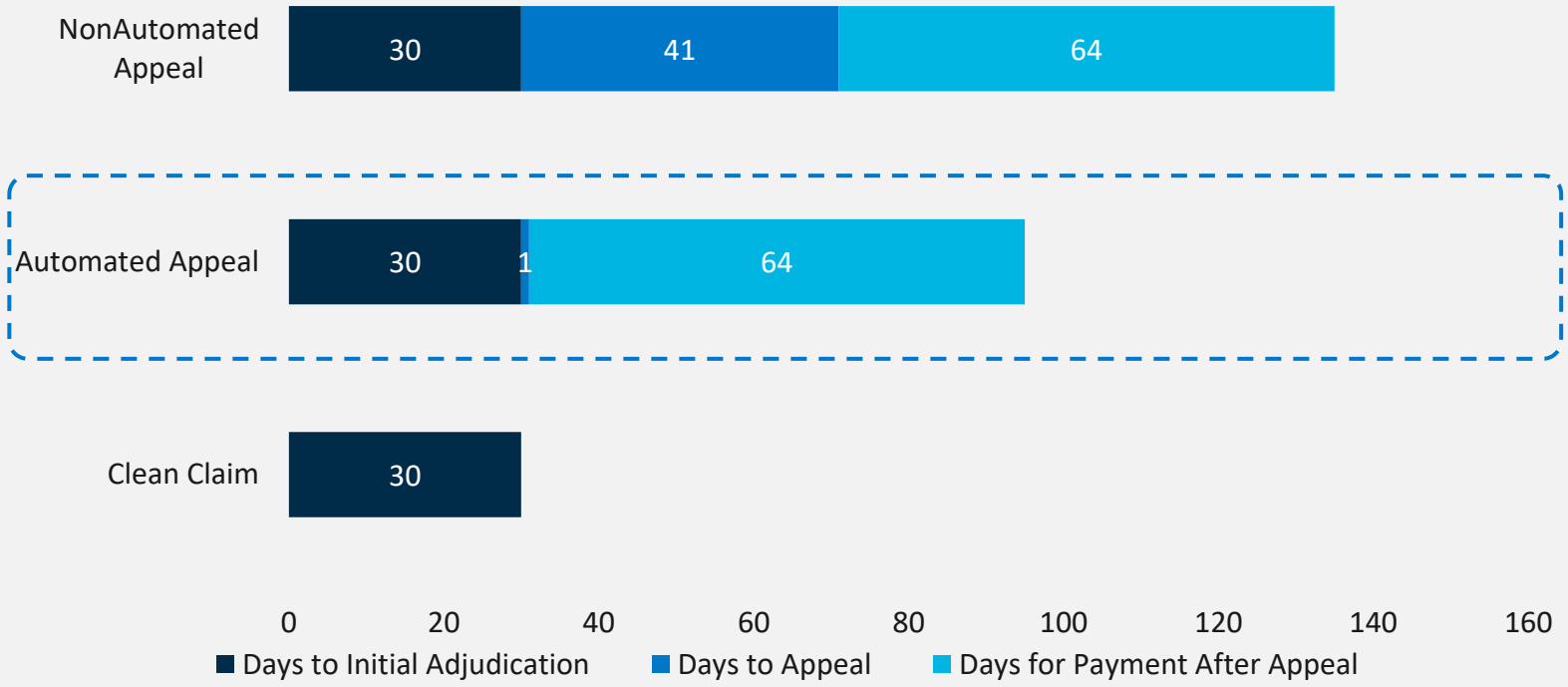
Published Payor Policies

- MUE
- Requests for Medical Records (XiFin Document Storage)

Repetitive Appeals Process

- Letters
- Documentation

Time for Full Adjudication



Manual Follow-up

Review of Manual Corrected Claims

- Update Front End Edits

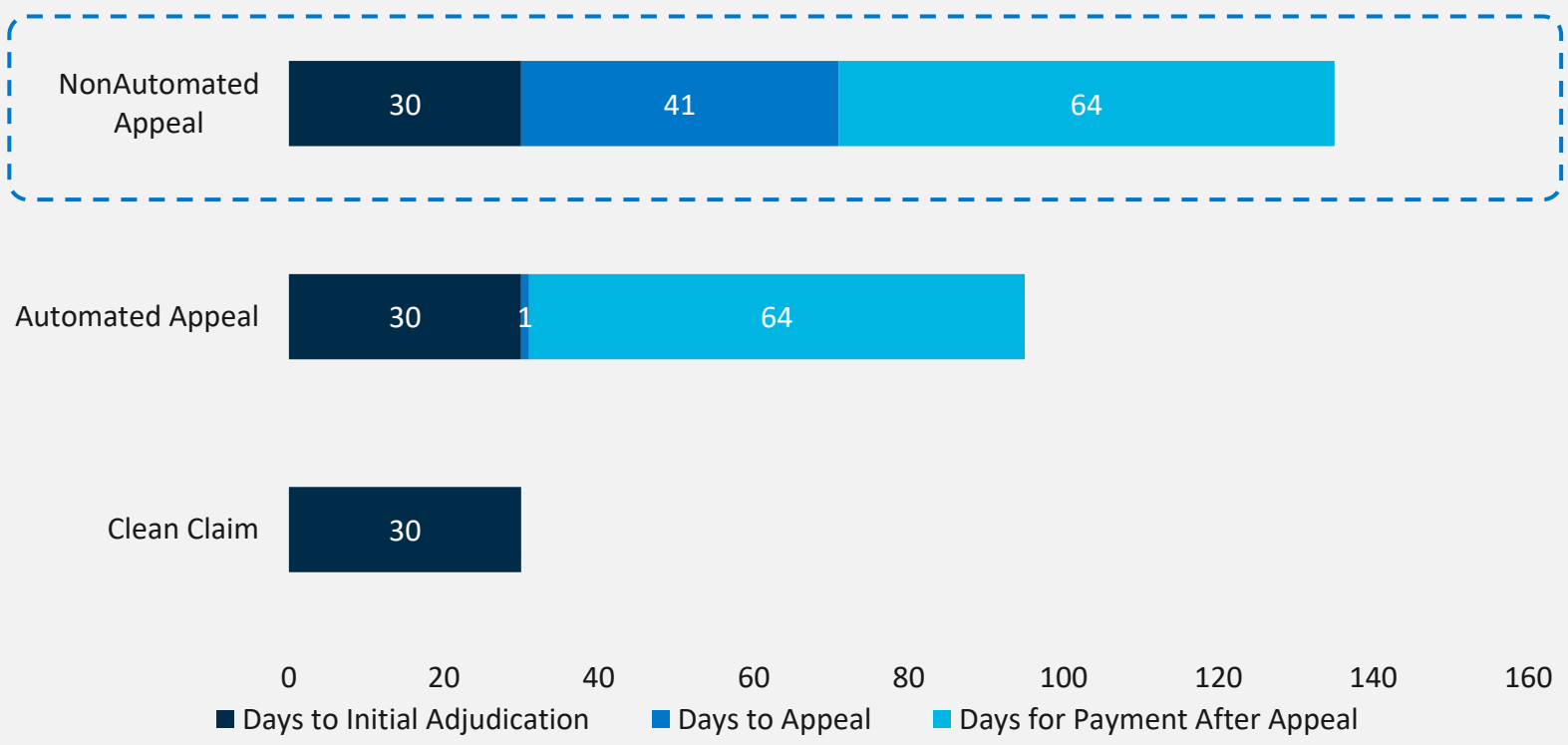
Review of Manual Appeals

- Identify repetitive appeals to automate

Trend Reporting

- Understand Changes in Payor Behavior
  - Educate Payors
  - Educate Clients

Time for Full Adjudication



QUESTIONS AND ANSWERS

THANK YOU

