Strategies and Multi-Dimensional Team Approach to Resolving/Preventing Clinical Denials

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Who are We?

Laurie Watkins, BSN, RN, CCM
Vice President
AdviCare

Lynette Stawicki, BSN, RN
Appeals Nurse
AdviCare
Objectives

1. Increase the overturn rate leading to increased cash
2. Decrease the dollars written-off as uncollectible
3. Identify root cause of denials
4. Implement strategies to prevent denials
5. Writing effective appeals
Clinical vs. Technical Denials
Defining Clinical vs. Technical

**Clinical Denial**
A denial of services for the requested treatment that does not appear to meet medical necessity criteria and cannot be medically certified based on the information provided by the treating clinician.

**Technical Denial**
A denial of services that is based on reasons other than a lack of medical necessity.
Inpatient Clinical Denials

Level of Care: Inpatient vs. OBS; (or) Bed Type

- Lack of Clinical Detail
  - Sent to Payer During Utilization Review to Support Inpatient Level of Care

- Difference in Criteria Used
  - Hospital versus payer

- Length of Admission
  - Less than 48 hours
Inpatient Clinical Denials

Length of Stay

- **Concurrent Reviews**
  - Lack of Clinical Detail Sent to Payer During Utilization Review to Support All Days of Hospital Stay

- **Delay in Treatment**
  - Consult Delays
  - Test Delays

- **Delay in Discharge**
  - Documentation is Key to Overturn Denials
Inpatient Clinical Denials

Readmissions

A readmission occurs when a patient is discharged/transfered from an acute care hospital, and is readmitted to the same acute care hospital within 30 days for symptoms related to, or for evaluation and management of, the prior stay’s medical condition.
Outpatient Clinical Denials

- ER visits denied as Non-Emergent Condition

A determination of a medical emergency focuses on the patient’s presenting symptoms rather than the final diagnosis
(EMTALA Prudent Layperson Standard)
Outpatient Clinical Denials

- Experimental/Investigational
  - PET Scans, MRIs
  - Elective Surgeries
  - Cardiac Procedures
  - Infusions
- Medical Necessity
  - Insurance medical policies
  - Conservative treatment
- Inpatient Only Procedures
“Hybrid” Denials

Notification

- A contractual requirement to notify payer of inpatient admission within specific time period
- Four main exceptions to Notification requirement:
  1. Patient presents incorrect insurance info
  2. Patient physically unable to present insurance info
  3. Natural disaster
  4. Evidence of provider attempts to comply
“Hybrid” Denials

Authorization Issues

- Notification versus Authorization
  - Reference number/authorization number
- Authorization not obtained prior to services rendered – Elective admissions
- Authorization not obtained within specified time period – Emergent admissions
- Authorization denied at time of request
- Authorization does not cover full admission
Medical Necessity
Defining Medical Necessity - THEN

Commercial Payers

PAST: “Medical necessity” are those services provided in accordance with “prevailing standards of care” or “generally accepted standards of medical practice.”
Defining Medical Necessity – NOW

**TODAY:** Medical necessity may now be defined in:

- Provider Contracts
- Provider Contract addenda or riders
- Payer specific policies and/or UR guidelines that are only available if you ask for them or may be available through the insurers website
A Tough Position To Be In

Without consensus on what is *Medically Necessary*:  

- Hospitals/health systems can lose thousands of dollars in reimbursement.  
- Patients and family members can be upset with the payer denial and almost certainly result in a negative patient experience.
## CARC Codes – Medical Necessity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>These are non-covered services because this is not <em>deemed</em> a ‘medical necessity’ by the payer.</td>
</tr>
<tr>
<td>55</td>
<td>Procedure/treatment/drug is <em>deemed</em> experimental/investigational by payer.</td>
</tr>
<tr>
<td>56</td>
<td>Procedure/treatment has not been <em>deemed</em> ‘proven to be effective’ by the payer.</td>
</tr>
<tr>
<td>58</td>
<td>Treatment was <em>deemed</em> by the payer to have been rendered in an inappropriate or invalid place of service.</td>
</tr>
<tr>
<td>114</td>
<td>Procedure/product not approved by the FDA.</td>
</tr>
<tr>
<td>150</td>
<td>Payer <em>deems</em> the information submitted does not support this level of service.</td>
</tr>
<tr>
<td>249</td>
<td>This claim has been <em>identified</em> as a readmission.</td>
</tr>
<tr>
<td>270</td>
<td>Claim received by the medical plan, but benefits not available under this plan. Submit to dental plan for consideration.</td>
</tr>
</tbody>
</table>
Resolving Denials
Levels of Appeal

- Informal Reconsideration
- Internal Appeal Process
- External Review
Preparing Your Case

1. Confirm root cause of denial
2. Obtain criteria used for decision

Is denial date the date of EOB or the date of denial notification?

Is informal level of review available?
Resolving Denials

The Art of Persuasion

Identifying the proper policy or medical records to dispute the denial is not enough!

Your appeals nurse or case manager must be able to persuasively document the medical necessity of the services in order to convince the payer they were WRONG.
Proving Your Case

Note:

Courts have stated the term “medical necessity” must refer to what is medically necessary for a particular patient. Where an insurer presents sufficient evidence to show that a treatment is not medically necessary in the usual case, the burden shifts to the patient/provider to show that this individual patient is different from the usual in ways that make the treatment medically necessary for him or her.
Proving Your Case

Use Applicable Contract Language
Proving Your Case

Courts have said that the treating physician’s opinion based on objective evidence should be accorded significant weight as to the determination of medical necessity.
Proving Your Case

Hindsight is 20/20

*But Not in Medical Necessity Determinations*

Payer should not have advantage that physician does not

- **consider only** the **medical evidence** which was **available to the physician at the time** an admission decision **had to be made**
- **do not** take into account other information (e.g., test results) which became available **only after admission**
  - except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

*CMS/QIO*
Proving Your Case

- InterQual Guidelines
- Milliman Care Guidelines
- Risk Stratification
- Payer-Specific Medical Policies
- Medical Documentation
Write
the
Appeal
Don’t End Up Here
Structure of Your Appeal

- ISSUE
- RULE
- ANALYSIS
- CONCLUSION
Effective Appeals – Inpatient Clinical

• Get the denial letter!
  ▪ Provides the clinical rationale used to deny the claim

• Dispute Payer’s findings directly with the medical record documentation

• Cite specific medical necessity criteria
  ▪ Interqual or Milliman Care Guidelines; Medical Policy

• Add risk stratification to your argument
  ▪ for example: comorbid conditions being treated concurrently that increased the risk of the patient for possible complications or deterioration of patient’s condition
Effective Appeals – Outpatient Clinical

• Know the **Medical Policy** used to issue the denial
  – Will need physician office medical records to support medical necessity for why the test was ordered
    • Signs/symptoms
    • Previous abnormal test result (x-ray abnormal so had to perform CT/MRI for further evaluation

• Diagnosis codes can trigger a denial
  – diagnosis must match the reason the test was performed
Authorization

Documentation

1. Be specific - just referencing authorization for MRI of spine could include 3 different CPT codes
2. Be careful when calling to get the authorization and the payer states authorization is not required - confirm it is for the specific CPT code being performed
3. All attempts to obtain authorization should be clearly documented
4. PCNR – get payer list of required codes for pre-auth
5. Auth obtained from incorrect insurance - must verify current insurance/coverage
Escalate Unresolved Issues to Appropriate Party
Preventing Denials
Denials are a prevalent and persistent problem causing financial strain and can occur at any point in the revenue cycle.

2/3 of denials are recoverable BUT 90% are preventable.
Preventing Denials

✓ Denial prevention begins before the services are rendered
  ✓ EVERYONE needs to “buy into” the process and understand why each step is important in the revenue cycle process to prevent denials
  ✓ EDUCATE, EDUCATE, EDUCATE
    ✓ Physicians
    ✓ Business office/registration staff
    ✓ Case Managers/Social Workers
    ✓ Nursing & all treating clinicians/disciplines
### Denial Prevention

**Avoidable versus Non-Avoidable Clinical Denials**

<table>
<thead>
<tr>
<th>Avoidable</th>
<th>Non-Avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Medical Necessity</td>
<td>Inappropriate use of ER</td>
</tr>
<tr>
<td>No Authorization</td>
<td>Pending medical review</td>
</tr>
<tr>
<td>Exceed approved IP Days</td>
<td>Medical record request</td>
</tr>
<tr>
<td>Delayed Discharge</td>
<td></td>
</tr>
<tr>
<td>Investigational Procedure</td>
<td></td>
</tr>
<tr>
<td>Service Classified as IP Only</td>
<td></td>
</tr>
<tr>
<td>No Order</td>
<td></td>
</tr>
<tr>
<td>Missing Clinical Information</td>
<td></td>
</tr>
</tbody>
</table>
Denial Prevention – The Data

“Data is Delicious”

• Track and Measure Everything!
• Identify your trends
• Share the data with all departments involved
  – Don’t forget Managed Care for contract negotiations
• Benefit is not only in the revenue collected but also in identifying areas where denials can be avoided and those dollars collected sooner
Denial Prevention – The Data

By Reason Code

By Payer

By CPT Code
Denial Prevention – Root Cause

Example:
Anthem BCBS denies inpatient claim
CARC code 197 – Precertification/Authorization/Notification Absent

Root Cause?

- Authorization was requested but denied at time of request
- Authorization was started but not completed
- Authorization was obtained from the wrong payer
Denial Prevention – Root Cause

• Identification on the true root cause is very important in order to:
  – Identify opportunities for improvement on both the hospital and payer processes
  – Feedback to the payer for follow-up, process revisions, medical policy reviews, etc.
Denial Prevention – Case Managers

• **Outpatient Case Manager(s)**
  – Ensure authorizations are obtained prior to services rendered
  – Diagnosis codes match the billed service(s)
  – Be specific with CPT codes when calling for prior auth

• **ER Case Manager**
  – Get admission status correct at time of admission
  – Ensure documentation/treatment supports admission status/level of care (Inpatient vs. OBS) ordered
Denial Prevention – Case Managers

• Hospital Case Managers
  – **OBS claims** should be reviewed **daily** for either discharge or change in admission status
  – **Submit detailed clinical information** to payers to support medical necessity for level of care
    • Not enough to cite the guideline but note specific information that meets the criteria
  – **Submit concurrent clinicals** to support ongoing hospitalization (symptoms, abnormal labs/tests, VS to support level of care or ongoing stay
  – Utilize **peer-to-peer review** when available
Denial Prevention - Documentation

- **Physician:**
  - DRG assignments affected
  - Support medical necessity of level of care and continued hospital stay

- **Case Management/Social Worker:**
  - Discharge planning efforts – must document all efforts to support an appeal if denial is received for length of stay

- **Nursing & other disciplines:**
  - Supports medical necessity for level of care, as well as, length of stay
Denial Prevention – Accountability

Hold the Payers Accountable

- Tracking important time frames to drive change
- Success rate of appeals
  » If success rate is high, question the payer’s policy on the original denial of the claim

Hold Internal Team Accountable

- Where denials are upheld - share the data with your team/physician offices to see what can be done to prevent the ongoing denials
- Share root cause information to support changes in internal processes to prevent future denials
Thank You!

Lynette Stawicki, BSN, RN
Appeals Nurse
863-279-3695
lstawicki@myadvicare.com

Laurie Watkins, BSN, RN, CCM
Vice President
863-877-3354
lwatkins@myadvicare.com