Problem # 1 – Verification of Benefits

- Hospital verifies benefits & obtains authorization for thoracotomy & 3 day stay.
- Payer retroactively identifies patient failed to pay premium & denies claim as non-covered, OR requests additional medical information and denies as not medically necessary, OR just doesn't pay unless Hospital appeals.

#1 Verification of Benefits

Hospital acknowledges that such information provided by Payor is subject to change retroactively under the following circumstances: (1) if Payor has not yet received information that an individual is no longer a Customer; (2) if the individual's Benefits Plan is terminated retroactively for any reason including, but not limited to, non-payment premium; (3) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information Payor receives is later proven to be false. Payor will make reasonable efforts to cause Payor to process eligibility changes within 90 days.

Problem #2 – Authorization Issues

1. Patient admitted through ED on weekend & patient admitted & discharged prior to Auth being obtained
2. CPT 123 Authorized, but surgeon performs CPT 456 (which requires authorization) and claim denies for no Authorization
3. Hospital told service does not require Authorization, but it does per Payer's clinical policies
4. Hospital attempts to obtain authorization, but auth is pended & Hospital receives only "tracking" or "reference" numbers
5. Etcetera, etcetera…

#2 Authorization

Hospital must request authorization for services from Payor by telephone prior to providing any services to a Member, regardless of the time of day or day of week or the requirements of the Benefit Contract regarding prior authorization. All Services provided to Members by Hospital must be prior authorized by Payor, and confirmed by Payor in writing. Only Emergency Health Services will be eligible for retroactive authorization at the sole discretion of Payor.

Problem #3 – Medical Necessity Issues

- Hospital documents that inpatient services meet Interqual (or Milliman) guidelines, and the inpatient level of care was approved by the Hospital's UR Department, but the inpatient level of care is denied for alleged failure to meet Payer's criteria.

#3 Medical Necessity

The decision as to whether a service or supply is Medically Necessary for purposes of payment rests with the Medical Director or his/her designee, provided however, that such decisions shall be based on standard criteria published by Milliman & Robertson, or such other reputable national guidelines as Corporation in its sole discretion employ.

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Problem # 4 Readmission Issues

- 76 yo patient with severe COPD and multiple co-morbidities admitted for COPD 12 days following a previous admission for COPD, even though the patient was stable, met all discharge screens, took medication as prescribed, and received standard of care home health care services and follow up.

#4 Readmission

Cases that are readmitted to the Hospital's inpatient facility within fourteen (14) days for the same episode of care are not eligible for two payments. For this policy the same episode of care will not include similar diagnoses or those admissions for chronic disease management where the standard of care would warrant readmission within fourteen (14) days.

Problem # 5 - ICD 10 Denials

- Patient treated for pneumonia. However, physician documentation is not specific enough for ICD 10 coding. Hospital queries Physician, and makes Query part of medical record. Payer denies saying Query was leading.
- OR, Hospital's efforts with Query are not fruitful, and an Unspecified Code must be billed resulting in an auto edit & denial.
- OR Payer uses Coding Audit vendor who provides very short timeframes for DRG reassignment appeals.
- Or Payer down codes ignoring coding rules & instead applies "clinical" judgement

#5 – ICD 10

All services identified by MS-DRGs are subject to verification by Payer using the Medicare Prospective Payment Grouper version of grouping software in use by Payer on the date of discharge. MS-DRGs submitted by the Hospital that do not coincide with the MS-DRG assigned by Payer's grouping software will be paid at the applicable rate for the assigned MS-DRG.

DRG Reassignment after denial of Diagnosis Code 486 (pneumonia, organism unspecified)

You, the provider, stated in your letter to appeal that you disagree with removing the secondary diagnosis code of organism unspecified pneumonia. According to Coding Clinic, Second Quarter 2000, Page: 17 to 18 states, coders may assign and report codes to diagnoses not stated in the physician's final diagnosis only if these diagnoses are specifically documented by the physician in the body of the medical record and this documentation is clear and consistent. Although the physician query lists pneumonia as a diagnosis, the discharge summary does not include this diagnosis. The medical records do not support the diagnosis of pneumonia, and state that his vital signs and oxygen saturation are within normal limits and he did not experience difficulty breathing. The documentation does not clearly and consistently support the original coding. Therefore, the RA's decision is upheld and the DRG will remain assigned to 164.

Evaluation

1. Requirements?
2. Achievable?
3. Fair?
4. Cost?
5. Recommendations?