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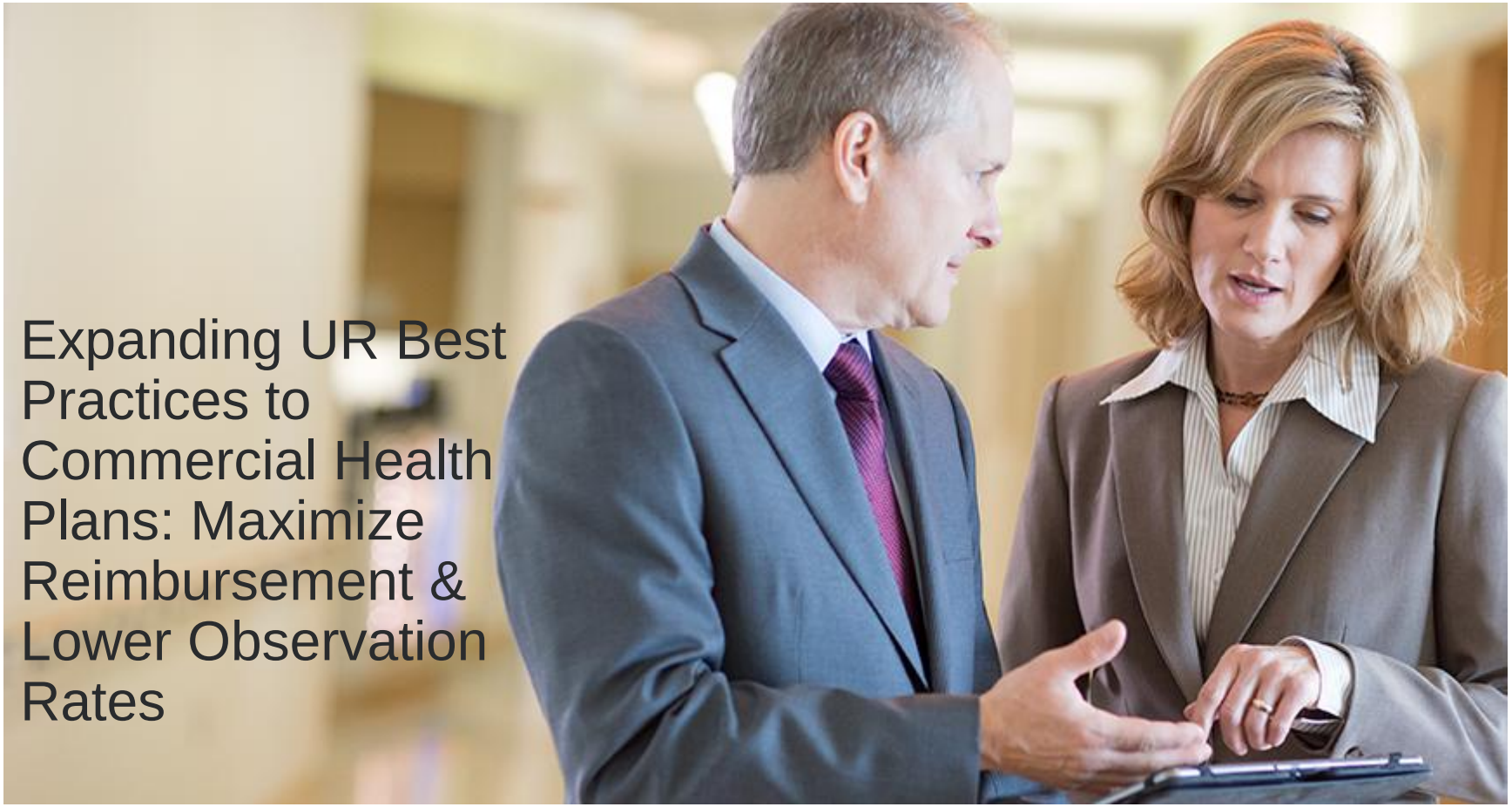

Expanding UR Best Practices to Commercial Health Plans: Maximize Reimbursement & Lower Observation Rates

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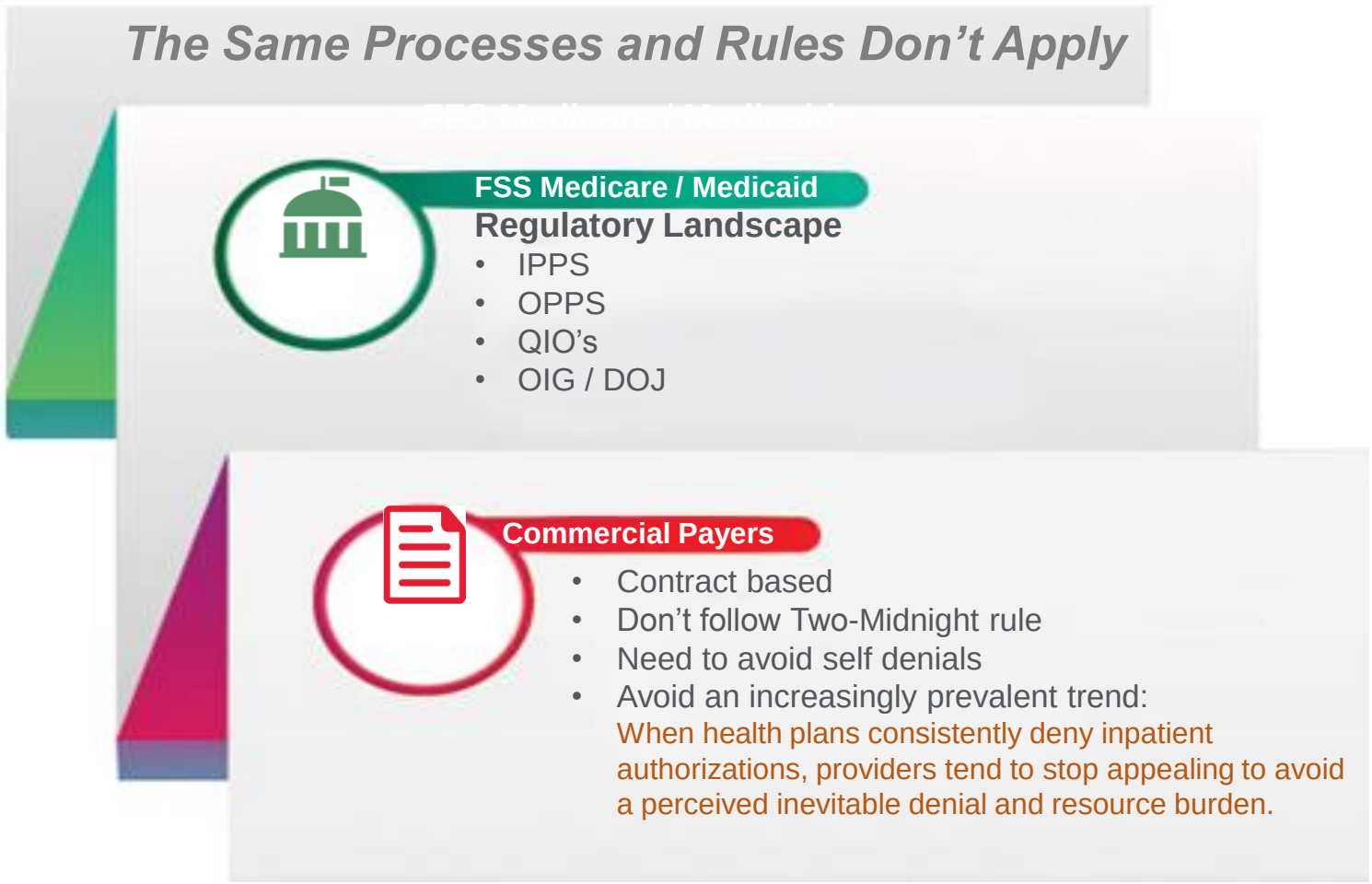
Agenda

1. Background
2. Overview of commercial denials process
3. Best Practice Approach
4. Denials Management
5. Keys to Success
6. Take Home/Q&A

Background

The Payer Landscape: Two Worlds



The Balance of Power

- Hospitals have been preoccupied with Medicare so they have little infrastructure to combat commercial denials.
- Payors have a cadre of full-time nurses/physicians in charge of issuing denials.
- Physicians drive a large segment of cost and revenue for hospitals, these dollars need to be aggressively managed.
- Need to know if physicians and the hospital have misaligned incentives from the same payor.

Overview of Commercial Denials Process

What is a Denial?

Any situation in which payment is less than that which was contractually agreed upon for the services delivered:

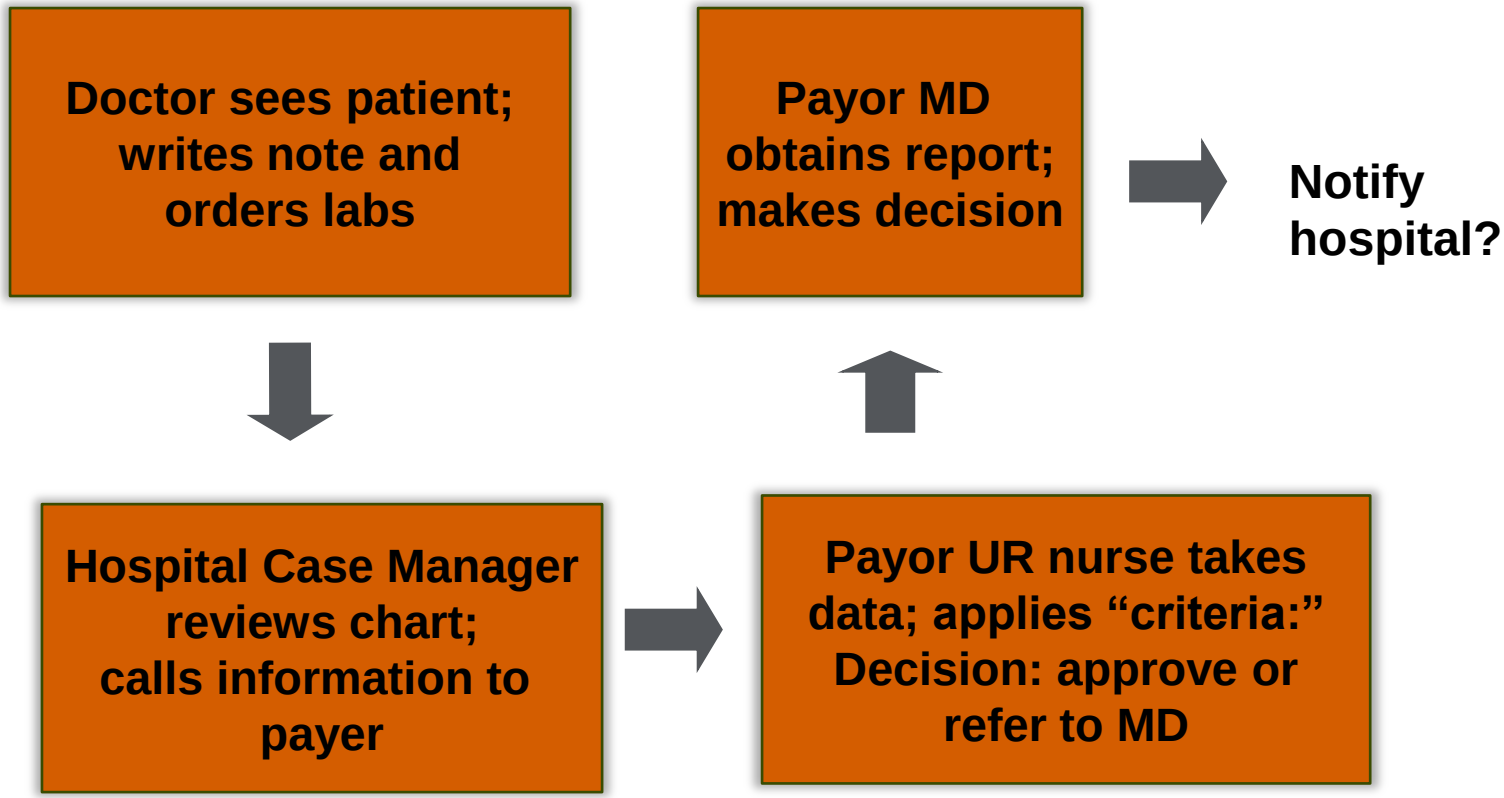
- Complete denial
- Downgrades
  - IP to OBS
  - Acute to SNF
  - ICU to Acute
  - DRG change
- Carved-out days/services

Evaluation of Denials

Type of denial:

- Administrative
- Not medically necessary
- Non-covered service
- Experimental/Investigational
- Another provider (e.g. mental health)
- Patient not eligible
- No pre-authorization or pre-certification
- Out-of-time filing
- Error in billing

How Does a Concurrent Denial Occur?



Best Practice Approach

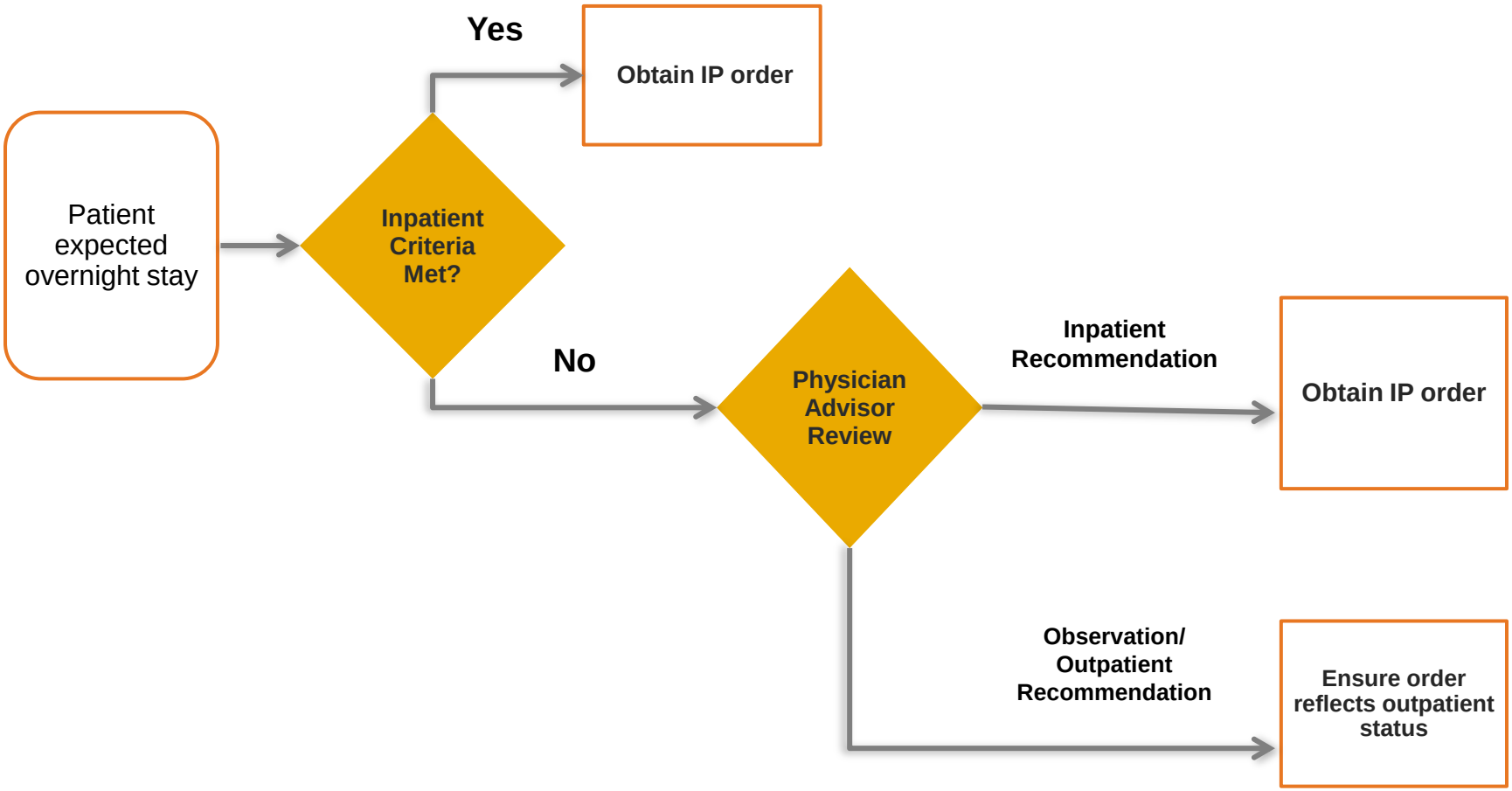
Best Practice Approach

- Avoiding denials and successful appeals are best achieved through a best practice approach.
- Recognize that your hospital will receive inappropriate denials, and be prepared to appeal.
- Hospitals need to defend their decisions and advocate for their rights (and those of the patients).
- Admission decisions must be based on clinical evidence (i.e. medical necessity); but, there are regulatory and legal (i.e. contracts) considerations.
- Educate medical staff on documentation best practices to avoid denials.

Best Practice Approach

- Specialize in denials management.
- Physician Advisor (or team) training:
  - Commercial/Managed care contracts
  - Utilization management
  - Screening criteria (e.g. MCG®, InterQual®)
  - Negotiating skills
- Levels the playing field and aggressively pursues appropriate reimbursement.
  - Criteria
  - Medical necessity
  - Contract terms
- Available for Medical Director calls.

Recommended UR Workflow* (General)

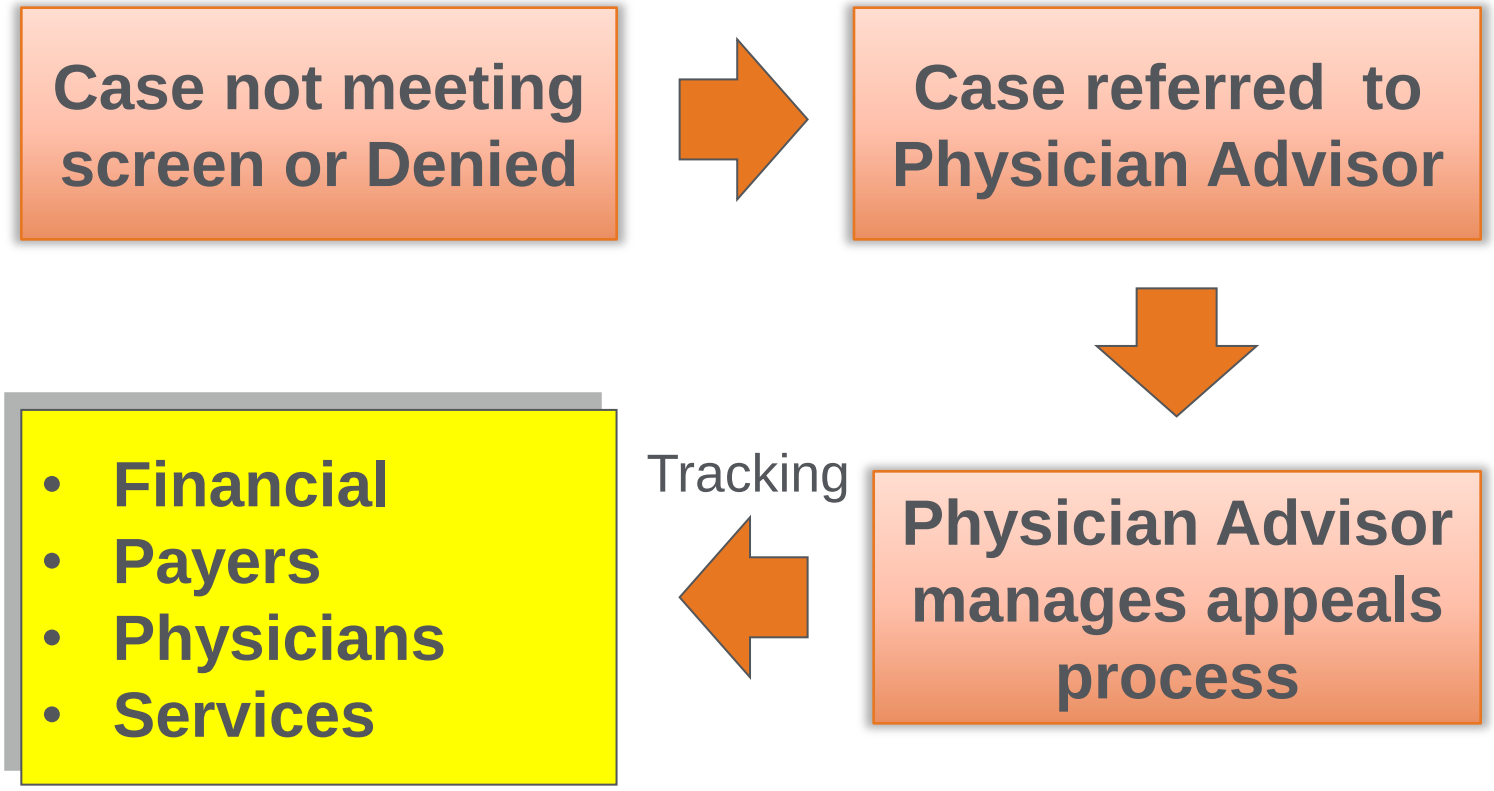


*For all admissions after January 1, 2016

Concurrent Review Process

- **Case Management Criteria-based Review**
  - IP screen applied to all Medical Necessity cases.
  - Cases that fail are sent to a Physician Advisor.
- **Physician Advisor Review**
  - Responsible physician contacted, if necessary.
  - Provides a medical necessity recommendation regarding admission level of care.
    - Order change
    - Documentation
  - CM is contacted with recommendation

Concurrent Review Process (Commercial)



Benefits of Commercial Payor Admission Reviews

Commercial Admission Review

- Streamlines case management UM processes and physician rules for documenting medical necessity across all payor types.
- Ensures identification of cases meeting IP criteria upon 2nd level review.
- A potential decrease in self denial rate of commercial payor cases.

Benefits For All Commercial Payor Admission Reviews

- A consistent UM process across all patient and payor types.
- Physician to appeal has knowledge of the case prior to a denial.
- This experience enables trending of payor denials and high risk areas.
- Physician rationale for IP can be leveraged during the appeals process.

Denials Management

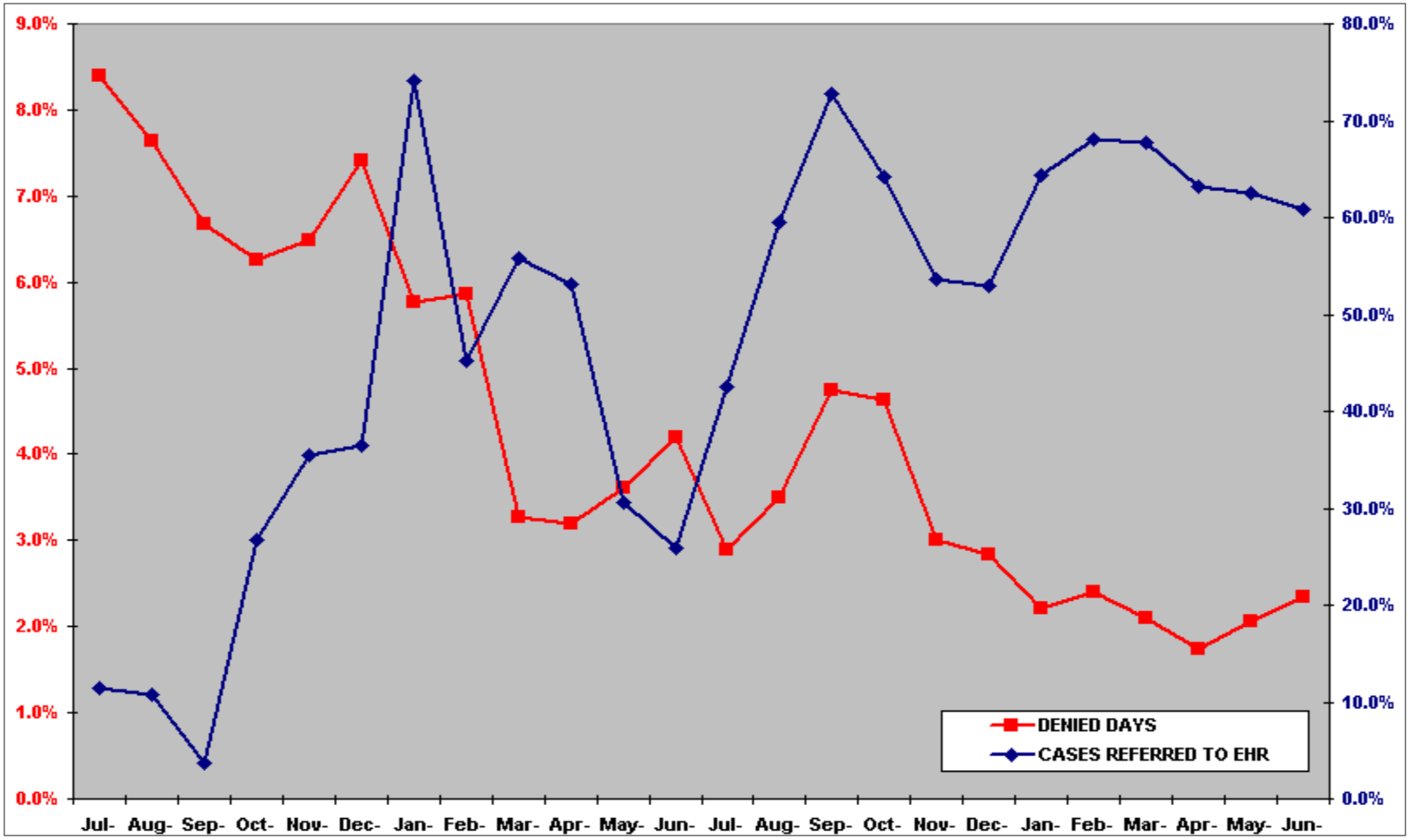
Commercial Levels of Appeal

- Different payers have different processes.
- Know the contract!
- Levels of appeal
  - Concurrent
  - Retrospective
    - 2 or 3 levels (per contract)
    - External (IRO)

Appeal Inappropriate Denials Early And Often

- Get paid for the services provided.
- Draw a line in the sand.
- Make the payor work for its money.
- Empower case management.
- **Best practice:** Appealing up to 85% of denials.
- **The more you appeal, the more you will overturn!**

The “Inverse Correlation”



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Retrospective Review

- Every denial is reviewed by a physician advisor.
- Decides to appeal or not on a case-by-case basis.
- Physician-authored letter composed.
- Copy of chart and letter sent to payor.
- Each case tracked through all stages of appeal.
- An aggressive retrospective appeals program has a “trickle up” effect on concurrent denials:

The payor is *less* likely to deny if they *know* there will be an appeal.

Important to Remember

- The clinicians' documentation in the medical record is more than just a communication vehicle for the clinical care team.
- Multiple entities inside (e.g. CMs, Coding/Billing) as well as outside the hospital (e.g. payors, auditors, lawyers) will review the medical record.
- **Remember:**

  If it isn't documented then it wasn't relevant to the decisions; hence, adds little weight to the appeal!

Denials Management

- **You will be judged by your process!**
- Demonstrate a consistently followed Utilization Review process for every patient.
- A consistent process must be paired with diligent oversight and data review.
- Prove that the error rate within your hospital is not accurate by focusing on successfully appealing denials.
- Identify procedural failures.

Denials Management

- Data Review
  - Expected volume
  - Staffing requirements
  - Get data from contracts
    - Set up payor reference sheets.
    - Find denials of which CMs are not aware.
    - Self-denials
- Implementation
  - Educate CMs on process and mindset
  - Educate physicians
- Appeal early and appeal often
  - Retrospective appeal if peer-to-peer not successful.
  - Tracking

Payor Reference Sheets

- Contract effective date, expiration date
- Termination notice required
- Renewal (auto, increases)
- Stop loss (type, rate, cap)
- Inpatient
  - DRG, per diem
  - Base rate
  - DRG CMI*Base rate
  - High volume DRGs
- Outpatient
  - High dollar, high volume procedures
  - Observation payment (% of charges, fixed, per diem)

Self-Denials

By aggressively denying cases over time, commercial payors have trained hospitals to **self-deny** cases that meet medical necessity:

- Cases that could have qualified for inpatient but failed first level inpatient screening.
- Observation cases that could have qualified for inpatient.

Self-Denials

- **A symptom of self-denials is a high observation rate.**
- **The primary drivers are:**
  - Commercial payors will often give incentives to physicians to status patients as observation – hospitals don't see this.
  - Hospitals are tired of fighting denials; payors make it difficult for hospitals to appeal.
  - Hospitals have focused primarily on lowering their Medicare FFS observation rate.
  - **Hospitals track payor denials, not self-denials!**
    - Decreasing denial rates or increasing overturn rates aren't necessarily desirable?
    - You want high appeal rates and $ recovered.

“Invisible” Denials

The approach should be not to have a high “overturn rate,” but delivering the highest net return by aggressively appealing almost every denial.

Would you rather overturn:

9 out of 10 (OT rate 90%)?

or

40 out of 100 (OT rate 40%)?

Keys to Success

Keys to Success – Avoiding Denials

Hospitals are frequently penalized for efficient care and/or rapid improvement of patients.

- Risk assessment is the key; BUT,
- ***Documentation is the difference!***
  - Detail why the care is/was medically necessary as an inpatient.
  - Document the *why* not just the *what*. **Explain!**
    - Summarize pertinent positives in assessment and plan.
    - Document the thought process.
  - What's obvious to us, may not be to the payors.
- UR/CM need to communicate with physicians.

Keys to Success – Avoiding Denials

Critical factors:

- The judgment of the admitting physician referencing:
  - Standards of care
  - Evidence-based medical literature
  - Published clinical guidelines
  - Other relevant materials
- Utilization management criteria
- When applicable (i.e. Medicare):
  - NCDs/LCDs
  - CMS guidance

Keys to Successful Appeals

- All medical records should be prepared to be appealed.
- All appeals should be prepared as if they will need to go to highest level.
- **3-Tiered approach:**
    1. **Clinical:** Strong medical necessity argument using evidence-based literature.
    2. **Compliance:** Need to demonstrate that a compliant process for certifying medical necessity was followed.
    3. **Regulatory:** Demonstrate, when applicable, that the denial is not consistent with the relevant regulations/contract at the time of the admission.

Keys to Success – Commercial Appeals

- Appeal denials while the patient still in the hospital, or immediately post discharge. (This is your best chance!)
- Develop a long-standing professional and respectful relationship with the payors. (NEVER LIE!)
- Hold payors accountable for their decisions.
- Know contracts: Does it makes financial sense to appeal?
- Important that CMs know when denials occur, and can start the appeals process.
- Track appeals and outcomes.
- You always have a right to appeal even when the denial occurs after the patient has been discharged.

Take Home

- Follow AR from beginning to end.
- Best practice approach to avoid denials and succeed in appeals.
- Physician involvement and communication *is critical*!
- Optimize resources

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Questions?

Thank you

Contact information

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