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 Same Processes and Rules Don’t Apply

**FFS Medicare / Medicaid**

- IPPS
- OPPS
- QIO’s
- OIG / DOJ

**Commercial Payers**

- Contract based
- Don’t follow Two-Midnight rule
- Need to avoid self denials
- Avoid an increasingly prevalent trend: When health plans consistently deny inpatient authorizations, providers tend to stop appealing to avoid a perceived inevitable denial and resource burden.
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
  o IP to OBS
  o Acute to SNF
  o ICU to Acute
  o 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?

Doctor sees patient; writes note and orders labs

Hospital Case Manager reviews chart; calls information to payer

Payor MD obtains report; makes decision

Payor UR nurse takes data; applies “criteria:”
Decision: approve or refer to MD

Notify hospital?
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)

- Patient expected overnight stay
- Inpatient Criteria Met?
  - Yes: Obtain IP order
  - No: Physician Advisor Review
    - Observation/Outpatient Recommendation
      - Yes: Obtain IP order (Ensure order reflects outpatient status)
      - No: Inpatient Recommendation

*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)

- Case not meeting screen or Denied
- Case referred to Physician Advisor
- Physician Advisor manages appeals process
- Tracking
- Financial
- Payers
- Physicians
- Services
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”
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
Questions?
Thank you

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