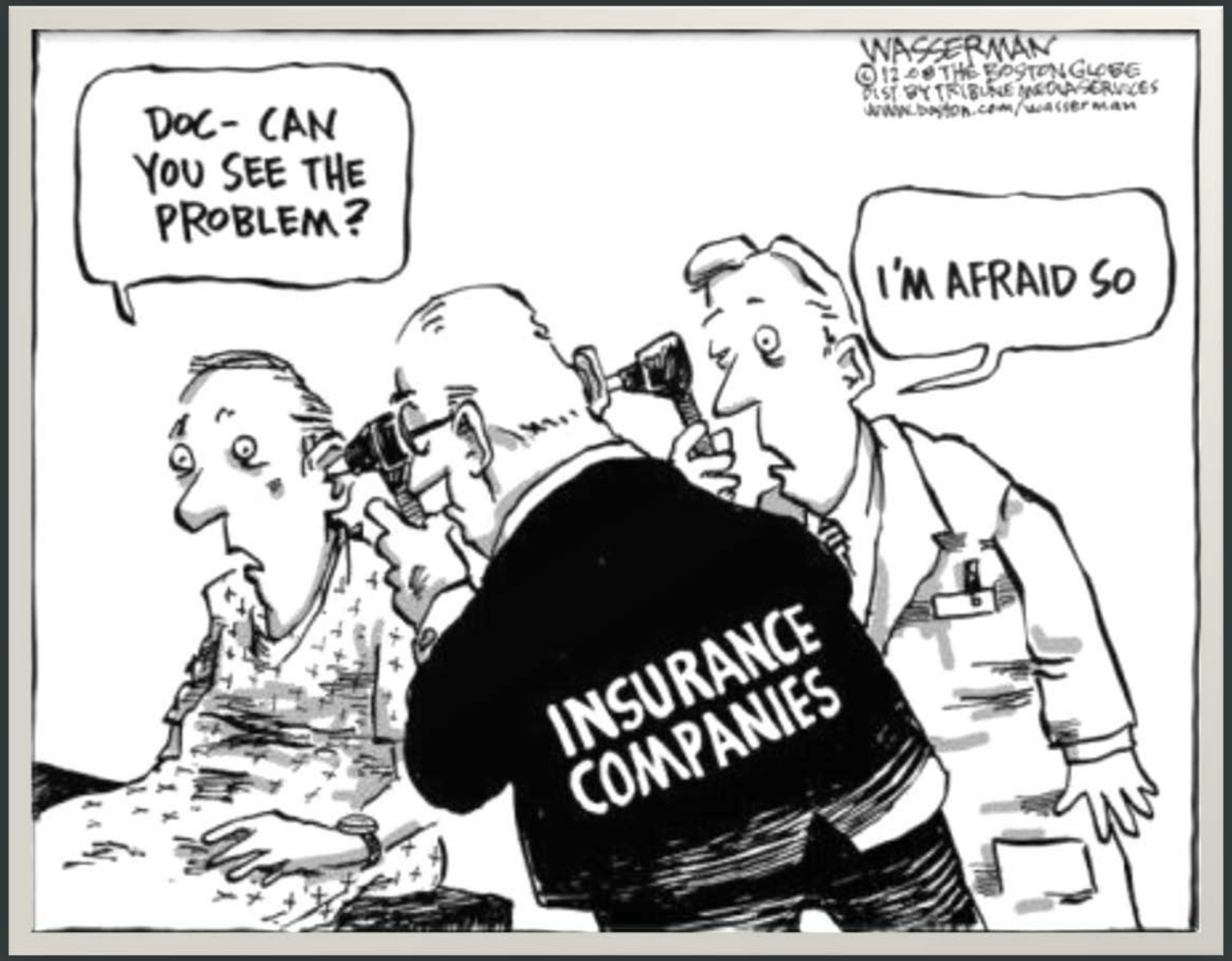
Denial Defense

EFFECTIVE USE OF VERIFICATIONS & PRE-AUTHORIZATIONS

presented by THE GIBSON FIRM
Healthcare Law


WASSERMAN
DOC- CAN YOU SEE THE PROBLEM?
I'M AFRAID SO
INSURANCE COMPANIES

TIMELINE NO. 1 – No Pre-auth Required (NPR)

01/02/2018	Physician refers patient to hospital for scheduled outpatient surgery – sends orders to facility
01/02/2018	Hospital contacts patient and schedules surgery for 01/08/2018
01/03/2018	INS VERIFIED - Hospital staff calls BCBS to verify benefits, notify of scheduled surgery, and ask if authorization is required BCBS verifies that hospital is IN-network with patient's policy, confirms that benefits are active, and procedure is covered; no pre-auth required for IN providers
01/08/2018	Patient arrives; surgery performed; patient discharged same day
01/12/2018	CLAIM BILLED – no changes to originally scheduled services
02/05/2018	INS DENIED claim for no pre-authorization – or not medically necessary

DISCUSSION:

- What is wrong with this scenario? What was missed?
  - Whose responsibility was it?
- What type of BCBS policy did the patient have?
  - What if the hospital is NOT in-network with this particular *type* of BCBS policy?
    - Was pre-auth required?
  - What if this patient's policy has no out-of-network coverage?
- What if the referring physician/surgeon is in-network?
  - And only has privileges at this facility?
- What if this procedure could only be performed at this facility? No other facility within 50 miles has the equipment necessary for this procedure.
- What if this claim was denied for no pre-auth or medical necessity?
  - Should a retro-auth be requested?
  - Should a medical necessity appeal be submitted with clinicals?
- What does NPR really mean?
- Can BCBS deny for no auth when they told the hospital it did not need to get an auth?
- Can a hospital reasonably rely on what they are told by an insurer or is it their responsibility to know?

TIMELINE NO. 2 – Pre-auth Required & Requested

01/02/2018	Physician refers patient to hospital for scheduled outpatient surgery – sends orders to facility
01/02/2018	Hospital contacts patient and schedules surgery for 01/08/2018
01/03/2018	INS VERIFIED - Hospital staff calls BCBS to verify benefits, notify of scheduled surgery, and ask if authorization is required BCBS verifies that hospital is IN-network with patient's policy, confirms that benefits are active and procedure is covered; pre-auth IS required for outpatient surgery, but not if performed inpatient
01/03/2018	Information transferred to auth department to initiate
01/04/2018	FAXED CLINICALS - Hospital auth department requests authorization for scheduled procedure (reference #A123456789) and sends physician orders and clinicals via fax to BCBS
01/08/2018	Patient arrives; surgery performed; patient discharged same day
01/12/2018	CLAIM BILLED – no changes to originally scheduled services
02/05/2018	INS DENIED claim for no pre-authorization – or not medically necessary

DISCUSSION:

- What is wrong with this scenario? What was missed?
  - Whose fault was it?
- Did the hospital meet BCBS's requirements?
- What happened to the requested auth that was not responded to?
- How long did BCBS have to respond to the auth request?
- Was it the hospital's responsibility to follow up?
- What if BCBS denied the auth but didn't inform the hospital?
  - What if the denial was sent to the patient or referring physician?
- What if the treating physician's orders were to admit the patient to IP for this procedure but BCBS informed it would only allow OP?
  - Would pre-auth be required if this was ordered as an IP procedure?
- Should a medical necessity appeal be submitted with clinicals since auth was not obtained?

TIMELINE NO. 3 – Pre-auth Required, Requested & Issued

01/02/2018	Physician refers patient to hospital for scheduled outpatient surgery – sends orders to facility
01/02/2018	Hospital contacts patient and schedules surgery for 01/08/2018
01/03/2018	INS VERIFIED - Hospital staff calls BCBS to verify benefits, notify of scheduled surgery, and ask if authorization is required BCBS verifies that hospital is IN-network with patient's policy, confirms that benefits are active and procedure is covered; pre-auth IS required for outpatient surgery, but not if performed inpatient
01/03/2018	Information transferred to auth department to initiate
01/04/2018	FAXED CLINICALS - Hospital auth department requests authorization for scheduled procedure (reference #A123456789) and sends physician orders and clinicals via fax to BCBS
01/05/2018	PT APPROVED OP - BCBS contacts hospital auth department and informs approved; issues same auth number as reference no.: A123456789
01/08/2018	Patient arrives; surgery performed; patient discharged same day
01/12/2018	CLAIM BILLED – no changes to originally scheduled services
02/05/2018	INS DENIED claim for no pre-authorization – or not medically necessary

DISCUSSION:

- What is wrong with this scenario? What was missed?
- Did the hospital meet BCBS's requirements?
- What if BCBS rescinded the authorization:
  - by sending a letter to the patient?
  - by contacting the referring physician's office?
  - by sending a letter or calling the hospital?
    - before the date of the scheduled procedure?
    - on the day of the scheduled procedure?
    - after discharge?
  - Should a medical necessity appeal be done to request that the rescinded auth be reconsidered?
- What if BCBS denied for medical necessity (without rescission of auth)?
  - Should a medical necessity appeal be submitted with clinicals?

TIMELINE NO. 4
Pre-auth NOT Required → Complications/Changes → IP Admit

01/02/2018	Physician refers patient to hospital for scheduled outpatient surgery – sends orders to facility
01/02/2018	Hospital contacts patient and schedules surgery for 01/08/2018
01/03/2018	INS VERIFIED - Hospital staff calls BCBS to verify benefits, notify of scheduled surgery, and ask if authorization is required BCBS verifies that hospital is IN-network with patient's policy, confirms that benefits are active and procedure is covered; pre-auth is NOT required for outpatient surgery, but IS required if inpatient
01/08/2018	Patient arrives for OP surgery; surgery performed but complications experienced → additional procedures undertaken; patient admitted to IP for monitoring – ACCOUNT CHANGED TO IP
01/09/2018	Patient discharged
01/12/2018	CLAIM BILLED as IP with additional surgical procedures added
02/05/2018	INS DENIED claim for no notification – or no pre-authorization – or not medically necessary

DISCUSSION:

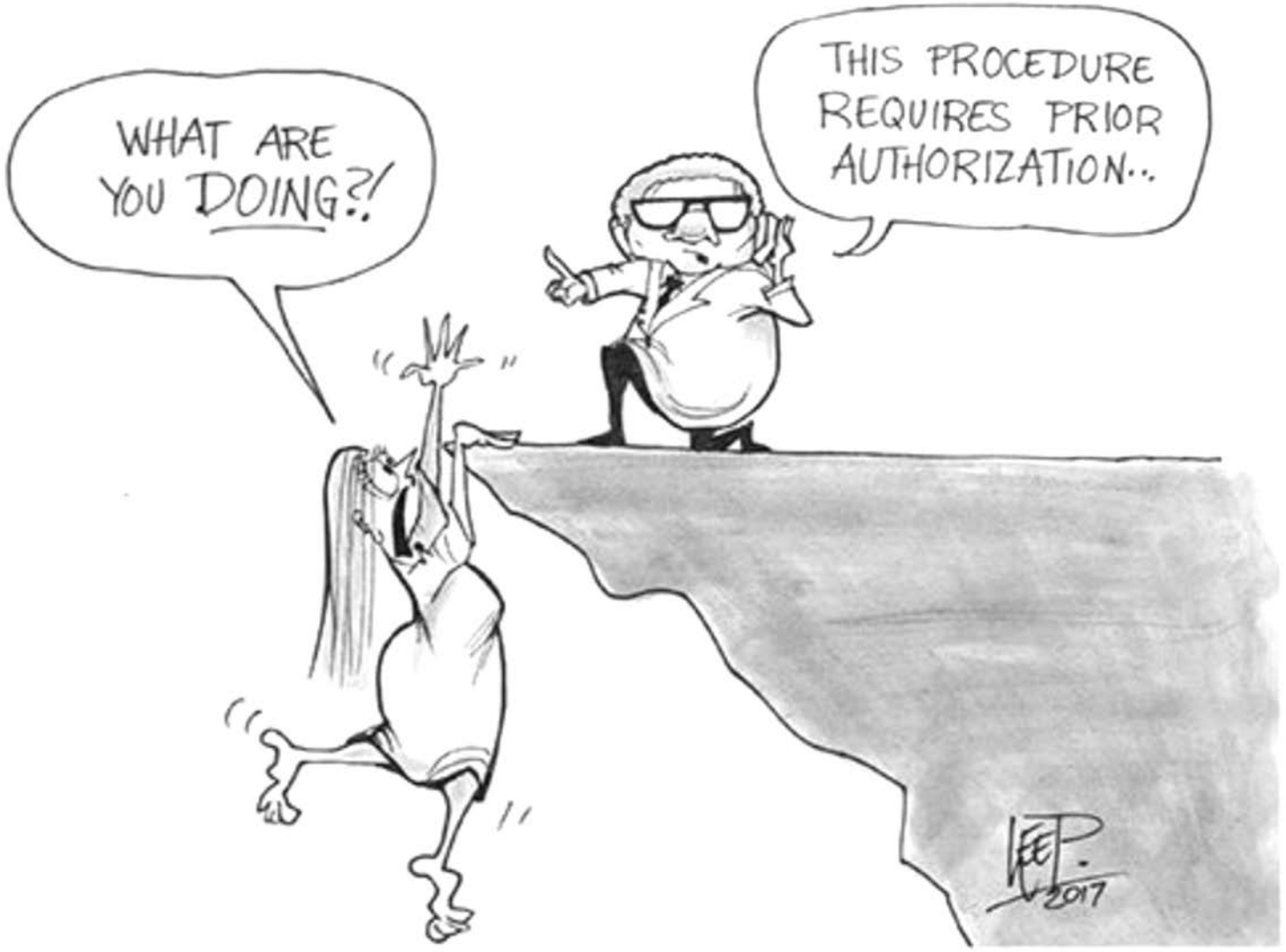
- What is wrong with this scenario? What was missed?
- Was inpatient notification required?
- Was the hospital required to request auth for:
  - the mid-procedure changes?
  - the inpatient admission?
- What if the facility requested auth on the same day as the scheduled procedure immediately upon receiving information about the mid-procedure change and IP order…
  - but BCBS did not respond to the request?
  - but BCBS denied the level of care change to IP?
  - but BCBS denied the mid-procedure change as not medically necessary?
- If BCBS denied for medical necessity or for failure to meet IP level of care --
  - Should a medical necessity appeal be submitted with clinicals?
- Is BCBS allowed to require auth or deny charges for changes in scheduled services that occur mid-procedure?

TIMELINE NO. 5 – Emergency Surgery

01/08/2018	Patient arrives via ambulance to facility's Emergency Department; patient rushed to emergency surgery; IP stay ordered by physician; patient transferred to IP bed ED TO IP ADMIT
01/08/2018	INS VERIFIED - Registration staff contacts BCBS to verify benefits, notify of patient's emergent arrival, surgical procedure and admission to IP, and to ask if authorization is required BCBS verifies that hospital is IN-network with patient's policy, confirms that benefits are active and procedure codes are covered; pre-auth is required for OP surgery, but no-precert required (NPR) for inpatient
01/12/2018	CLAIM BILLED
02/05/2018	INS DENIED claim for no pre-authorization – or not medically necessary – or no notification of IP admission

DISCUSSION:

- What is wrong with this scenario? What was missed? What was required?
- What if the patient was unconscious upon arrival and no insurance information was available or known until the next day or after discharge?
- What if the hospital was OON…
  - and pre-auth was required for same services for OON facilities?
  - or the patient's policy had no OON benefits?
- Was inpatient notification provided?
- Was the hospital required to request auth?
- What does NPR mean?
- What if the facility was OON – was it required to notify or request auth for emergency services?
- If BCBS denied for medical necessity or for failure to meet IP level of care --
  - Should a medical necessity appeal be submitted with clinicals?


WHAT ARE YOU DOING?!
THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION..
2017

PREPAREDNESS FOR TYPES OF DENIALS

BENEFITS / ELIGIBILITY-RELATED

- Benefits available In-Network vs. Out-of-Network based on reliance on insurer information
- Pre-cert required/not required based on IN vs. OON

PRE-AUTH-RELATED

- When authorization was…
  - received and provided on claim form
  - requested but denied
  - requested but no response by insurer
  - not required – NPR
- Authorization was obtained but not being honored or was retracted pre/post-treatment
- Authorized services do not match treatment codes billed due to mid-procedure change
- Ongoing authorization not obtained
- Retro-authorization
- No auth denial for emergency services
- Level of care or Procedures denied

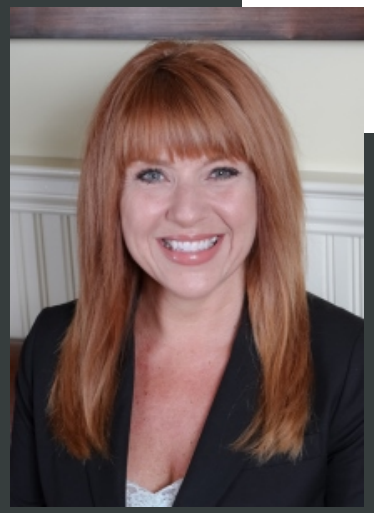
EVIDENTIARY SUPPORT
for Authorization, Notification & Medical Necessity Denials

YOUR DOCUMENT ARSENAL INCLUDES...

- Assignments of Benefits
- Consents for Treatment
- Faxed Clinicals/Requests for Auth
- Fax Confirmation Pages
- Insurance ID Cards
- Nurse Auditor Notes
- Patient Account (PA) Notes
- Physician Referrals / Orders
- Reference #s from Calls
- Surgical Reports
- Triage Records
- Utilization Management (UM) Notes
- Verifications of Benefits

THE GIBSON FIRM

Healthcare Law



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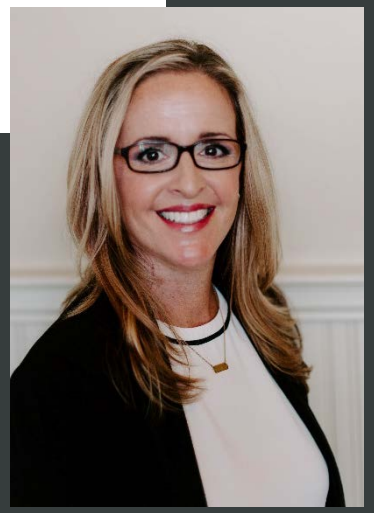

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