



# The Invisible Denial:

## A Closer Look at Commercial Denials and Appeals Strategies

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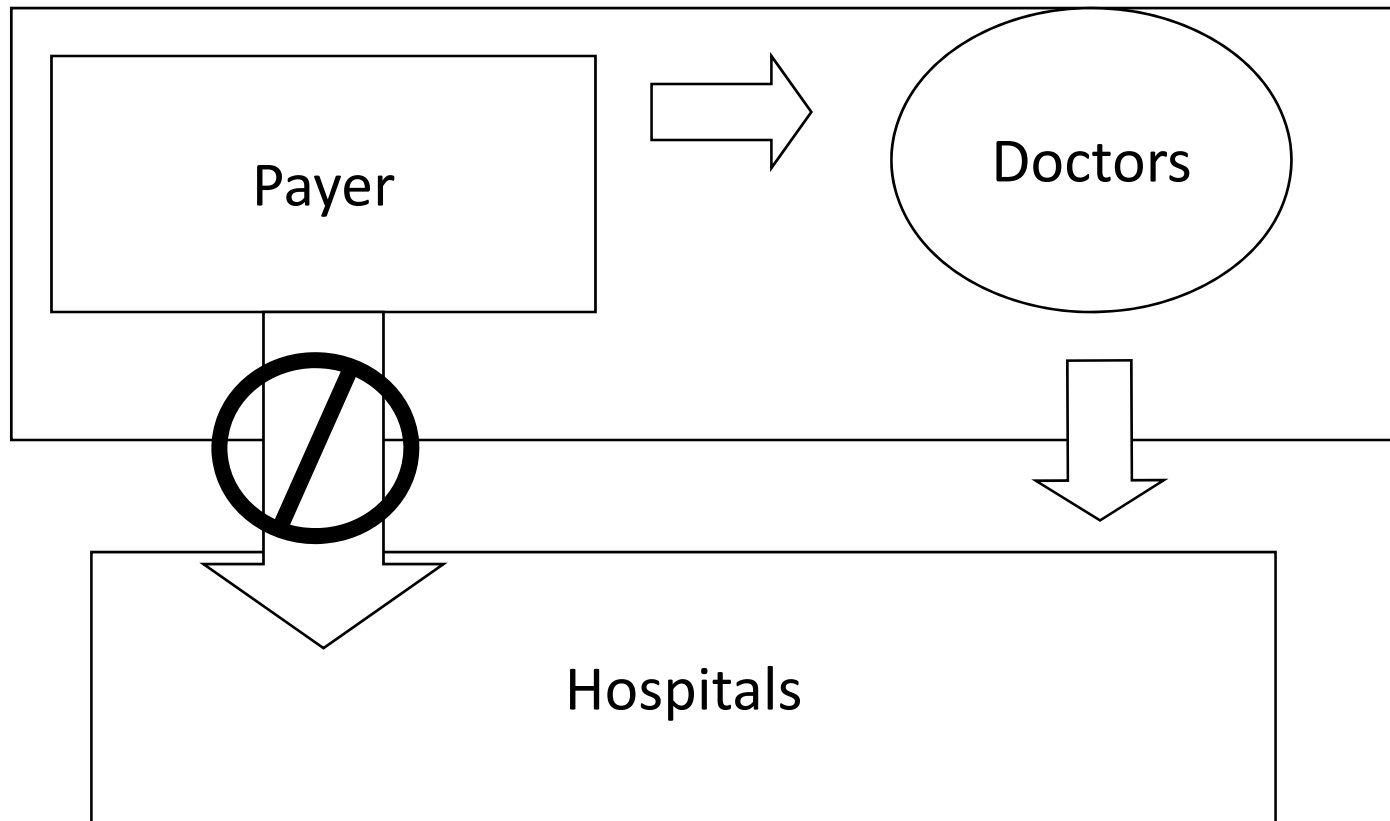
# AGENDA

- Overview of commercial denials process
- Problem areas and pain points
- Best practices and approaches to minimizing denials
- Evaluation metrics

# Managed Care vs. Medicare FFS

- Significant differences between payers can be problematic:
  - **Timing of review:** now vs. later
  - **Definitions:** contractual vs. regulatory
  - **Flexibility:** some vs. none (little)
  - **Retro auditing:** little vs. aggressive
  - **Concurrent appeal:** present vs. absent

# Hospitals Should Be Paid



# The Balance of Power:

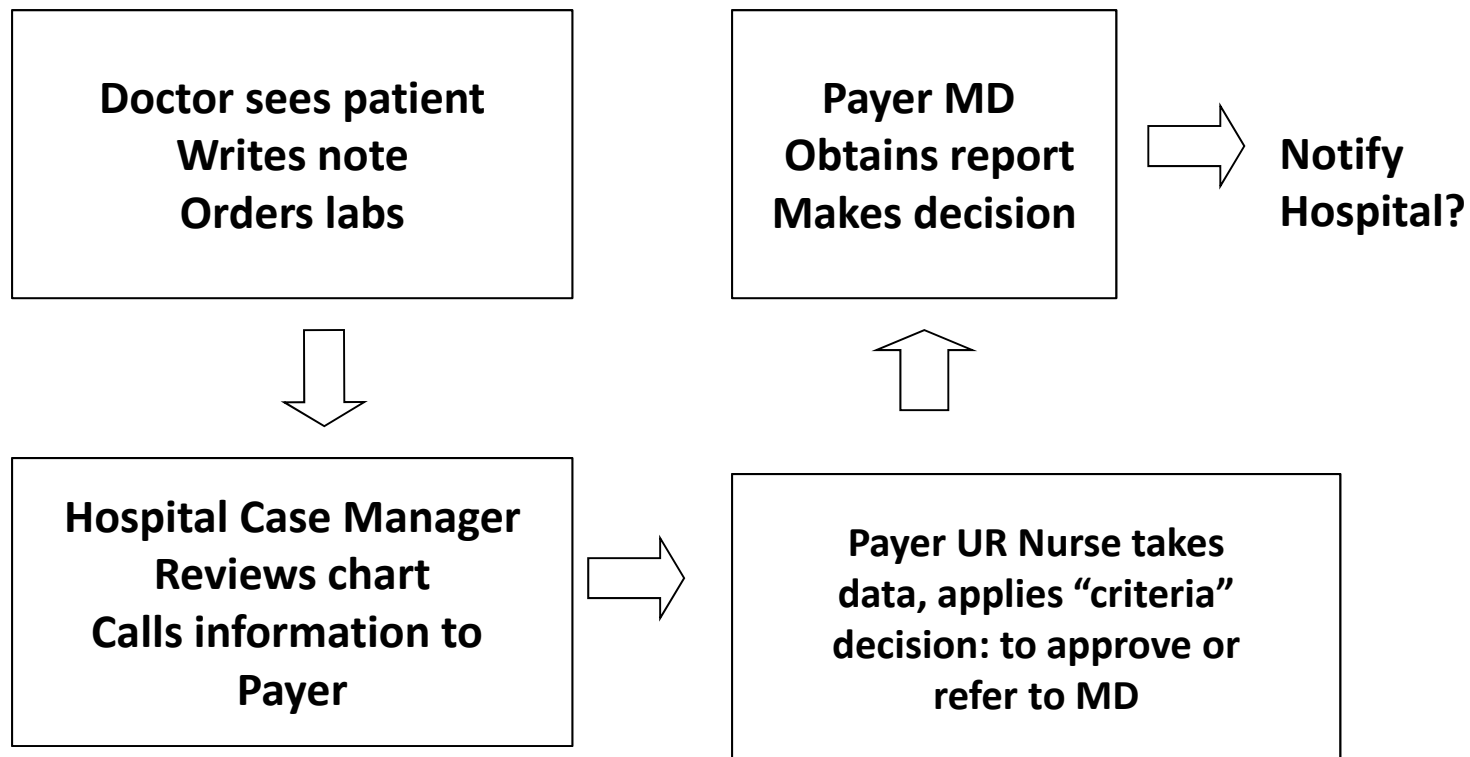
## Why Utilization Review (UR) is a Great Tool

- Managed care has a cadre of full-time physicians in charge of issuing denials
- Hospitals have little infrastructure to combat managed care UR decisions
- Misaligned incentives between physicians and hospitals
- Physicians drive a large segment of the cost and revenue for a hospital; these dollars need to be proactively managed

# Managing Commercial Denials

- Know the rules
- Have a strategy
- Understand the different positions and roles
- Recognize the implications of “winning” and “losing”

# How Do Most Concurrent Denials Occur?



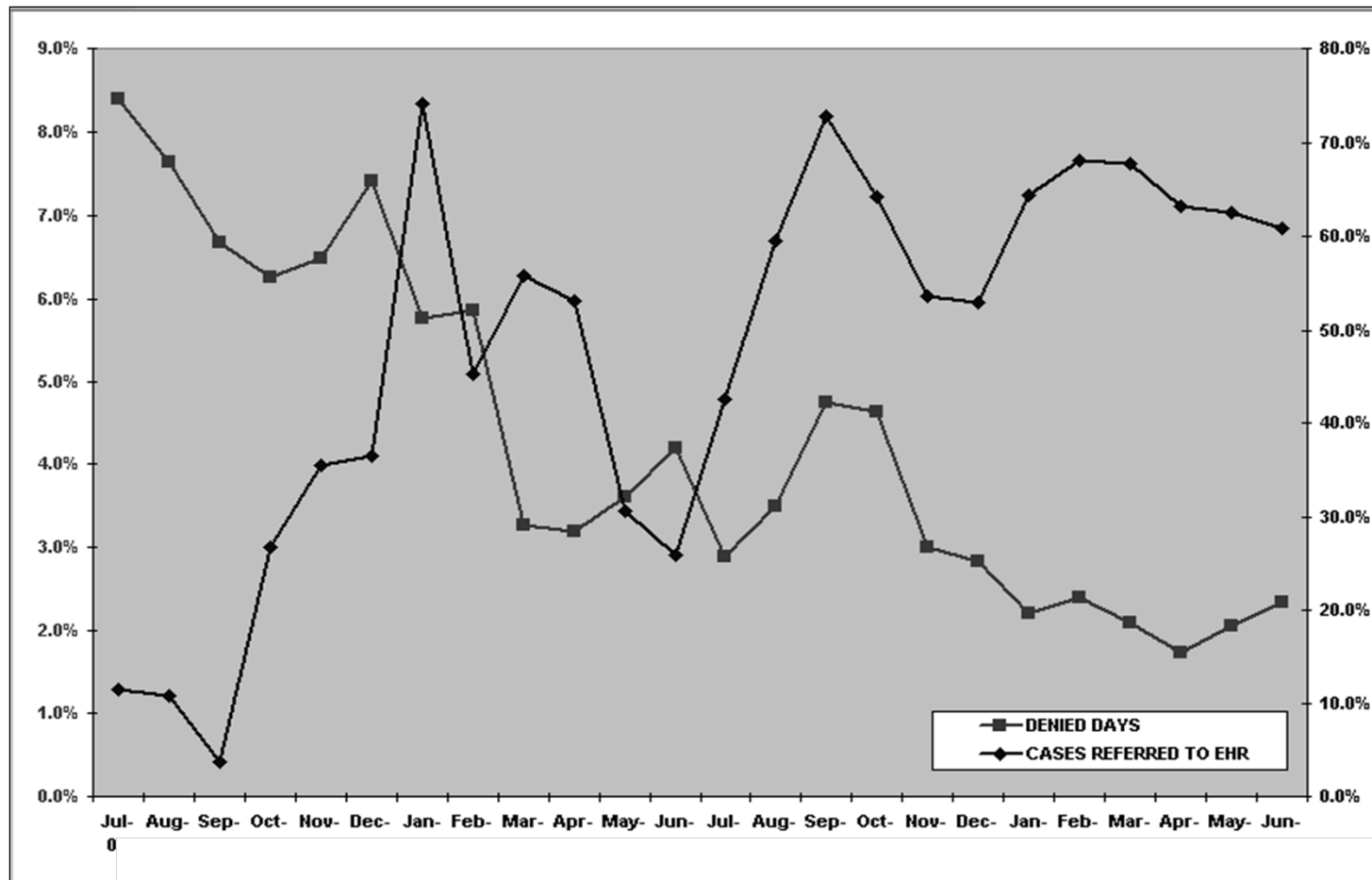
## When the Denial is Inappropriate, Appeal Early and Often

- The organization must draw a line in the sand
- Make the payer work for its money
- Empower case management
- Best practice - is appealing up to 85% of denials
- Get paid for the services provided

*'The more you appeal, the more you will overturn'*



# The “Inverse Correlation”





# Finding “Invisible” Denials



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# Self Denials: Background

- By aggressively denying cases over time, commercial payers have trained hospitals to self-deney cases that meet medical necessity criteria:
  - Cases that could have qualified for inpatient but failed first level inpatient screening
  - Observation cases that could have qualified for inpatient

# Self Denials: Background

## Two potential ‘symptoms’ of self denials:

- High observation rate
  - Commercial payers will often give incentives to physicians to status patients as observation – hospitals often don’t see this
  - Hospitals are tired of fighting denials; payers make it challenging
  - Hospitals have primarily focused on Medicare FFS
- High overturn rate
  - *We have a “great relationship” with the payer*
  - Hospitals track payer denials, not self-denials – celebrating denials going down as opposed to focusing on cases not denied, appeal rate on denials and \$\$ won through appeals
  - **Question:** *Would you rather win 9/10 or 50/100?*

# Estimation of Payer Denials by Hospital Internal Screen

Commercial Cases/yr:	5,000
Cases Screened with IQ	5,000
% of Cases Not Meeting	20%
"Internal" Denials	1,000
Cases Going to Payer	4,000
Typical Denial Rate:	5%
Denied Cases/yr:	200
Overturn Rate:	40%
Net Payer Denials:	120
<b>Net Total Denials:</b>	<b>1,120</b>

## Estimation of Payer Denial, Hospital Internal Screen and Physician Advisor Review

Commercial Cases/yr:	5,000
Cases Screened with IQ	5,000
% of Cases Not Meeting	20%
Cases Referred to PA	1,000
PA Defends as IP *	750
Net "internal" denials	250
Cases Going to Payer	4,750
Typical Denial Rate:	7.5% (50% increase)
Denied Cases/yr:	356
Overturn Rate:	35% (5% less)
Net Payer Denials:	231
<b>Net Total Denials:</b>	<b>481</b>
* Ave. input rate is 75%	

# Impact of Commercial Payer Admission Review

Net Total Denials <b>without</b> PA Review:	1120
Net Total Denials <b>with</b> PA Review:	481
Net add'l IP Cases:	639
Add'l IP Dollars/case	\$2,500-\$5,500
<b>Net Financial Benefit</b>	<b>\$1.6M - \$3.5M</b>
Add'l Review Cost*	\$290,000
<b>Return on Investment (x:1)</b>	<b>5.5 - 12</b>
*\$290/Case * 1000 cases	

# Two Approaches to Commercial Cases

1. Cases that fail screening criteria may (or may NOT) be sent to the payer with most being subsequently denied
  - Appeal after the denial is received
  
2. Case is reviewed by UR staff; cases that fail are sent for second level review
  - Physician certification letter sent to payer
  - IF case is denied, then case is appealed
  - Prevents “self-denials”





# Best Practices: Day-to-Day Reviews



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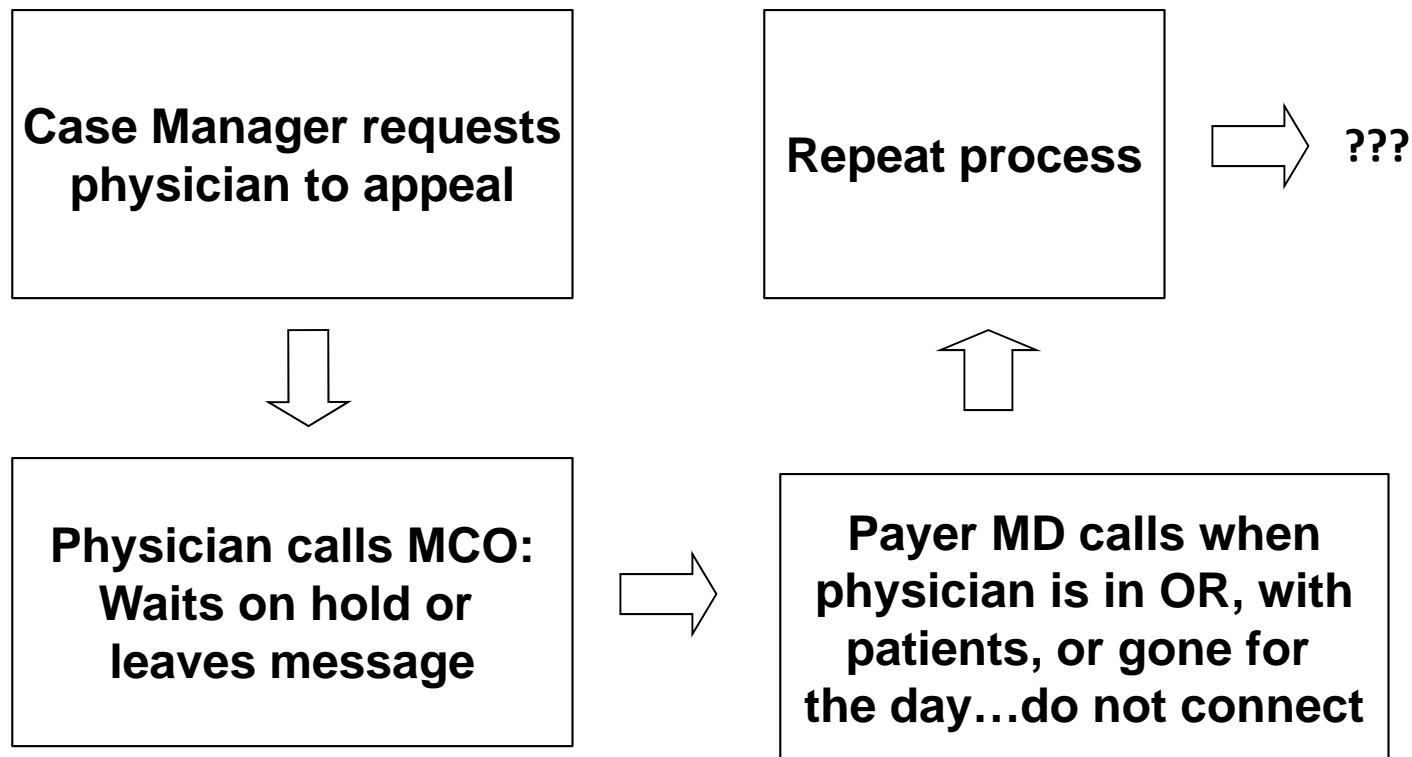


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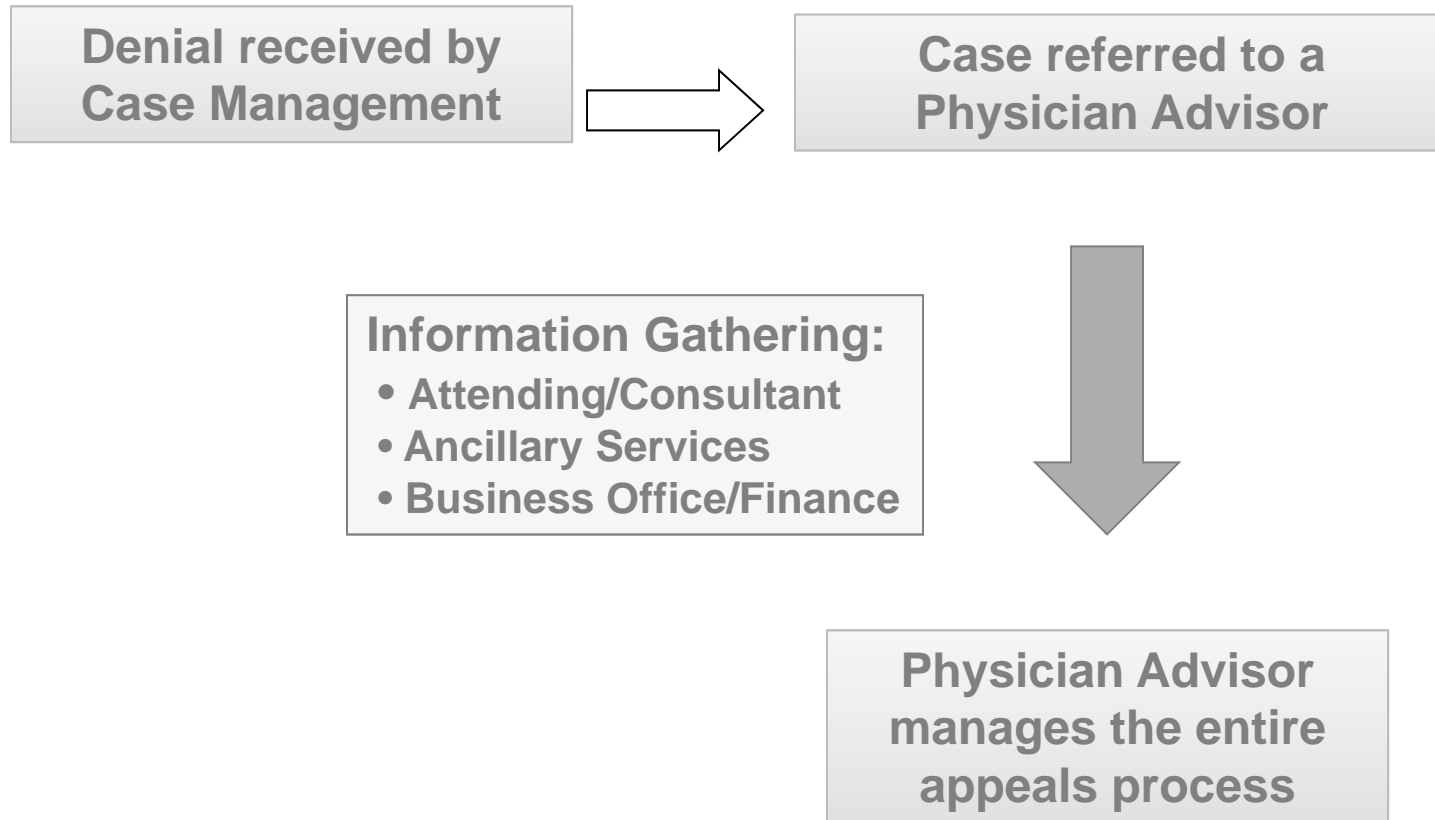
# What is a Denial?

- Any situation in which the payment is less than the amount that was contractually agreed to for the services delivered
  - Complete denial
  - Carved-out day
  - Change to observation (which MCO might say isn't really a denial – just a lower payment) on DRG or per diem contracts
  - Acute downgrade to SNF on per diem contracts
  - ICU downgraded to Acute

# How Does an Appeal Usually Occur?



# Recommended Concurrent Review Process



# Commercial Insurance Denials

- Concurrent program has delivered a 4:1 return on investment and 30-35% overturn rate
- Retrospective program delivers a 3.8:1 ROI (these are the more challenging cases that were not overturned concurrently) and 38% overturn rate
- The approach should be not to have a high “overturn rate” by cherry-picking, but by delivering the highest net return of income through rigorously appealing almost every denial

# Concurrent Denial Best Practices

- Physician Advisor (or team) with training:
  - Managed care
  - Negotiating skills
  - Utilization management
  - Screening guidelines (Milliman, InterQual®, other)
- Specializing in denials management
- Available when the insurance company Medical Director calls
  - Scheduled calls
- Levels the playing field with managed care and actively pursues appropriate reimbursement
  - Criteria
  - Medical necessity
  - Contract terms

# Commercial Levels of Appeal

- Different payers have different processes. It is imperative to know the contract.
- Levels of appeal
  - Concurrent
  - Retrospective
    - May be two or three levels based on the contract
  - Emerging areas of importance:
    - Coding Appeals
    - ALJ Appeals
      - Managed Medicare and Managed Medicaid
    - External appeals

# Retrospective Review

- Each downgrade or denial is reviewed by the physician advisor
- Decision to appeal or not to appeal is determined on a case-by-case basis
- Physician-authored letter composed
- Copy of chart and letter sent to MCO
- Each case tracked through multiple appeal stages
- A rigorous retrospective review program has a ‘trickle up’ effect on the concurrent denials – the payer is more likely to not deny if they know there will be an appeal



# How to Achieve Success:

- Denial appealed while patient still in hospital – or immediately post discharge
  - This is your best chance
- Develop long-standing, professional, respectful relationships with payers
  - NEVER LIE
- Hold payer accountable for their decisions
- Contractual data - know when it makes financial sense to appeal
- You always have a right to concurrent review and reconsideration – even when the hospital is notified of the denial after the patient has been discharged

# Physician Advisor Keys to Success

- Team approach is best
- If the team is limited, consider where most denials originate
- Key physician specialities to include:
  - Anesthesiology
  - Internal Medicine**
  - Family Medicine**
  - Emergency Medicine**
  - Neurology
  - Obstetrics and Gynecology
  - Ophthalmology
  - Otolaryngology
  - Endocrinology
  - Infectious Disease
  - Gastroenterology
  - Pulmonary and Critical Care
  - Pediatrics

# Your Documentation Plan is Key to Success

- Encourage physicians to “Think in Ink”
  - Documentation is the key
  - Just because it is obvious to them, it may not be obvious to someone else, especially the payer
- Summarize pertinent positives in your documentation plan, especially findings specific to a particular specialty
- Facilities are frequently penalized for rapid improvement of patients; risk assessment is key!
- Communicate with the treating physician

# Know the Rules: Denial Reference Sheet

- Contract effective date
- Expiration date
- Termination notice required
- Renewal
  - Auto
  - Increases
- Stop loss
  - Type, rate, cap
- Inpatient
  - DRG, per diem
  - Base rate
  - High volume DRGs
  - (DRG CMI \* Base rate)
- Outpatient
  - High dollar, high volume procedures
    - Chemo
    - Radiology
  - Observation payment
    - Percent of charges
    - fixed per diem

# Client Example - Average Reimbursement Per Case

	0-1 Day Medical IP Stay	Medical Observation Case	0-1 Day Surgical IP Stay	Surgical OP Case
COM	\$ 5,863	\$ 6,153	\$ 15,080	\$ 7,967
MCD	\$ 3,420	\$ 1,504	\$ 7,362	\$ 1,249
MCD-MC	\$ 3,125	\$ 863	\$ 4,496	\$ 855
MCR	\$ 5,141	\$ 1,661	\$ 10,428	\$ 4,239
MCR-MC	\$ 5,157	\$ 1,842	\$ 10,298	\$ 4,451
OTHER	\$ 4,604	\$ 3,747	\$ 10,668	\$ 4,905

# Client Example: Metrics to Track

	<b>0-1 Day Medical IP Stay Rate</b>	<b>Medical Observation Rate</b>	<b>0-1 Day Surgical IP Stay Rate</b>	<b>Surgical Observation Rate</b>
COM	20.3%	58.4%	21.3%	15.1%
MCD	18.2%	23.0%	12.8%	6.9%
MCD-MC	29.6%	47.6%	23.9%	20.4%
MCR	13.8%	12.7%	16.6%	4.0%
MCR-MC	11.1%	22.6%	14.3%	7.0%
OTHER	19.6%	25.3%	19.5%	9.0%

# Evaluation of Denials

- Team approach, follow the AR from beginning to end:
  - PFS/registration
  - MD/physician advisor
  - RN
  - CM
  - Contracting
  - Coding
  - Legal
- Where do most denials originate?
- What diagnosis or procedure is driving denials?
- Set up a scorecard/dashboard of payers and cases

# Evaluation of Denials

- Type of denials:
  - Administrative?
  - Not medical necessity?
  - Non-covered service?
  - Experimental/Investigational?
  - To be provided by another provider (mental health)
  - Patient not eligible (medicaid)
  - No preauthorization or precertification
  - Out-of-time filing
  - Error in billing
- ***Ask: What cases can you best impact?***



## Contract Terms to Keep in Mind

- We will not speak with 3<sup>rd</sup> party, only the attending physician
- Never events and readmission are areas of nonpayment
- “Waive right to jury trial” instead goes to a mediator
- Risk share agreement with Rehab/SNF for self-pay patients. This helps to avoid denials, or delays, in transfer DC

# Summary

- Hold the payers accountable
- Watch for missed opportunities and internal denials
- Consistency is the key to success for Medicare/Medicaid/traditional payers
- This is a battle that can be won!

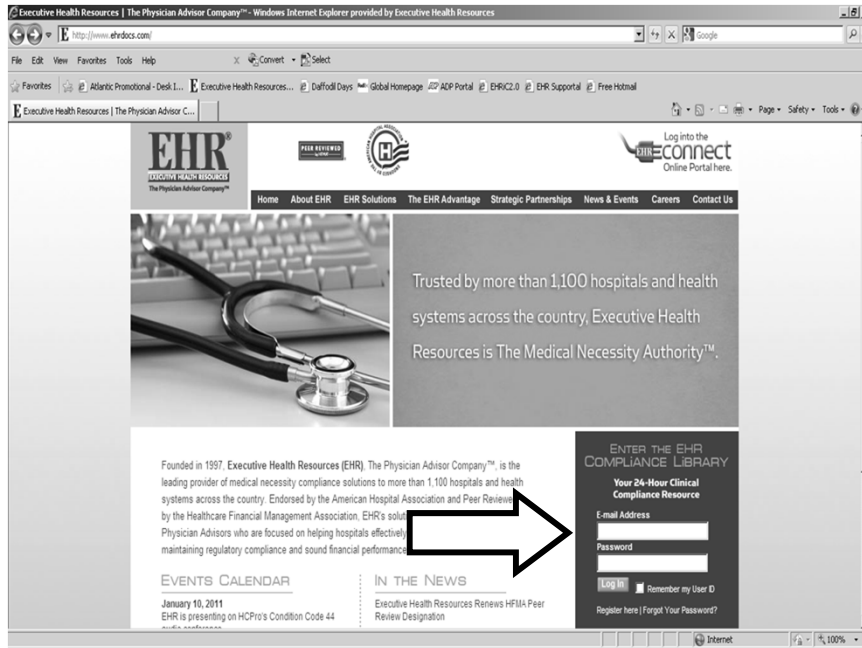
# Questions?

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EHR has been awarded the exclusive endorsement of the American Hospital Association for its leading suite of Clinical Denials Management and Medical Necessity Compliance Solutions Services.

EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

EHR was recognized as one of the “Best Places to Work” in the Philadelphia region by Philadelphia Business Journal for the past five consecutive years. The award recognizes EHR’s achievements in creating a positive work environment that attracts and retains employees through a combination of benefits, working conditions, and company culture.

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