Navigating Medical Necessity Denials Management for All Payers

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Agenda

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

The Payer Landscape: Two Worlds

The Same Processes and Rules Don’t Apply

FFS Medicare / Medicaid

FFS Medicare / Medicaid

Regulatory Landscape
- 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.
Overview of Commercial Denials Process

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.
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.
Overview of Medicare Review Process

Governmental Audit and Fraud Fighting Entities

<table>
<thead>
<tr>
<th>Who</th>
<th>What</th>
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<tbody>
<tr>
<td>OIG</td>
<td>Office of the Inspector General</td>
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<tr>
<td>DOJ</td>
<td>Department of Justice</td>
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<td>MCR RA</td>
<td>Medicare Recovery Auditors</td>
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<td>SMRC</td>
<td>Supplemental Medical Review Contractor</td>
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<td>MAC</td>
<td>Medicare Administrative Contractors</td>
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<td>HEAT</td>
<td>Health Care Fraud Prevention and Enforcement Action Team</td>
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<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
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<td>MIP</td>
<td>Medicaid Integrity Plan</td>
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<td>MIG</td>
<td>Medicaid Integrity Group</td>
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<td>MICs</td>
<td>Medicaid Integrity Contractors</td>
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<td>Medicaid Inspector General</td>
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<td>MCD RAC</td>
<td>Medicaid Recovery Audit Contractors</td>
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<td>PERM</td>
<td>Payment Error Rate Measurement</td>
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<td>BFCC-QIO</td>
<td>Beneficiary and Family Centered Care Quality Improvement Organization</td>
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<td>ZPICs/UPICs</td>
<td>Zone Program Integrity Contractors/Unified Program Integrity Contractors</td>
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Medicare Levels of Appeal

HOW A BILL BECOMES A FLAW

Hospital: Provides medically necessary inpatient services and then bills Medicare.

Medicare administrative contractor: Pays the bills within 30 days, or may decide to withhold payment.

Recovery audit contractor: Audits patient charts to determine medical necessity, finds errors and reclaims payments within three years.

Medicare administrative contractor: Reviews hospital appeals of RAC decisions.

Qualified independent contractor: Uses physician panels to review appeals of RAC decisions.

Administrative law judge: Hears appeals of QIC decisions.

Departmental Appeals Board: Renders final administrative decisions in appeal denial appeals.

U.S. District Court: Federal judges may review RAC decisions, though it doesn't appear to have happened.

Graphic: Modern Healthcare

QIO Reviews
2+ Midnight Inpatient Audit Targets

- 2-MN cases are not automatically IP.
- **Cases with custodial care, care for convenience, or delays in care (CDC) are the highest risk for audit and denial.**
- There are no national standards defining what is custodial, delay, or convenience:
  - How does your facility define custodial care, care for convenience, and delays in care?
  - How are you reviewing for these?
- A case that “only” meets OBS criteria for 2 nights could represent a CDC.
- Commercial payers have targeted these for years.

Custodial, Delay, and Convenience (CDC)

- “Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for custodial care.”
  
  – *Social Security Act, §1862(a)(9)*

- “CMS’ longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment.”
  
  – *CMS Q&A relating to Patient Status Reviews (3/12/14)*

- “Any evidence of systematic gaming, abuse or delays in the provision of care in an attempt to receive the 2-midnight presumption could warrant medical review.”
  
  – *CMS Q&A relating to Patient Status Reviews (3/12/14)*
QIO Review of Short IP Hospital Stays

“We are changing our medical review strategy for short hospital stays and will have QIO [Quality Improvement Organization] contractors conduct reviews of short inpatient stays.” (80 FR 70546)

- The MACs will no longer be responsible for conducting these types of reviews (as they had been under Probe & Educate).
- This change in medical review strategy was effective as of October 1, 2015.

A Shift in Medical Review Strategy

- QIOs, not MACs, responsible for reviews of short inpatient stays
- 2 BFCC-QIOs: Livanta and KePRO
- Current audit activity includes:
  - Patient status reviews for claims with dates of admission within 6 months of October 1, 2015.
  - Biannual patient status reviews
- Provider education
- Referral to Recovery Auditors
Regulatory Update

• Centers for Medicare & Medicaid Services (CMS)
  – CMS expects final PRA approval of the MOON around October 1, 2016. Hospitals and CAHs must fully implement use of the MOON and comply with all NOTICE Act requirements no later than 90 calendar days from the date of PRA approval.

• Medicare Administrative Contractors (MACs)
  – Noridian, operating in JE and JF, is the first MAC to request CMS approval to deny “related” claims pursuant to CMS Transmittal 541
  – Transmittal 541, issued September 2014, provides the MAC, ZPIC, and RA with the discretion to deny “related” claims submitted before or after the claim in question
  – CMS approved “cross recovery” of professional claims related to denied institutional facet injection services, CPT codes 64493 – 64495; 64635 – 64636
  – While this is only the first instance of CMS approval of a MAC request to deny related claims, other MACs may soon follow.

• Quality Improvement Organizations (QIOs)
  – After a 4+ month pause in the performance of short stay reviews, CMS announced the QIO resumption of reviews effective September 12, 2016
  – CMS lifted the temporary suspension after the QIOs completed re-training on the Two-Midnight policy and re-reviewed claims that were previously denied

• Recovery Auditors (RAs)
  – CMS continues to be engaged in an active procurement process for the next round of Medicare FFS RA Program contracts
  – While CMS had estimated the contract and award start dates to be in the Summer of 2016, there have been no further procurement status updates
  – October 1, 2016 is the last day an RA may send claim adjustment files to the MACs.
QIO Referral to Recovery Auditors

Under the QIO short-stay inpatient review process, hospitals that are found to exhibit the following pattern of practices will be referred to the Recovery Auditor:

- Having high denial rates;
- Consistently failing to adhere to the 2-midnight rule;
- Having frequent inpatient hospital admissions for stays that do not span one midnight; or,
- Failing to improve their performance after QIO educational intervention.

– 80 FR 70546
One more thing about BFCC-QIOs

• In the final rule, CMS said, “BFCC-QIOs will educate hospitals about claims denied under the 2-midnight policy and collaborate with these hospitals in their development of a quality improvement framework to improve organizational processes and/or systems.”
• Based on the post-payment review results, your hospital’s processes may come under scrutiny.
• Don’t wait for the QIO to ask! Now is the time to ask:
  – What is our process to make appropriate inpatient admission decisions?
  – Is this process consistent with recommended best practices?
  – Does it comply with all applicable Conditions of Participation?

Commercial Review Process
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

- Financial
- Payers
- Physicians
- Services

Tracking

Physician Advisor manages appeals process

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.
Commercial 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!**

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.
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.

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%)?

Medicare Review Process
Recommended UR Workflow*

* For all admissions after 1/1/16. Medical necessity reviews include an evaluation of physician documentation.

Scope of Compliance Analysis

1st level screening: Is your hospital screening 100% of Medicare admissions and documenting the results?

2nd level review: Is your hospital obtaining a physician review when first level screening fails and documenting the results?

What’s your hospital’s compliance performance in each area?

Claims based on medical necessity recommendations: Are you submitting claims that reflect the appropriate level of care in the appropriate setting?

What types of cases fall into the gaps, if any?
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.

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 was not documented then it was not relevant to the decisions; hence, adds little weight to the appeal!
Keys to Success for Medicare and Commercial

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 – Medicare

- 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:
  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

• Know the rules.
• Best practice approach to avoid denials and succeed in appeals.
• Physician involvement, documentation, and communication is critical!
• Optimize resources.
Questions?

Thank you

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