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Navigating Medical Necessity Denials for All Payers

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Agenda

- Background
- Best Practice Approach
- Denials Management
- Keys to Success
- Take Home/Q&A

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The Payer Landscape: Two Worlds

The Same Processes and Rules Don't Apply

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.

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The Benchmark & Medical Necessity

- Hospital stays (as opposed to inpatient hospital stays) spanning or approaching a 2 midnight stay should not be automatically changed to an inpatient admission.
- While generally Part A payment is available for cases meeting the 2 midnight benchmark, the appropriateness of Part A payment for these cases is governed by the following:

  For Medicare payment purposes, both the decision to keep the patient at the hospital and the expectation of needed duration of the stay must be supported by documentation in the medical record based on factors such as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event during hospitalization. (2016 CY2016 OPPS, 80 Federal Register 70539)

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2-MN Rule Review: Benchmark and Presumption

The 2-Midnight Presumption:

"Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption."

80 FR 70539

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Medical Necessity (MBPM, Ch. 1, Sec. 10)

"**(T)he decision to admit a patient is a complex medical judgment** which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents."

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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 this for years.
  - **EHR is defining these terms for EHR clinical groups to be added to our EHR Logic™.**

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Custodial, Convenience, and Delay

- "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)

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What is a Denial? Non Medicare

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 (Transmittal 585)
- Carved-out days/services

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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

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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

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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)

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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

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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!

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Best Practice Approach

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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

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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

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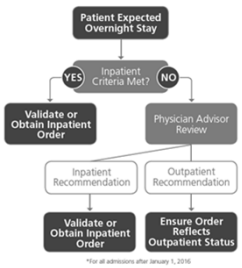
Recommended UR Workflow* (General)



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

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Concurrent Review Process (Medicare)

- **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

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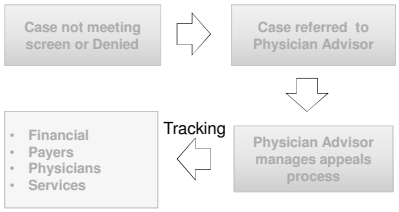
Concurrent Review Process (Commercial)



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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

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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.

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Denials Management

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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

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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

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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)

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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

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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

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"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%)**?

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Keys to Success

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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 payers
- UR/CM need to communicate with physicians

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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

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Keys to Success – Medicare 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 at the time of the admission

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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 payers
- 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

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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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Thank you

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