



**Navigating Medical
Necessity Denials
Management for All
Payers**

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Conflict of Interest Disclosure

John D. Zelem, M.D.
has no real or apparent
conflicts of interest to report.

AGENDA

- Governmental vs. Commercial
- Overview of commercial denials process
- Problem areas and pain points
- Best practices and approach to keeping denials to a minimum
- Case example
- Evaluation metrics

The Governmental Side
2016 OPPS Final Rule (CMS-1633-FC)

2016 OPPS Final Rule

- The 2016 Outpatient Prospective Payment System final rule was published on October 30, 2015 and became effective on January 1, 2016.
- **The rule finalized two key provisions:**
 1. Short inpatient hospital stays (stays when the physician expects the beneficiary to require less than two midnights of hospital care) are payable on a case-by-case basis; and
 2. A shift in medical review strategy to have Quality Improvement Organizations (QIOs), and not the Medicare Administrative Contractors (MACs), conduct these reviews of short inpatient stays.

QIO Review of Short Inpatient Hospital Stays Background

QIO Review of Short Inpatient 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.

QIO Review of Short Inpatient Hospital Stays

- Short stay reviews will be performed by the two Beneficiary and Family Centered Care QIOs (BFCC-QIOs): **Livanta and KePRO**.
- “BFCC-QIOs have begun to conduct post-payment reviews of claims and refer findings to the MACs for payment adjustments.” – 80 FR 70546
- “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” – 80 FR 70546

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

Source: 80 FR 70546

QIO Referral to Recovery Auditors

- In the CY 2016 OPPS final rule, commenters stated the need for transparency in the medical review process and requested additional information regarding the **process for identifying providers deemed to be appropriate for Recovery Auditor referral.**
- **CMS Response:** We will address technical medical review questions posed by the commenters in subregulatory guidance.

Source: 80 FR 70548

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.
- But don’t wait for the QIO to ask! Now is the time to ask yourself:
 - What is our process?
 - What is the process we engage with to make appropriate inpatient admission decisions?
 - Is this process consistent with recommended best practices and does it comply with all applicable Conditions of Participation?

Update about BFCC-QIOs

- **Temporary Pause of QIO Short Stay Reviews- Update 6/6/2016**

- On May 4, 2016, the Centers for Medicare & Medicaid Services (CMS) temporarily paused the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations' (QIOs) performance of initial patient status reviews to determine the appropriateness of Part A payment for short stay inpatient hospital claims. CMS took this action in an effort to promote consistent application of the medical review of patient status for short hospital stays.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

Update about BFCC-QIOs

- **Why is CMS pausing short stay reviews?**

- CMS became aware of inconsistencies in the BFCC-QIOs' application of the two-midnight policy for short hospital stay reviews, and on May 4, 2016, we temporarily paused short stay patient status reviews to give us time to improve standardization in the BFCC-QIOs' review process.
- CMS is requiring the BFCC-QIOs to re-review all claims they denied in their medical review process since October 2015 to make sure medical review decisions and subsequent provider education are consistent with current policy. The current “pause” will allow time for the BFCC-QIOs to conduct these re-reviews.

- **When will the reviews resume?**

- The pause is temporary, and the claim reviews will resume after the BFCC-QIOs have completed retraining on the two-midnight policy, completed the re-review of previously denied claims, and performed any needed provider outreach and education. Many of these improvement steps have begun. CMS believes that BFCC–QIOs reviews will resume within 60-90 days. CMS will advise stakeholders when the pause is lifted.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

Regulatory Update

- **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 Audit Program Updates

The Recovery Audit Program – Latest Updates

June 2, 2016 - Recovery Auditor Contracting Update

- CMS is in an active procurement process for the next round of Medicare Fee-for-Service Recovery Audit Program contracts. In anticipation of this contract transition, CMS must ensure that the current Recovery Auditors complete all outstanding claim reviews by the conclusion of the active recovery auditing phase of their current contracts. Providers should note the important dates below:

https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/recent_updates.html

The Recovery Audit Program – Current Status

- May 16, 2016 - the last day that a Recovery Auditor could send Additional Documentation Request (ADR) letters or semi-automated notification letters
- July 29, 2016 - the last day that a Recovery Auditor may send notification of an improper payment to providers. This includes sending a review results letter or no findings letter, and/or providing a portal notification to each provider.
- August 28, 2016 - Recovery Auditors will complete all discussion periods that are in process by this date. Recovery Auditors continue to be required to hold claims for 30 days, starting with the date of the improper payment notification (via letter or portal) to the provider, to allow for discussion period requests.
- October 1, 2016 - the last day a Recovery Auditor may send claim adjustment files to the MACs

Recovery Audit Program - Latest Updates

- Providers may still receive some correspondence related to the current Recovery Auditors while CMS transitions to the new contracts. However, at no time will providers have to respond to ADRs more frequently than every 45 days, or from two different Recovery Auditors.
- Providers should contact RAC@cms.hhs.gov for questions concerning the transition. CMS will continue to update this Website with more information on the procurement and awards as information becomes available.

https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/recent_updates.html

Breaking News

Hospital Appeals Settlement Updated 9/28/2016

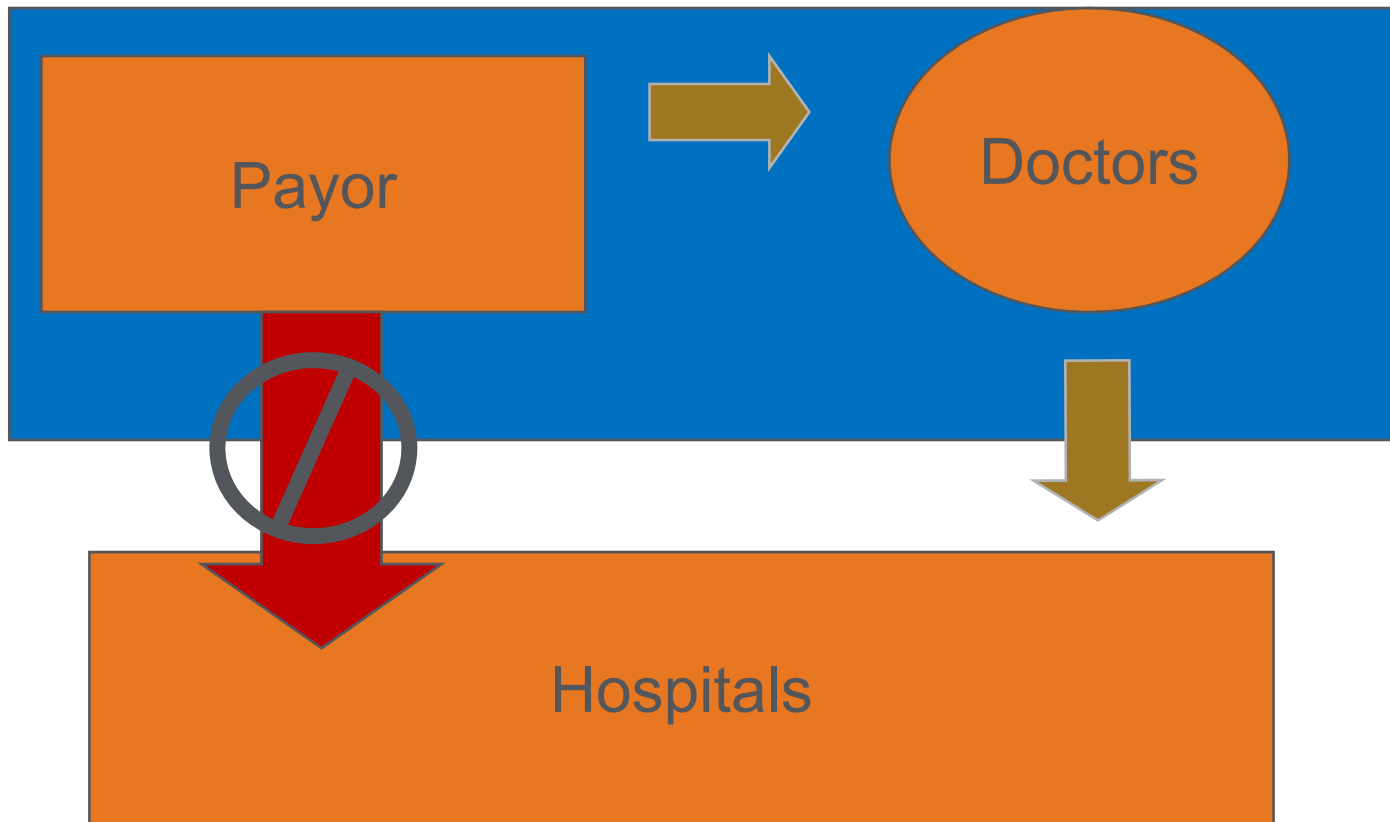
- **What's New:** CMS has decided to once again allow eligible providers to settle their inpatient status claims currently under appeal using the Hospital Appeals Settlement process. Specific details of the settlement will be released in the near future. Please continue to monitor CMS' website for additional information:
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

Commercial Denials

Managed Care vs. Medicare FFS

- Significant differences between payers can be problematic:
 - Timing: now or later
 - Definitions: contractual vs. regulatory
 - Flexibility: some vs. none
 - Auditing: little vs. aggressive
 - Concurrent appeal: present vs. absent
 - Game theory: multi-play vs. single-play

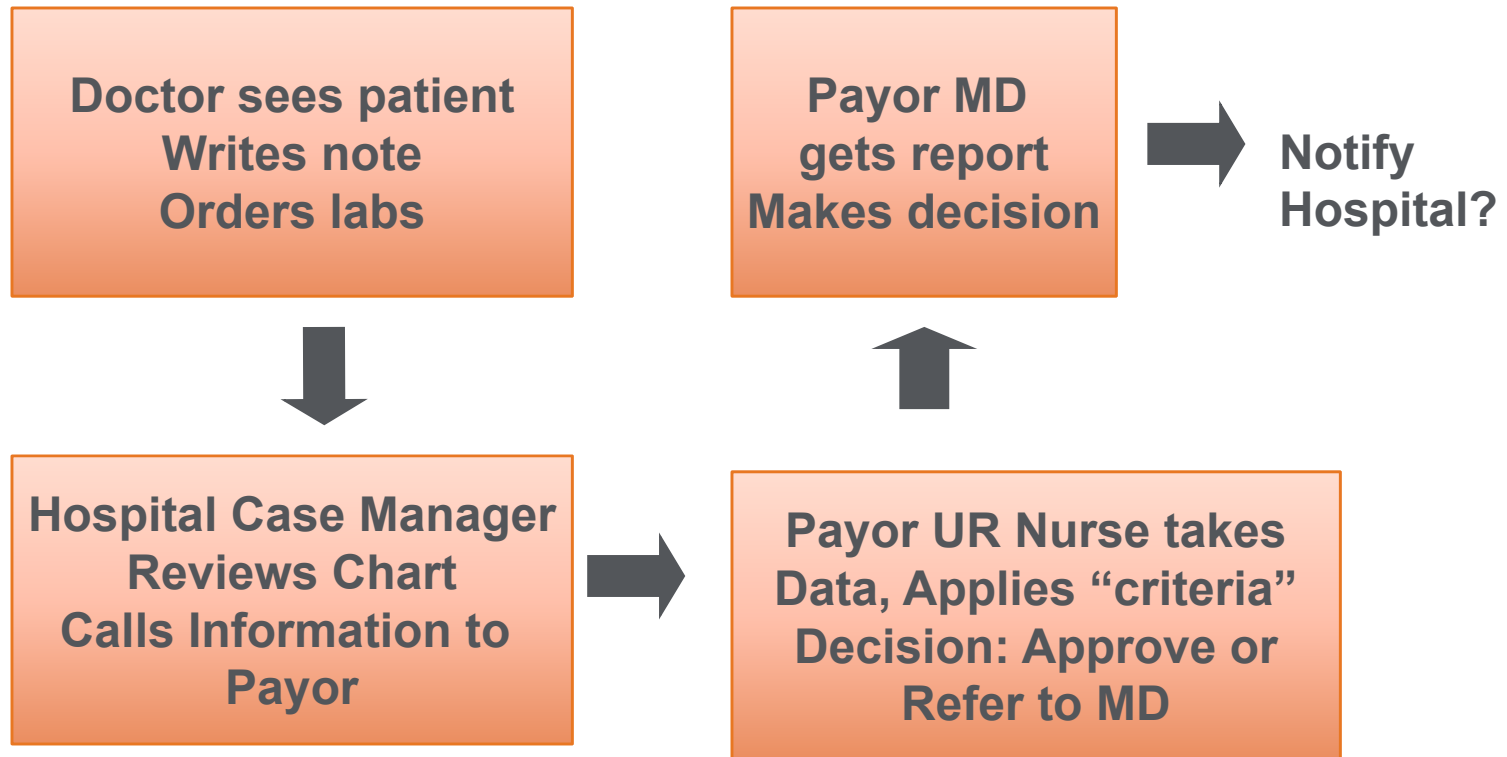
Hospitals Should Be Paid...Period.



The Balance of Power- Why UR is a Great Tool for Payers

- 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 physician and hospital
- Physicians drive a large segment of cost and revenue for hospital, these dollars need to be aggressively managed

How Does a Concurrent Denial Occur?



Managing Commercial Denials

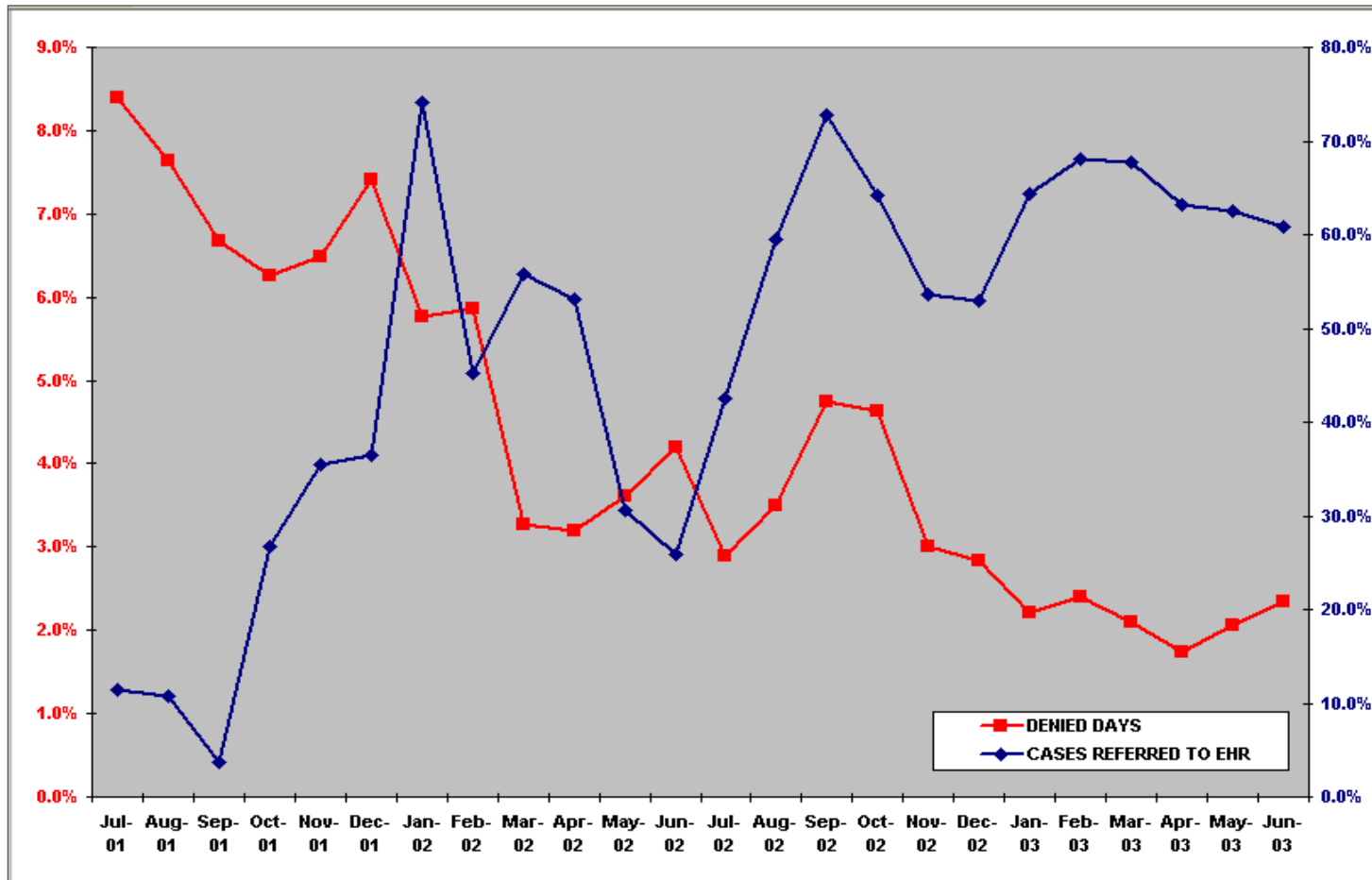
- Know the rules
- Have a strategy
- Understand the different positions and roles
- Recognize the implications of “winning” and “losing”

When The Denial Is Inappropriate, Appeal Early And Often

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

***Truism:
the more you appeal,
the more you will overturn***

The "Inverse Correlation"



Finding “Invisible” Denials

Two Approaches to Commercial Cases

1. Cases that fail screen may (or may NOT) be sent to payor 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 payor
 - IF the case is denied, then case is appealed
 - Prevents “self-denials”

Self-Denials: Background

- By aggressively denying cases over time, commercial payers have trained hospitals to self-deny 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

- A symptom of self-denials is a high observation rate. The primary drivers of this are:
 - Commercial payers will often give incentives to physicians to status patients as observation – hospitals don't see this
 - Hospitals are tired of fighting denials; payers make it difficult/tiresome for hospitals
 - Hospitals have focused primarily on lowering their Medicare FFS observation rate
 - Hospitals track payor denials, not self-denials – celebrating denials going down as opposed to focusing on cases not denied, appeal rate on denials and \$\$ won through appeals

The Best Defense is a Good Offense – Use of a PA

Estimation of Payor 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 Payor	4,000
Typical Denial Rate:	5%
Denied Cases/yr:	200
Overturn Rate:	40%
Net Payor Denials:	120
Net Total Denials:	1,120

Hospital Internal Screen Plus 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 *	850
Net "internal" denials	150
Cases Going to Payor	4,850
Typical Denial Rate:	5%
Denied Cases/yr:	243
Overturn Rate:	40%
Net Payor Denials:	146
Net Total Denials:	296
* Average input rate is 85%	

Impact of Commercial Payor Admission Review

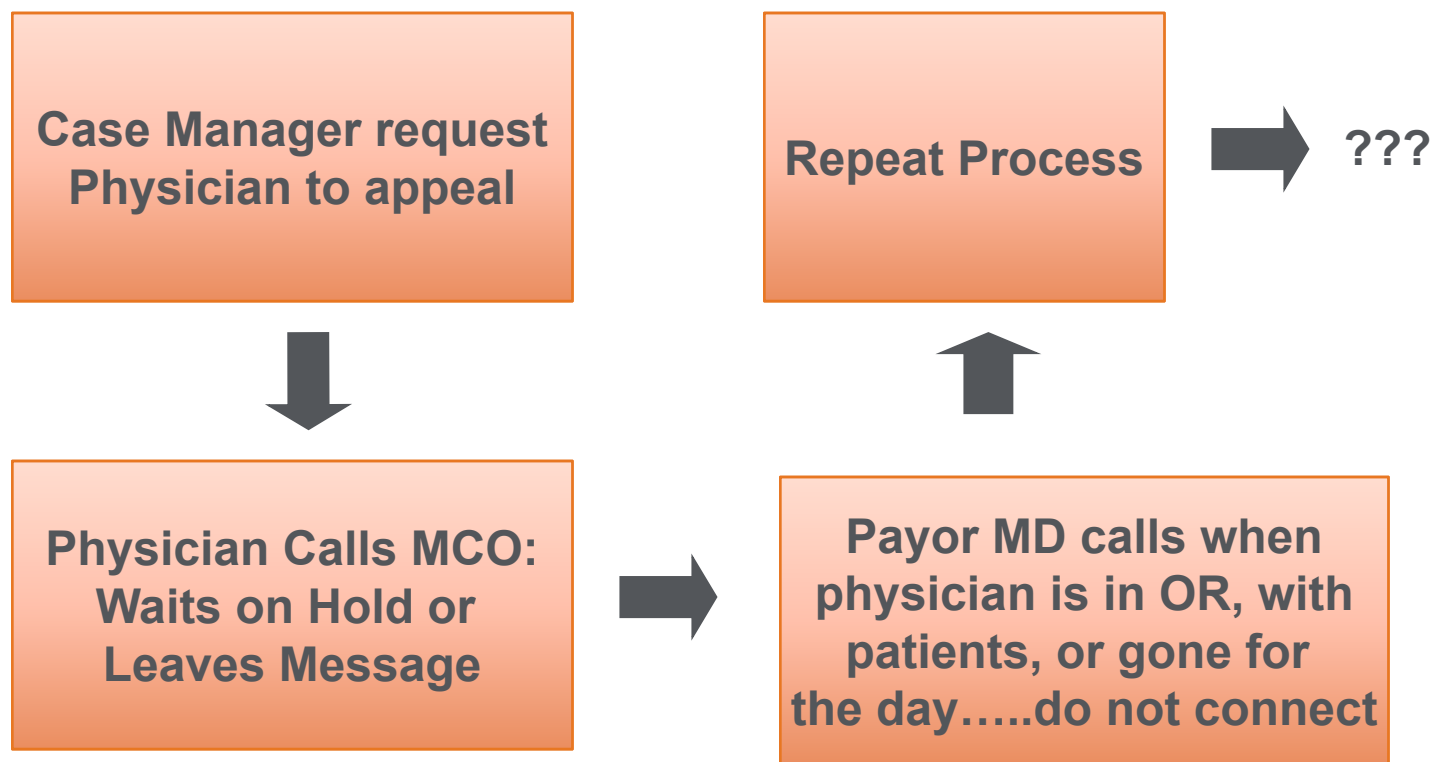
Net Total Denials without PA Review:	1120/5000
Net Total Denials with PA Review:	296 /1000
Net add'l IP Cases:	824
Add'l IP Dollars/case	\$2,500-\$5,500
Net Financial Benefit	\$2.060M- \$4.532M
Add'l Review Cost*	\$290,000
Return on Investment (x:1)	7.1-15.6
*\$290/Case	

Best Practices

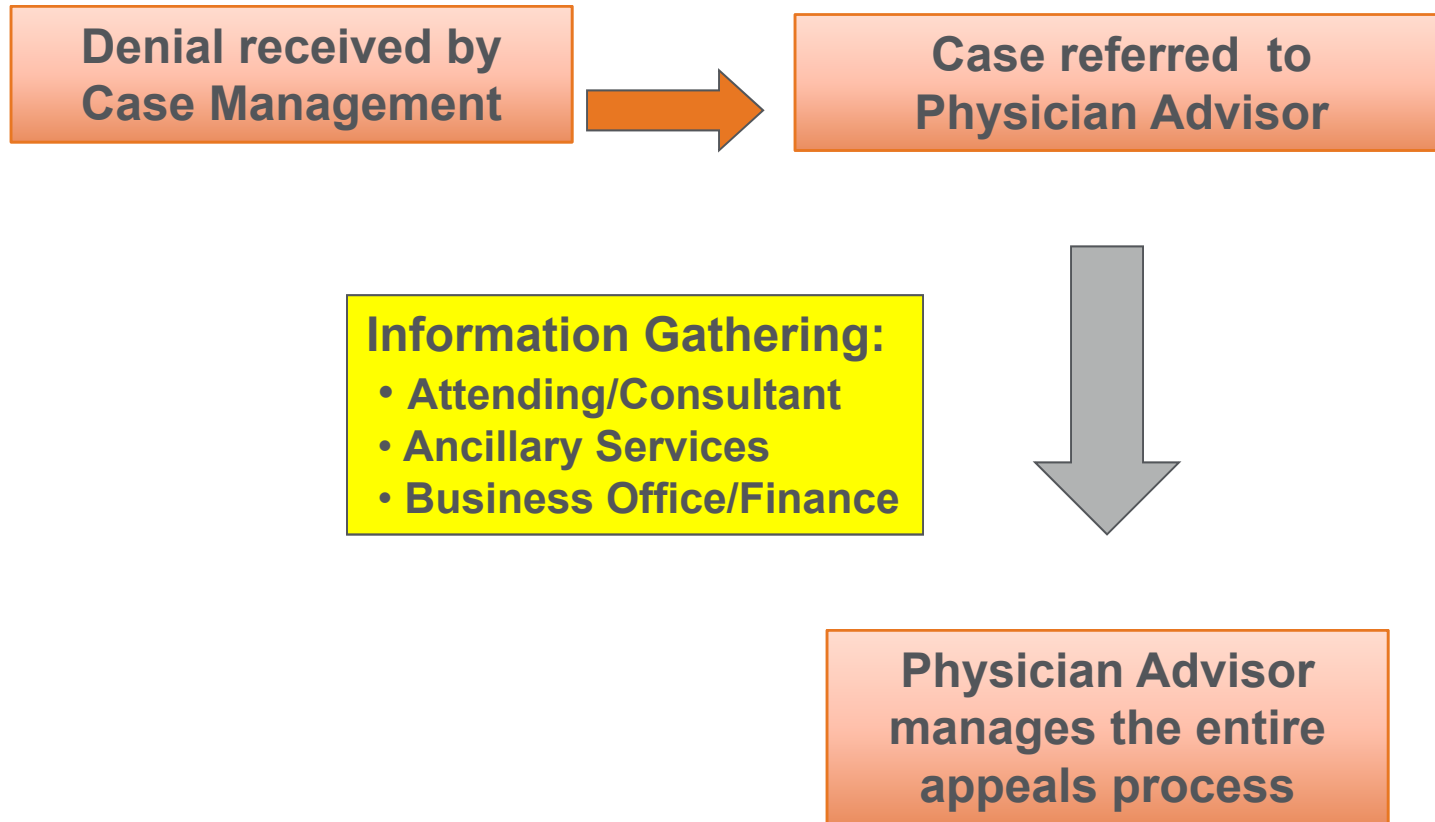
What is a Denial?

- Any situation in which payment is less than that which 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



Pure Commercial Insurance Denials

- Concurrent program has delivered a 4:1 return on investment and 40% overturn rate
- Retrospective program delivers a 3.8:1 ROI (and these are the harder 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 delivering the highest net return of income by aggressively 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 aggressively pursues appropriate reimbursement
 - Criteria
 - Medical necessity
 - Contract terms

Keys to Success: Who

- 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

Getting Started

- Data Review
 - Expected volume
- Evaluate staffing requirements
- Implementation
 - Get data from contracts (set up payor reference sheets)
 - Review your data to find denials case management is not aware of
 - Self-denials
 - Educate Case Managers on process and on the mindset
 - Educate staff physicians
- Appeal early and appeal often
- Follow through with a retrospective appeal if peer-to-peer not successful

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
 - Etc.
 - Observation payment
 - Percent of charges, fixed per diem, etc

Evaluation of Denials

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

Evaluation of Denials

- Type of denial:
 - Administrative?
 - Not medical necessity?
 - Non-covered service?
 - Experimental/Investigational?
 - To be provided by another provider (mental health)
 - Patient not eligible (medicaid)
 - No pre-authorization or pre certification
 - Out-of-time filing
 - Error in billing

Summary

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



Thank you

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