THE INVISIBLE DENIAL: A Closer Look at Commercial Denials and Appeals Strategies

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Sr. Medical Director ACE

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Agenda

• Overview of commercial denials process
• Problem areas and pain points
• Best practices and approaches to minimizing denials
• Evaluation methods
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
― Retrospective auditing: little vs. aggressive
― Concurrent appeal: present vs. absent
― Game theory: multi-play vs. single-play
IPPS and Commercial Payers

- 2014 IPPS Does **NOT** apply to commercial plans (including Managed Medicare and Managed Medicaid)
- CMS does not require payers to utilize the two midnight presumption (CMS Hospital/Quality Initiative Open Door Forum, 10/29/13)
- Some hospitals are unnecessarily applying the two midnight presumption to commercial plans and experiencing significant reductions in inpatient short stays and reimbursement (without an uptick in > two midnight conversions to inpatient)
- Very few payers have attempted to adopt this criteria with their providers, to date
2014 IPPS Impact Analysis

• Analysis of 2014 IPPS Changes on STAC hospitals:
  – Used 2010 IPPS and 2011 OPPS files
  – Short-Term Acute care only (excluded SNF, LTAC, Psych, Rehab, etc.)

• Range of potential % change in Medicare FFS reimbursement was -2% to -7%
Managing Commercial Denials

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

Diagram showing the flow from Payer to Doctors, then to Hospitals.
Managed care companies have a cadre of full-time physicians with the directive to deny your claims.

Hospitals often have difficulty building the infrastructure and corralling the necessary resources to combat these managed care denials.

Misaligned incentives exist between treating physicians and hospitals.

Physicians drive a large segment of the cost and revenue for a hospital; these dollars need to be proactively managed.
How Does a Concurrent Denial Occur?

Doctor sees patient; writes note and orders labs

Hospital Case Manager reviews chart; calls information in to the payer

Payer MD obtains report; makes decision

Payer UR nurse takes data; applies “criteria:”
Decision: approve or refer to MD

Notify hospital?
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: appealing up to 85% of denials
- Get paid for services provided

‘The more you appeal, the more you will overturn’
The “Inverse Correlation”
Finding Invisible Denials

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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 claim denial
  — Carved-out day(s)
  — Change to observation on DRG or per diem contracts (payer might say this is not really a denial; just a reduced payment)
  — Acute downgrade to SNF on per diem contracts
  — ICU downgraded to Acute
Self-Denials: Background

• By aggressively denying cases over time, commercial payers have trained hospitals to self-deny cases that meet their medical necessity criteria:

  — Cases that could have qualified for inpatient but failed first-level inpatient screening

  — Ever-tightening commercial screening tools

  — “Observation” cases that could have qualified for inpatient status
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 have primarily focused on Medicare FFS
  – Hospitals are tired of fighting denials; payers make it challenging

• Low Denial Rate/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 revenue recaptured through appeals
  – **Question:** Would you rather win 9 out or 10 cases or 50 out of 100 cases?
Potential Adverse Effects

Results in Adverse Effects on:

- Observation rates
- Denial rates
- Payer medical management intervention (telephonic, onsite)
- Mindset of hospital case management staff
### Estimation of Payer Denials by Hospital Internal Screen

<table>
<thead>
<tr>
<th>Description</th>
<th>%</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial/Mgd Care Cases Per Year:</td>
<td></td>
<td>5,000</td>
</tr>
<tr>
<td>Internal Downgrades/Denials via Commercial Screening Criteria:</td>
<td>20%</td>
<td>1,000</td>
</tr>
<tr>
<td>Cases Billed to Payer as IP:</td>
<td>80%</td>
<td>4,000</td>
</tr>
<tr>
<td>Denial Rate (cases/yr):</td>
<td>5%</td>
<td>200</td>
</tr>
<tr>
<td>Overturn Rate:</td>
<td>40%</td>
<td>80</td>
</tr>
<tr>
<td>Net Payer Denials:</td>
<td>60%</td>
<td>120</td>
</tr>
<tr>
<td>Total Denials = Self Denials (b) + Net Payer Denials (f):</td>
<td></td>
<td>1,120</td>
</tr>
</tbody>
</table>
# Estimation of Payer Denials by Hospital Internal Screen

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<tr>
<th>Description</th>
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<tr>
<td>Commercial/Managed Care Cases Per Year:</td>
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<td>5,000</td>
</tr>
<tr>
<td>Internal Downgrades/Denials via Commercial Screening Criteria/</td>
<td>20%</td>
<td>1,000</td>
</tr>
<tr>
<td>Referred to Physician Advisor:</td>
<td></td>
<td></td>
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<tr>
<td>PA Supports for IP status*</td>
<td></td>
<td>750</td>
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<tr>
<td>Net IP to OP/OBS Downgrades</td>
<td></td>
<td>250</td>
</tr>
<tr>
<td>Cases Billed to Payer as IP:</td>
<td>80%</td>
<td>4,750</td>
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<tr>
<td>Denial Rate (50% increase):</td>
<td>7.5%</td>
<td>356</td>
</tr>
<tr>
<td>Overturn Rate (12.5% less)</td>
<td>35%</td>
<td>124</td>
</tr>
<tr>
<td>Net Payer Denials:</td>
<td>65%</td>
<td>231</td>
</tr>
<tr>
<td><strong>Total Denials = Self Denials + Net Payer Denials:</strong></td>
<td></td>
<td>481</td>
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### Impact of Commercial Payer Admission Review

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tr>
<td>Net Total Denials without PA Review:</td>
<td>1,120</td>
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<tr>
<td>Net Total Denials with PA Review:</td>
<td>481</td>
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<tr>
<td>Net additional IP Cases:</td>
<td>639</td>
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<tr>
<td>Additional IP Dollars/Case:</td>
<td>$2,500</td>
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<tr>
<td>Net Financial Benefit:</td>
<td>$1,600,000</td>
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<td>Additional Review Cost*</td>
<td>$290,000</td>
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<tr>
<td>Return on Investment</td>
<td>5.5: 1</td>
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Two Approaches to Commercial Cases

• 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

• Case is reviewed by UR staff; cases that fail are sent for second-level physician advisor review
  – Physician certification letter sent to payer
  – If the case is denied, then the case is appealed
  – Prevents self denials
Self Assessment

Key indicators that your hospital may have a commercial opportunity to increase reimbursement

- High commercial observation rate (or you don’t know your commercial observation rate)
- Not managing the commercial business to the same level as your Medicare FFS business
- “Great relationship” with your payers
- “We win 90% of our appeals”
- “We have great success with our peer-to-peer conversations”
- “Our denial rate is <1%”
Quantifying the Commercial Opportunity

- >700 hospital commercial analyses since January 1, 2013
- Significant opportunities exist in:
  - Managed Medicare, Traditional Commercial, Managed Medicaid
  - All contract structures – case rate, % of charges, per diem
  - Hospitals of all shapes and sizes
- Hospitals more often self deny cases under Managed Medicare plans
- Managed Medicaid plans are most aggressive with denials, downgrades and “pends”
- “Flat” or “upside down” reimbursed payer contracts may limit opportunity, but need to be monitored closely as future contract changes are made
- Regional payer contracting trends impact opportunity
Case Study: Single Hospital in Southeast

- Started EHR Commercial/Managed Care case referrals in June 2013
- Annualized value of EHR commercial review services estimated at $1.2M (6:1 ROI) for two payers

<table>
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<tr>
<th>AccURate™ Program Report</th>
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<tr>
<td>436</td>
<td>Cases did not meet InterQual®'s IP criteria and were referred to EHR for Admission Review</td>
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<tr>
<td>307</td>
<td>Cases supported by EHR as Inpatient</td>
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<tr>
<td>70%</td>
<td>Of all referred cases supported by EHR as Inpatient</td>
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<tr>
<td>47</td>
<td>Concurrent Denials (i.e., Peer to Peer) referred during period</td>
</tr>
<tr>
<td>12</td>
<td>New Commercial Appeals started during period</td>
</tr>
<tr>
<td>2.8%</td>
<td>Denial rate of cases reviewed by EHR</td>
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<tr>
<td>$614,000</td>
<td>Value of EHR recommended IP (assumption: $2000 differential b/w 2 day IP and OBS)</td>
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</table>
Case Study: Large Academic Medical Center with Children's Hospital

- Started EHR Commercial/Managed Care case referrals in March 2013
- Client reported a 17% reduction in medical observation rate in first four (4) months
- Annualized value of EHR commercial review services estimated at $9.7M (5:1 ROI)
- Without EHR Physician Advisor recommendation, an estimated 4,851 inpatient cases would be self-denied and billed as observation (1,617) in the first four (4) months

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>2,867</td>
<td>Cases did not meet InterQual's IP criteria and were referred to EHR for Admission Review</td>
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<tr>
<td>1,617</td>
<td>Cases supported by EHR as Inpatient</td>
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<tr>
<td>56%</td>
<td>Of all referred cases supported by EHR as Inpatient</td>
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<tr>
<td>123</td>
<td>Concurrent Denials (i.e., Peer to Peer) referred during period</td>
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<tr>
<td>109</td>
<td>New Commercial Appeals started during period</td>
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<tr>
<td>3.9%</td>
<td>Denial rate of cases reviewed by EHR</td>
</tr>
<tr>
<td>$ 3,234,000</td>
<td>Value of EHR recommended IP (assumption: $2000 differential b/w 2 day IP and OBS)</td>
</tr>
</tbody>
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AccURate™ Process

**Step 1**

Hospital

- 1st Level Admission Screening Review on all Selected Payer Cases
- Cases Not Meeting IP Status Referred to EHR

**Step 2**

EHR

- 2nd Level Physician Advisor Review
- Recommendation on Status
- Process Validation and Data Reporting

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**AccURate™ Opportunity**

- Eliminate self denials/downgrades
- Reduce observation rates; increase reimbursement
- Target high opportunity payers where IP and OBS differential is substantial and OBS rates are high
- Validate accuracy and progress through quarterly analytics
AccURate Program

Admission Reviews
- Selected Payers
- Criteria Application
- Medical Case Referrals
- Surgical Case Referrals

Peer to Peer
- Concurrent Payer Medical Director Discussion by EHR Physician Advisor
- Preparing Attending Physicians for Peer to Peers

Retrospective Appeals
- Appeal Management
- External Appeal Support (IRO, ALJ, etc.)
Key Takeaways

• Best approach is to prevent the denial
• After the denial is received, peer-to-peer conversations are your best shot at getting a case overturned
• Focus on the cases and payers where you can make a difference
• Watch for and investigate ‘invisible’ or self-denials
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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