Appeals-Tools For Success

FACING INTENSE PAYER CHALLENGES WITH EFFECTIVE INTERNAL PROCESSES

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The Challenges We Face

- High rates of admission denials
- Payer misapplication of readmission review
- Overwhelming/unmanageable volumes of mail
- The ever-growing list of third party auditors
- Simply egregious & unmerited findings
- Canned & meaningless payer responses
- Purposed delays in response or no response at all
- Cryptic messages/letters
- Unnecessary delays

The Challenges We Face

Admission/Readmission

- Payers denying admission too quickly/purposely avoiding obtaining additional clinical information or not returning a call for a Peer to Peer
- Blatant misapplication of readmission review guidelines

Clinical Audits

- Soaring numbers of requests for medical records/ADR's
- Post-Pay Audits
- Pre-pay audits
- Avoidance of coding standards
- Obscure articles to substantiate denials/"findings"

The Responses We Receive

- Multiple pieces of mail for each patient
- Redundant language, but different letter dates-what is the true response date?
- “Just follow our handy tools/guides/this web link”….”have you used our shiny new web portal?”

The Strategies They Use

- PRE-PAY AUDITS-The challenges
  - The claim goes out and the audits begin
  - As soon as the payer receives the claim, they generate an ADR requesting your entire medical record
  - You have no payment until they get the record
  - They review the record and generate a “findings”

The Strategies They Use

- PRE-PAY AUDITS-The challenges
  - Aggressive and egregious audit practices have now gone to a new level

    The query does not indicate it is a permanent part of the medical record.
    The query response is not documented in the medical record itself.

  - Above rationale was used by the payer to avoid a query which substantiated our DRG
  - The query is a part of our the permanent medical record. We called them out as egregious and provided a copy of our HIM policy

The Strategies They Use

- PRE-PAY AUDITS-The challenges
  - Even if you win and receive a favorable decision, you have a NEW challenges
    - The account with a zero balance in you’re A/R.
    - The payer will contractualize the DRG reduction on the remit, assess a patient portion, and you have a zero balance posted electronically.
    - Now you’ve won an appeal—but you have the NEW challenge of ensuring their honesty of paying you back.

The Strategies They Use

- POST-PAY AUDITS-The challenges
  - Voluminous of additional documentation requests (ADR's)
  - Technical denials for records not received, when in fact, they have the records
  - Disregard for clinical coding guidelines
  - In the denial rationale: Article references without complete citations, even though the letter states "complete reference below"

The Strategies They Use

- POST-PAY AUDITS-The challenges
  - Making unsubstantiated claims in the findings rationale

Review of the medical record and the paid claim data reveals that an error in billing for procedure 43246 has been reported. CPT procedure 43246 was reported on two line items; both procedures were paid for on the same date of service, which is inappropriate. Only one billed procedure may be reported and reimbursed from this claim. Therefore, one line item of CPT procedure 43246 has been removed from the claim. The revised reimbursement amount will be reduced to reflect this billing error change.

  - We had to submit a letter of appeal to ask them to read the UB they received. We also asked them to review the remittance, which they had issued, neither of which showed what is described above.
  - While this claim was not a substantial amount of money, if we had not acted on it, they would have recouped on this egregious findings

The Strategies We Use

- Be a student of the payer
  - What are their methods, ways, characteristics?
    - Mail analysis-constantly changing formats
    - Appeals-related web portal tools, emerging changes
    - Emerging appeals-related "concierge" services via email
    - Can you file appeals online?
    - Are there available appeal responses in the payer's portal?

The Strategies We Use

- What are the expectations in the appeals process?
  - You’ve met THEIR filing limit expectations, now what?
  - Tracking system for pending appeals
  - Does your contract give a reverse expectation to the payer to answer to your submitted information?
  - Make the payer decrypt the cryptic coding that they are issuing in correspondence
  - If they are denying and citing an “NCD”, then what NCD are they citing?

The Conversations We Have

- Bring the egregious examples to the on site payer meetings
- Show the payer what a week's worth of their mail looks like in real life
- If you can't have an on site meeting with the payer, then provide a page count of the weekly mail average in your phone conferences
- Are your percentages of audits incorrectly flagged in the payer's system

Our Voices Are Being Heard

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
June 2018	Centers for Medicare & Medicaid Services	Inappropriate Denial of Services and Payment in Medicare Advantage	Office of Evaluation and Inspections	OEI-09-18-00260	2020

Our Voices Are Being Heard

- Stay VIGILANT
- Stay involved in your state and with your state's hospital association
- Collaborate with the other hospitals around your state
- Stay involved in the RAC Monitor community and other provider-related communities
- SHARE the information, keep the momentum