Architecture of the Internal Appeals Process

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7th Annual Physician Advisor and UR Boot Camp

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About Infirmary Health

Mobile Infirmary

Thomas Hospital

North Baldwin Infirmary

J L Bedsole Rotary Rehabilitation Hospital

Infirmary LTAC

Infirmary Cancer Care

Malbis FED

IMC Diagnostic and Medical Clinics

- Infirmary Health grew from a community-based campaign in 1896, and the original Mobile Infirmary opened in 1910
- The 669-bed Mobile Infirmary remains the flagship facility of Infirmary Health
- Infirmary Health is the largest non-governmental health care system in the state of Alabama.
- Serves an 11-county area of south Alabama and north Escambia County, Florida, with more than 700 active physicians on the medical staff and more than 5,700 employees.
- Composed of five acute care hospitals, three post-acute facilities, a physician clinic network with more than 60 locations, six diagnostic imaging centers, two full service breast centers and a freestanding emergency department, along with other affiliated entities.

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Architecture of the Denials Process

Denial Types

- Concurrent Denials (Inpatient vs. OBS status denials received in the concurrent process/patient is in-house)
- Denials of Readmission (or "30 day readmission review)
- Clinical Audit "Denials" (Review Results/Findings Letters generated from "complex audits")
- EOB Level Denials ("automated denials")

The process (contracted):

- Concurrent-MA will give first level reconsideration and formal level of appeal (unless contract dictates otherwise)
- Denials of Readmission-MA Should follow CMS guidelines and cannot impose more stringent guidelines than what CMS has established (the Medicare Advantage cannot limit the original Medicare coverage[1]
- Clinical Audits generate a "findings" by the Medicare auditor (i.e., RAC, SMRC, CERT, TPE, ZPIC, UPIC, OIG) or the Medicare Advantage plan (or their third party auditor)
- EOB Level Denials can occur for a variety of reasons, some of which may require intervention by the clinical audits & disputes staff vs. the Rev Cycle/Billing staff (i.e., automated denial on a Medicare Advantage that is citing either an NCD or LCD)

Deconstruction of the Denial or Findings

- What is stated in the denial or findings? (i.e., citation of a specific policy #, LCD or NCD vs. a narrative that is free formed by an auditor)
- If the denial or findings is specific to a policy #, LCD or NCD
  - Tic and tie each item in their rationale to the policy, LCD or NCD to ensure their rationale has not misinterpreted any of the criteria
  - If you do not understand it, seek the appropriate service-line colleague who may be able to shed light for you (i.e., DRG validation denial on a structure heart procedure such as a TAVR, Watchman, etc. Incorporate the assistance of your structure heart team to check for understanding)
  - Your record may not paint the entire picture, thereby causing the denial or findings. Do you need an outside record from the ordering provider that could have a progress note to support your appeal? [i.e., CMS MAC, Targeted Probe and Educate (TPE) denial for Neulasta™ (pegfilgrastim) subcutaneous injection or Neulasta OnPro™]
- If the denial or findings is a free formed narrative, seek to deconstruct it using your medical record[2] and incorporate the appropriate department or service line to assist with the defense

Planning the Internal Appeals Process

RESEARCH IT
(WHAT WAS THE DENIAL REASON AND IS IT DEFENSIBLE

CRAFT IT
(ADDRESS EACH COMPONENT OF THE DENIAL RATIONALE)

FINE TUNE IT
(ENSURE SERVICE-LINE AGREEMENT; CHECK BACK THROUGH CROSS REFERENCES; ACCURACY CHECK

When there are no construction materials to build your defense…

WHEN YOU CANNOT APPEAL, THEN….

RESEARCH IT—IF IT WAS NOT DEFENSIBLE, WHAT ARE THE REMEDIAL STEPS FOR PREVENTION OF FUTURES?

CRAFT IT --SEND SOME FOLLOW UP COACHING AND FEEDBACK TO THOSE WHO CAN IMPACT CHANGE IN THE SERVICE LINE

FINE TUNE IT –REPORT OUT TO YOUR AUDIT STEERING COMMITTEE AND/OR EXECUTIVE COMMITTEE TO KEEP THEM IN THE LOOP. SHOULD IT CONTINUE TO HAPPEN, THEY CAN IMPACT CHANGE IN THE SERVICE LINE.

WHEN THE VOLUME IS TOO MUCH

INCORPORATING OUTSIDE VENDOR APPEAL SERVICES FOR:

- Concurrent Denials
- Denials of Readmission
- Clinical Audit "Denials"
- EOB Level Denials

TIPS FOR DECISIONS REGARDING OUTSIDE VENDOR SUPPORT:

- Most work on a contingency fee
  - Best when you are not looking for a long term commitment but just need some back-log support
  - Often provide really good a la carte services
- Some will have a contracted per case rate (best for long term commitments)
- Those with case rates may have "contract minimums"

WHEN IS IT TIME FOR LEGAL SUPPORT

- Payer contract violations
- When you have gone through all available appeal options and choose to go to arbitration (if this is a contract provision)
- If you do not have appropriate in-house support to handle ALJ hearings or OIG proceedings
- May not be an option in a small facility with limited resources; or may be totally necessary for the small facility in order to protect from financial ruin

Thank you

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