

Denials/Appeals with Part C Medicare Advantage Plans

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Care Management
Holland Hospital



- ❖ Founded in 1917
- ❖ Located in West Michigan lakeshore area
- ❖ Non-for-profit
- ❖ Serves 250,000 people in the greater Holland area and surrounding communities in Ottawa and Allegan counties
- ❖ 189 Licensed inpatient beds

By the numbers* ...

- ❖ Over 330 Physicians
- ❖ 2,100 Employees
- ❖ 550 Registered Nurses
- ❖ 8,100 Patient Discharges
- ❖ 29,900 Patient Days
- ❖ 1,700 Births
- ❖ 15,800 Surgeries/Endoscopies
- ❖ 4,100 Emergency Room Visits

*2013 vital statistics

Part C – Payors and Providers

Medicare Plus Blue (BCBSM)

Blue Care Network


Humana Gold Choice




Recent Improvements

- ❖ 100% Electronic Medical Record
- ❖ Cerner Go-Live – May 2014
- ❖ 100% of verbal order entries cosigned by physician before discharge order

Top 5 DRGs Audited & Denied

- ❖ 470 – Major Joint Replacement w/o MCC
 - ❖ 310 – Cardiac Arrhythmia & Conduction Disorders w/o CC/MCC
 - ❖ 491 – Back & Neck Proc Exc Spinal Fusion w/o CC/MCC
 - ❖ 871 – Septicemia or Severe Sepsis w/o MV 96+ Hours w/ MCC
 - ❖ 714 – Transurethral Prostatectomy w/o CC/MCC
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Denial Rationale by Insurance

- ❖ Medical Necessity
 - ❖ Inadequate Documentation
 - ❖ Coding
 - ❖ Patient had no complaints/complications
 - ❖ Care provided as outpatient
 - ❖ No surgical complications documented
 - ❖ OR Report documents no complications, minimal blood loss, taken to Recovery in good condition
 - ❖ Discharged home in stable condition
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2013 Appeals/Overtured ...

- ❖ Overall Overtured Rate: 74%
- ❖ Peer to Peer
 - ❖ Needs improvement
- ❖ Appeals:
 - ❖ Well written letters
 - ❖ Use of Cheat Sheet (template)
 - ❖ Research based
 - ❖ Hindsight vision
 - ❖ Timeliness
 - ❖ Continue to learn and evolve
 - ❖ Accurate record keeping

Cheat Sheet Template

ADR:
Findings:
Demand:
Lev 1 Sent:
Lev 1 Decision:

Surgical Cheat Sheet

CGI
Patient

Review Results Findings – Medical Necessity Review – Findings

Beneficiary Name	Claim Reference #	Audit #	HIC Number	Dates of Service	Disp Code(s)
Original DRG				New DRG	
Original Diag Code(s)				New Diag Code(s)	
Original Proc Code(s)				Review Proc Code(s)	

Additional Information:

This is a [redacted] years old patient who was admitted [redacted] based on chart documents, there was no evidence that this procedure was performed urgently or patient developed any complications [redacted] This procedure is not on the [redacted] list. There is no further documentation supporting the need for an inpatient admission. The inpatient admission is denied because the medical record does not establish the medical necessity for the inpatient admission.

Age:

LOS:

Doc:

DRG:

Dx:

OR:

ASA:

EBL:

Anesth:

PreOp Clearance

IP Consults

PACU

In:

Out:

PACU Pain

Nsg Floor

DOS

Ht:

Wt:

BMI:

Fall Risk

Comorbid

Boarding

Admit Date


Admit Orders

QR Sheet

d/c date

Total Hours

Accurate Record Keeping

- ❖ Use to your advantage
 - ❖ Technical wins
 - ❖ Keep the insurance accountable
 - ❖ Go up the chain of command
 - ❖ Don't take "no" as an answer
 - ❖ Educate hospital staff/medical staff/case management
 - ❖ Change is inevitable
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Thank you

Questions?

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