Appeal And Denial Prevention: *Strategies For Internal Appeals*

THE FIFTH NATIONAL PHYSICIAN ADVISOR AND UTILIZATION REVIEW BOOT CAMP

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INFIRMARY HEALTH

JULY 21, 2017

Infirmary Health: About Us

Infirmary Health is the largest non-governmental healthcare system in Alabama, and the second largest not-for-profit healthcare system in the state. More than one million patient visits are made to Infirmary Health facilities each year.

Infirmary Health is the governing organization of 5 acute care hospitals, 2 post-acute care facilities, a physician clinic network with more than 30 locations, 3 diagnostic centers, 3 urgent care clinics, and other affiliates. The healthcare system serves an 11-county area of south Alabama and north Escambia County, Fla., with 700 active physicians and more than 5,000 employees.

Before you can strategize, you must:

- Have access to and understanding of contractual language
  - Prompt pay provisions
  - Dispute resolution process
  - Timely filing limits for claims, corrected claims & appeals
  - Recoupment limits

- Access to the appropriate payer resources
  - Payer contacts (Org structure, names, email addresses, direct phone numbers, fax numbers)
  - Provider manuals
  - Web portals
  - Levels of appeal
  - Where to send appeals (READ THE FINE PRINT)
  - Opt for emailing or faxing over mail whenever possible (just because there's not a fax number listed in the appeal rights doesn't mean that one doesn't exist. ASK FOR IT.

- Collaborative relationships with PA's, CDI, Case Management, Patient Financial Services/Rev Cycle

F. I. G. H. T.

Find

Inexplicable

Garbage *and*

Hound

Them with it

ACTUAL text in "denial letter" received from a LARGE payer

After review, the claim has processed and denied correctly. Claim denied with 1123 reason code for NOT COVERED PER MEDICARE NCD. Thank you. Therefore, no additional payment will be made.

Five, count them, (5) emails later……VOILA

Issue: Claim denied as not meeting NCD guidelines; provider needs specific NCD criteria.

Root Cause: Claim is billed incorrectly based on CMS NCD 20.4 (NCD 20.4 - Implantable Automatic Defibrillators)

Remediation: Claim is billed with CPT 33249, which is linked to NCD 20.4. Per this NCD, patient must not have had a CABG or PTCA within the past 3 months and claim is billed with diagnosis Z95.1 – presence of aortocoronary bypass graft. Please review claim in accordance with CMS guidelines.

***The final outcome on this claim was that we had a coding error and a corrected claim was subsequently billed to the payer. Our coder *should have coded* Z95.5 status post angioplasty with stent (2013). Once that was corrected, we were able to get this rebilled since it was longer than 3 months. The patient in question met requirements for NCD 20.4.

F. I. G. H. T.

Find [redacted]

Inexplicable

Garbage *and*

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Them with it

CASE NO [redacted]
ID #: [redacted]
PATIENT NAME: [redacted]
GROUP #: [redacted]
PROVIDER #: [redacted]
DATE(S) OF SERVICE: November 15, 2016 through November 27, 2016

Dear [redacted]:

NO THEY DIDN'T

We're responding to your request to reconsider our previous decision.

We carefully reviewed the documentation submitted, our payment policies and the patient's benefit plan. However, we uphold our original decision, and these services are not eligible for payment as you requested related to the denial for authorization. The documentation submitted on appeal is insufficient to support overturn of the denial on the claim therefore; no additional reimbursement is due. Please understand that this is your final level of appeal with us.

*****This claim was denial of inpatient admission for a TWELVE DAY STAY. A peer to peer was requested on day following inpatient order. A peer to peer was done with the payer on day six of the stay. The payer upheld their decision to deny. The account was sent for appeal post discharge. The reconsideration level failed. The above is the beginning of the response to our formal appeal.**

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An appeal review for the denial of payment for an inpatient hospitalization on November 15 to November 23, 2016 has been completed. We reviewed the medical records and case notes. After reassessing the entire clinical situation the result is that the initial denial is upheld. This 58-year-old patient came to the hospital on November 15, 2016, with hyperglycemia and the blood glucose over 800. The patient admits to not checking her blood glucose levels or taking her medications. The physician order for inpatient admission was written on November 16, 2016. Blood glucose levels improved with initial treatment but the patient developed a cellulitis of a forearm stump. The hemoglobin A1c was over 20%. This is a high risk comorbid condition and treatment of cellulitis would require inpatient admission. Information provided at the time of the appeal does support medical necessity for inpatient hospitalization on November 16 to November 23, 2016 per: health plan evidence-based guidelines MCG 20th edition ® Cellulitis ORG: M-70 (ISC), Diabetes ORG: M-130 (ISC) and Medicare Benefit Policy Manual 100-2 Chapter 1, 10 - Covered Inpatient Hospital Services Covered Under Part A (Rev. 1, 10-01-03) A3-3101, HO-210. However, this inpatient hospital stay is incorrectly billed. The physician order for inpatient admission was not written on

NO IT WASN'T

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November 15, 2016. The physician admission order is required by the Code of Federal Regulations, Title 42, Chapter IV, Part 412, subpart A, 412.3. Consequently, the inpatient hospitalization is not covered and the denial is upheld

Remember, as stated in your participation agreement, you may not bill the patient for any charges above the applicable patient responsibility.

UnitedHealthcare's reimbursement policies are available online at www.unitedhealthcareonline.com. In addition, you can reference this website to check patient eligibility, review claim status, and submit claims and more.

At UnitedHealthcare, we make every effort to respond clearly and completely to your concerns. If you have further questions, you may use our automated telephone response system or speak with a Provider Services representative at 877-842-3210.

Sincerely,

UnitedHealthcare Medicare & Retirement Provider Disputes
Appeals and Grievances Unit

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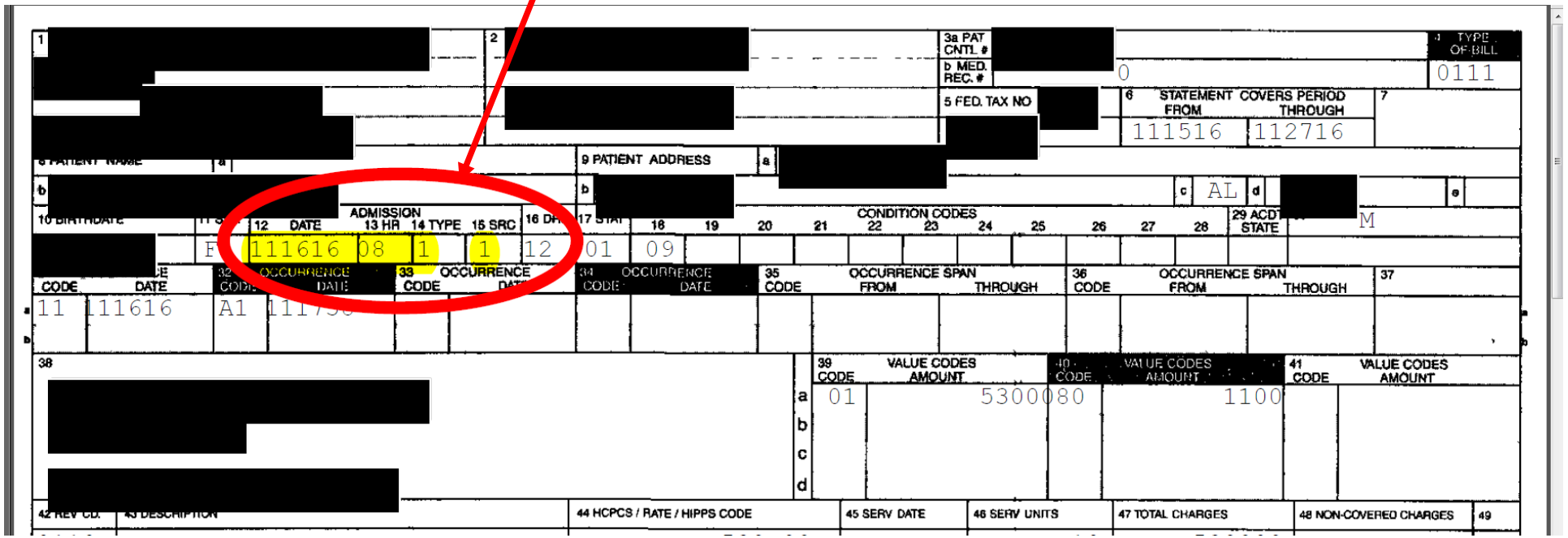
The UB04 billed with the correct date of admission in Form Locator 12.



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WHAT???

DID

THEY

JUST

SAY

TWO

MIDNIGHTS?

Dear [redacted]:

The Physician completed the 3rd level appeal review, which included the submitted medical records for the below referenced patient. Based on the submitted documentation, the appeal is overturned.

Insurance Company:	Humana
Review Conducted by:	All Med
Patient Name:	[redacted]
Member Number:	[redacted]
Patient's Date of Birth:	[redacted]
Admittance Date:	05/19/2015
Discharge Date:	05/22/2015
Claim Number:	[redacted]
Audit Type:	Short Stay Audit
Legal Entity:	HUMANA INSURANCE CO

The results of this review are outlined below:

The audit was overturned due to the claim hitting the 2 midnight rule.

If you have any additional questions or need further assistance, please reference the Humana Financial Recovery Clinical Appeal Policy on **Humana.com** at **http://www.humana.com/providers/claims/financial_recovery/audit_appeals.aspx** or contact Humana's financial recovery customer service department at 1-800-438-7885, Monday through Friday between 8 a.m. and 4 p.m. Eastern time.

Sincerely,

Isn't that the same 2MN rule that the MA's tell us that they don't follow?

***This claim was an appeal that had been closed in the previous year as appeal options exhausted. This letter came in the mail in the last few days. We are currently pursuing full repayment of this DRG.

If we have to spell it out, so should they…

- Demand that the payer use clear language in a denial--not cryptic codes that are meaningless outside of their organization
  - Bring this up in every payer meeting. Bring your CASE FILE. Make them a copy and put it in front of them.
- You need the descriptive rationale in order to know how to either detect the error on your part or to determine if you need to appeal something for their misinterpretation of an NCD
- Just stating that it denied for and NCD without providing the appropriate description is not enough
- In the case on the previous slide, the payer has a whole team of people who are now dedicated to providing this information, but only if you hound them for it.
- Why not just provide it on the denial THE FIRST TIME and save the need for additional FTE's, contractors, new departments, new "concierge services"?

Effectuating Change

- Memorize contract language and provisions
  - If your contract says they have no more than 60 days to respond to an appeal, then HOLD THEM TO IT
  - Use your tracking tools to track and monitor final outcomes by payer
  - When the claim ticks over the deadline for their response, be ready to fire off a letter immediately—and demand payment of the full expected payment.
- Develop in house protocols for delinquent appeal responses
  - If there is nothing in your contract that you can reference as a hard and fast deadline, then develop a "Dunning message" for your payer. Use template letters so that they get used to your procedures You don't have to restate what was in your appeal. You are just demanding an answer to what you can prove that they have received via your proof of delivery
  - Decide how many they will get prior to moving to legal/arbitration…make a plan and stick to it. If you are repetitive in your actions, then they should not be surprised when they are put on notice regarding legal pursuit
  - When they continue to re-request records for what you can prove has been received, stop them. Let them know that you need them to file a HIPAA breach. Let them know that if they don't or can't do this, you'll be happy to start the process for them. Their insured will most certainly be notified. They'll find the records. (Thank you Dr. Hirsch!)
- MAIL ANALYSIS
  - Determine the weak points in your organization's mail distribution process and fix them
  - Give the payer a spreadsheet of your tax id's/NPI's and corresponding addresses, fax numbers email—tell them where you want them to send your ADR's, appeal responses, itemized billing requests etc.
  - Identify all auditors for all payers—you're not just dealing with the payer but with their contractors as well

Scenarios—Opportunities For Strategy

Scenario:

1. Readmission review ADR issued on account currently in appeal for denial of admission
2. Payer is “on site” for your facility--issues remit denial for medical records before they can process and pay what they concurrently approved
3. MAO medical director (*non-PFFS plan) concurrently approved the inpatient LOC (either up front or after successful P2P) and then claim later denies for medical necessity
4. Any denial that cannot be traced to an audit process or to a concurrent denial
5. They think that you are going to “just forget about it”

Opportunity For Strategy:

1. Advise the payer to withdraw the Readmission Review until they settle the appeal for what they would not approve as an admission
2. If the payer is an onsite reviewer, pull the electronic footprint in your EHR system. Show them the days and times they’ve already accessed the medical records, the same ones that they claim to need for processing.
3. Call the plan immediately. Provide the documentation of the concurrent approval. Challenge as an invalid denial. This also applies on cases where the MAO has originally denied but then later overturned on P2P, only to deny on adjudication or audits for medical necessity.
4. Identify the denial type and then identify the steps or documentation missing from the payer—demand reopening/re-review. Appeal is not used when they payer just simply cannot figure out how to respond to your question. HOLD. THEM. ACCOUNTABLE.
5. DON’T. FORGET. ABOUT. IT.

Finishing Well:

- Centralize tracking and responding
- Why? Why? Why? Why? Why?
- Be skeptical
- Know the rules
- You can be nice, while still demanding answers
- BE the squeaky wheel! BE vigilant!
- Use your resources like —Monitor Monday, RAC Monitor, RAC Relief Google group because you are not in this alone!
- **Participate** in statewide advocacy and networking—STRENGTH. IN. NUMBERS.

INFIRMARY HEALTH

Thank You!

Enjoy the rest of Boot Camp!