Clinical Denials

Prevention is the Best Medicine

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Who's Doing Clinical Audits?
Government Payers

BFCC-QIO
Beneficiary and Family Centered Care Quality Improvement Organization

MAC
Medicare Administrative Contractor

RAC
Recovery Audit Contractor

CERT
Comprehensive Error Rate Testing

Who's Doing Clinical Audits?
Government Payers

SMRC
Supplemental Medical Review Contractor

UPIC
Unified Program Integrity Contractor

OIG
Office of Inspector General of Health and Human Services

DOJ
Department of Justice

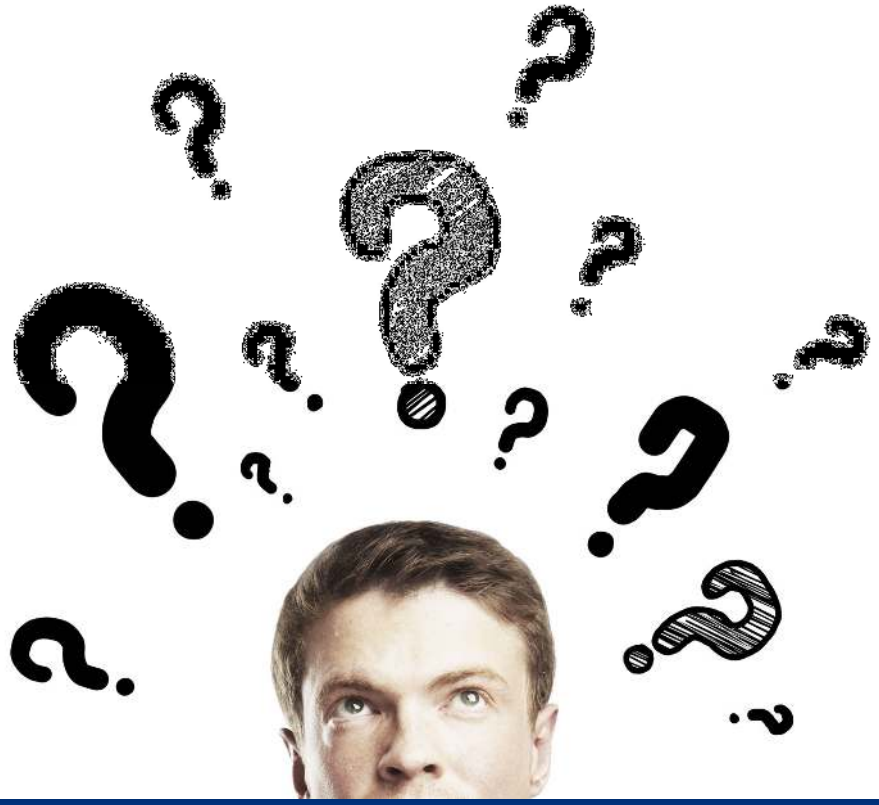
Who's Doing Clinical Audits?
Other Payers

Internal Audits with Payer Staff

Outsourcing Audits

What Are They Questioning?

- ✓ **Prior Authorizations**
- ✓ **Concurrent Reviews**
- ✓ **Retrospective Reviews**



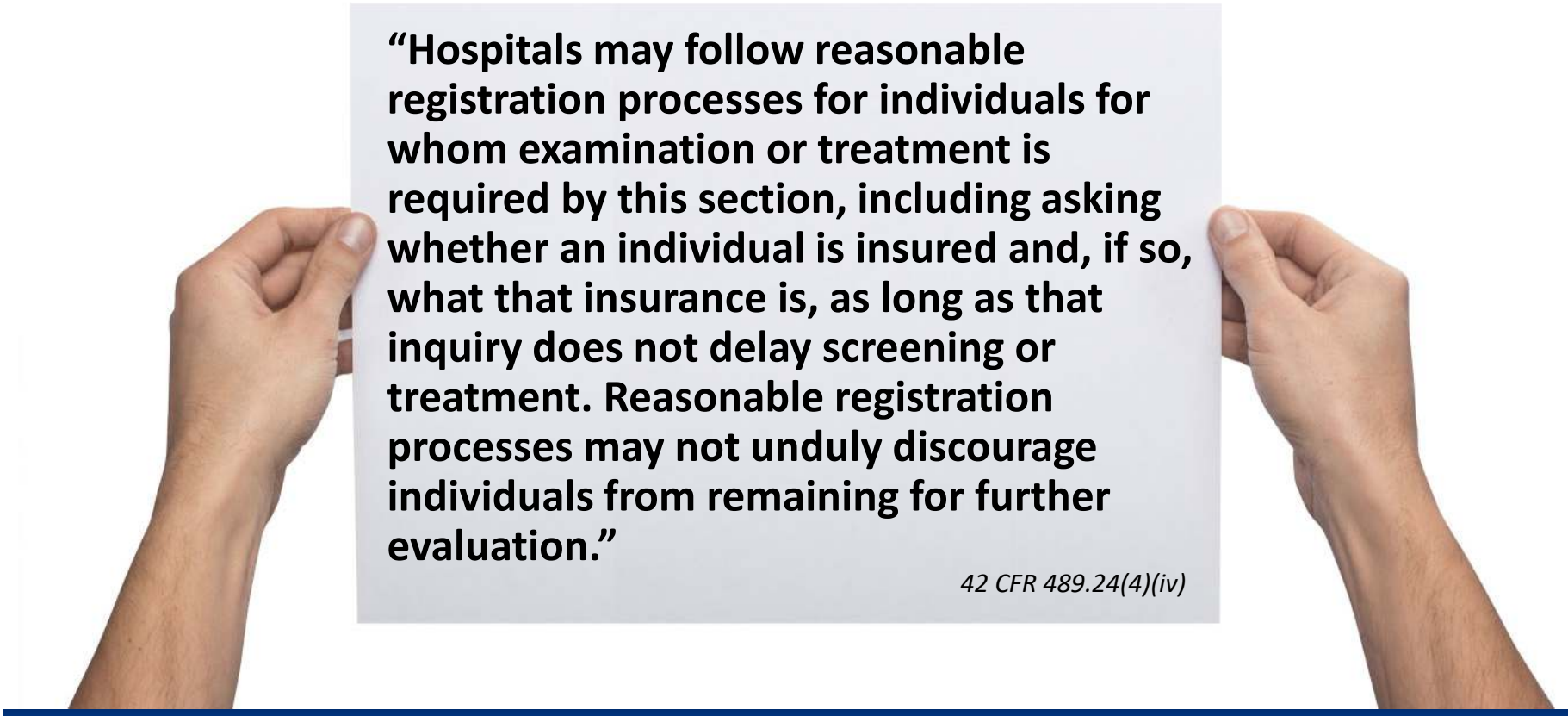
Start at the Beginning

- **Accurate registration is key**
- **Payer information used every step of hospital course**
- **Inaccurate registration leads to delays in care and denials**

Real-Time Insurance Verification

- Start Registration Process Early
- Use technology to verify and check benefits

But What About EMTALA?

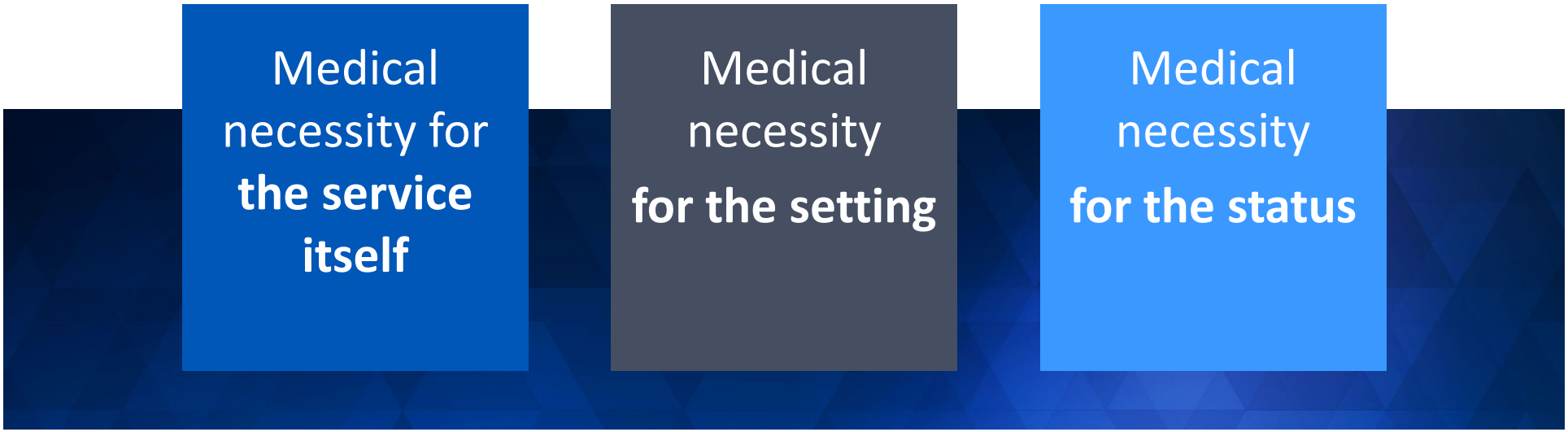


Payer Agnostic Policies – Not Patient-Centered Care

“We don’t look at the insurance; we treat everyone the same.”

Insurance verification is patient-centered!

Medical Necessity
Three Types



Medical Necessity for the Service

- Health insurance is a defined benefit plan

Medical Necessity for the Service

- Determining necessity
  - Medicare- NCDs, LCDs, standards of care, judgement of reviewer
  - Other payers- published coverage guidelines
- FDA approval ≠ covered by payers

Back Pain – A Case Study

NEJM Journal Watch

Another Look at Vertebroplasty for Patients with Painful Vertebral Compression Fractures

Paul S. Mueller, MD, MPH, FACP reviewing Firanescu CE et al. *BMJ* 2018 May 9

Vertebroplasty was no better than sham procedures in a randomized trial.

FDA Approved But Not Covered By Insurance

- AccuraScope procedure;
- Annulus repair devices (Xclose Tissue Repair System, Barricaid, Disc Annular Repair Technology (DART) System)
- BacFast HD for isolated facet fusion;
- Biomet Aspen fusion system (an interlaminar fixation device) (see Appendix);
- Chemical ablation (including but not limited to alcohol, phenol or sodium morrhuate) of facet joints;
- Coccygeal ganglion (ganglion impar) block for coccydynia, pelvic pain, and all other indications;
- Cooled radiofrequency ablation for facet denervation;
- Cryoablation (cryoanesthesia, cryodenervation, cryoneurolysis, or cryosurgery) for the treatment of lumbar facet joint pain;
- Deuk Laser Disc Repair;
- Devices for annular repair (e.g., Inclose Surgical Mesh System);
- Dynamic (intervertebral) stabilization (e.g., BioFlex, CD Horizon Agile Dynamic Stabilization Device, DSS Dynamic Soft Stabilization System, Dynabolt Dynamic Stabilization System, Dynesys Spinal System, Graf ligamentoplasty/Graf artificial ligament, Isobar Spinal System, NFix, Satellite Spinal System, Stabilimax NZ Dynamic Spine Stabilization System, and the Zodiak DynaMo System);
- Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System;
- Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation);
- Endoscopic transforaminal diskectomy;
- Epidural fat grafting during lumbar decompression laminectomy/discectomy;
- Epidural injections of lytic agents (e.g., hyaluronidase, hypertonic saline) or mechanical lysis in the treatment of adhesive arachnoiditis, epidural fibrosis, failed back syndrome, or other indications;
- Epidural steroid injections for the treatment of non-radicular low back pain;
- Epiduroscopy (also known as epidural myeloscopy, epidural spinal endoscopy, myeloscopy, and spinal endoscopy) for the diagnosis and treatment of intractable LBP or other indications;
- Facet chemodenervation/chemical facet neurolysis;
- Facet joint allograft implants (NuFix facet fusion, TruFuse facet fusion)

FDA Approved But Not Covered By Insurance

- Facet joint implantation (Total Posterior-element System (TOPS) (Premia Spine), Total Facet Arthroplasty System (TFAS) (Archus Orthopedics), ACADIA Facet Replacement System (Facet Solutions/Globus Medical);
- Far lateral microendoscopic diskectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications;
- Hardware injections/blocks;
- Interlaminar lumbar instrumented fusion (ILIF);
- Interspinous and interlaminar distraction devices (see Appendix);
- Interspinous fixation devices (CD HORIZON SPIRE Plate, PrimaLOK SP, SP-Fix Spinous Process Fixation Plate, and Stabilink interspinous fixation device) for spinal stenosis or other indications (see Appendix);
- Intradiscal injection of platelet-rich plasma;
- Intradiscal, paravertebral, or epidural oxygen or ozone injections;
- Intradiscal steroid injections;
- Intravenous administration of corticosteroids, lidocaine, magnesium, Toradol or vitamin B12 (cyanocobalamin) as a treatment for back pain and neck pain;
- Khan kinetic treatment (KKT);
- Laser facet denervation;
- Least invasive lumbar decompression interbody fusion (LINDIF);
- Microendoscopic discectomy (MED; same as lumbar endoscopic discectomy utilizing microscope) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications;
- Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications;
- Microsurgical lumbar sequestrectomy for the treatment of lumbar disc herniation;
- Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications;
- Minimally invasive lumbar decompression (MILD) procedure (percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements under indirect image guidance) for lumbar canall stenosis or other indications;

FDA Approved But Not Covered By Insurance

- **Minimally invasive thoracic discectomy for the treatment of back pain;**
- **Minimally invasive endoscopic transforaminal lumbar interbody fusion (endoscopic MITLIF; same as endoscopic MAST fusion) for lumbar disc degeneration and instability or other indications;**
- **OptiMesh grafting system;**
- **Percutaneous cervical diskectomy;**
- **Percutaneous endoscopic diskectomy with or without laser (PELD) (also known as arthroscopic microdiskectomy or Yeung Endoscopic Spinal Surgery System [Y.E.S.S.]);**
- **Piriformis muscle resection and other surgery for piriformis syndrome;**
- **Psoas compartment block for lumbar radiculopathy or myositis ossification;**
- **Racz procedure (epidural adhesiolysis with the Racz catheter) for the treatment of members with adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications;**
- **Radiofrequency denervation for sacroiliac joint pain;**
- **Radiofrequency lesioning of dorsal root ganglia for back pain;**
- **Radiofrequency lesioning of terminal (peripheral) nerve endings for back pain;**
- **Radiofrequency/pulsed radiofrequency ablation of trigger point pain;**
- **Sacroiliac fusion or pinning for the treatment of LBP due to sacroiliac joint syndrome; Note: Sacroiliac fusion may be medically necessary for sacroiliac joint infection, tumor involving the sacrum, and sacroiliac pain due to severe traumatic injury where a trial of an external fixator is successful in providing pain relief;**
- **Sacroiliac joint fusion (e.g., by means of the iFuse System and the SImmetry Sacroiliac Joint Fusion System);**
- **Sacroplasty for osteoporotic sacral insufficiency fractures and other indications;**
- **Total Facet Arthroplasty System (TFAS) for the treatment of spinal stenosis;**
- **Vesselplasty (e.g., Vessel-X).**

Scheduled Procedures

Who obtains the pre-authorization?

Physicians

Scheduled Procedures

Who obtains the pre-authorizatior

Facility

Scheduled Procedures Best Practice

Physician obtains authorization for procedure itself

Hospital Gets medical records from physician

- Confirms authorization with insurer
- Obtains approved status

If any step missing, the procedure does not get scheduled

Side Note about Status for Procedures

No clinical difference between procedure performed inpatient or outpatient at hospital

- Inpatient-DRG- **$20,000**
- Outpatient- 70% of charges– total charge= **$40,000** – Payment= **$28,000**

Which status do you want approved?

Medical Necessity Can Vary Within Same Payer

Insurer X Commercial Plans

The following transcatheter heart valve devices and/or procedures are unproven and not medically necessary to to insufficient evidence of efficacy:

- Cerebral protection devices (e.g., Sentinel™)
- Mitral valve repair or replacement
- Tricuspid valve repair or replacement
- Valve-in-Valve (ViV) replacement within a failed bioprosthesis

Insurer X Medicare Advantage Plans

Overview:
Transcatheter mitral valve repair (TMVR) is used in the treatment of mitral regurgitation. A TMVR device involves clipping together a portion of the mitral valve leaflets as treatment for reducing mitral regurgitation (MR). Abbott Vascularfs MitraClipR is the only one with Food and Drug Administration (FDA) approval.

Guidelines:
Nationally Covered Indications
TMVR for MR under Coverage with Evidence Development (CED) is covered by the Centers for Medicare & Medicaid Services (CMS) with the following conditions.

Don’t Forget Infusion/Oncology Center

South Carolina Results

A total of 97 claims were reviewed, with 81 of the claims either completely or partially denied. The total dollars reviewed was $677,251.37 of which $431,708.53 was denied, resulting in a charge denial rate of 63.7%.

There was no physician certified diagnosis submitted in the medical record that would substantiate the medical need for use of bevacizumab.

For the diagnosis of non-squamous non-small cell lung cancer (unresectable, locally advanced, recurrent or metastatic), the recommended dose for bevacizumab of less than or equal to 15 mg/kg intravenously every 3 weeks in combination with carboplatin and pacilitaxel was not ordered or followed.

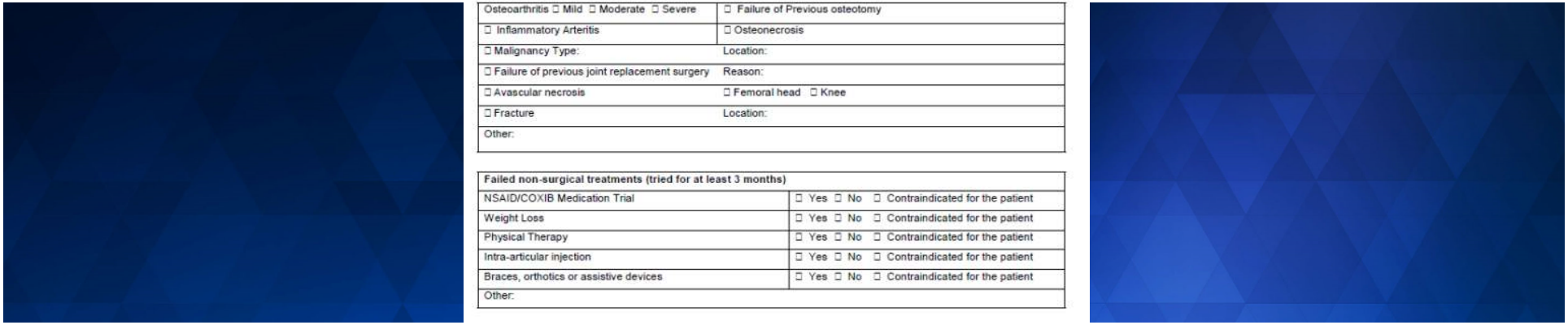
Who is reviewing these services for medical necessity?

Medicare Planned Procedures

No prior authorization available

Obligation of hospital and physician to ensure medical necessity per CMS standards

Medicare Planned Procedures



Medical Necessity for Joint Replacement Surgery page 1 of 2

Primary Joint(s) Affected	Right	Left	Bilateral	Duration of Symptoms	
Hip				☐ 3-6 months	☐ 6-12 months ☐____Years
Knee				☐ Other: (*specify*)	

Joint Replacement Related History

Osteoarthritis ☐ Mild ☐ Moderate ☐ Severe	☐ Failure of Previous osteotomy
☐ Inflammatory Arteritis	☐ Osteonecrosis
☐ Malignancy Type:	Location:
☐ Failure of previous joint replacement surgery	Reason:
☐ Avascular necrosis	☐ Femoral head ☐ Knee
☐ Fracture	Location:
Other:	

Failed non-surgical treatments (tried for at least 3 months)	
NSAID/COXIB Medication Trial	☐ Yes ☐ No ☐ Contraindicated for the patient
Weight Loss	☐ Yes ☐ No ☐ Contraindicated for the patient
Physical Therapy	☐ Yes ☐ No ☐ Contraindicated for the patient
Intra-articular injection	☐ Yes ☐ No ☐ Contraindicated for the patient
Braces, orthotics or assistive devices	☐ Yes ☐ No ☐ Contraindicated for the patient
Other:	

Radiology Indications for Replacement	Highest Level of Walking Support (*for the affected joint that the pt currently uses to carry out activities, e.g. work, leisure*).
☐ Subchondral cysts:	☐ None/Orthotics
☐ Subchondral sclerosis:	☐ Brace/Cane
☐ Periarticular osteophytes:	☐ Crutches/Walker
☐ Joint Subluxation:	☐ Wheelchair
☐ Joint Space Narrowing:	

Medicare Planned Procedures

Best Practice

- Review for medical necessity per NCD, LCD, etc.
- Determine proper admission status
  - Inpatient only- always inpatient
  - Not inpatient only- outpatient or inpatient
- Get inpatient admit order when scheduled
- If no medical necessity, contact physician
- If no response, ABN or HINN

Medical Necessity for the Setting - Commercial

In an effort to minimize out-of-pocket costs for Insurer X members and to improve cost efficiencies for the overall health care system, we are implementing prior authorization guidelines that aim to encourage more cost-effective sites of service for certain outpatient surgical procedures.

The following will be taken into account to determine whether the elective procedure is being performed in a cost effective setting:

- Member's specific benefit plan
- Geographic availability of an in network provider
- Ambulatory surgical care (ASC) capability
- Physician privileging
- Significant member comorbidities (see list of examples of Qualifying Conditions below)
- American Society of Anesthesiologist (ASA) physical status (PS), classification system

The Growing Threat/Opportunity from ASCs

CMS added 15 “surgery-like” cardiac procedures to ASC-approved list for 2019

CMS asked to allow total joint replacements at ASCs in 2019

MA plans claim Inpatient Only List does not apply to them

Non-Scheduled Hospital Care

In the Emergency Department

- Medical necessity for hospital care must be present
- Determine payer and admission rules

Non-Scheduled Hospital Care

- **Documentation review- The EMR Copy-Paste Curse**
  - Physical findings
  - Diagnostic studies
  - Response to ED treatment
  - Treatment plan after ED
- **UR staff needs access to physician advisor for questionable cases, secondary review, physician intervention**

Working 9 to 5

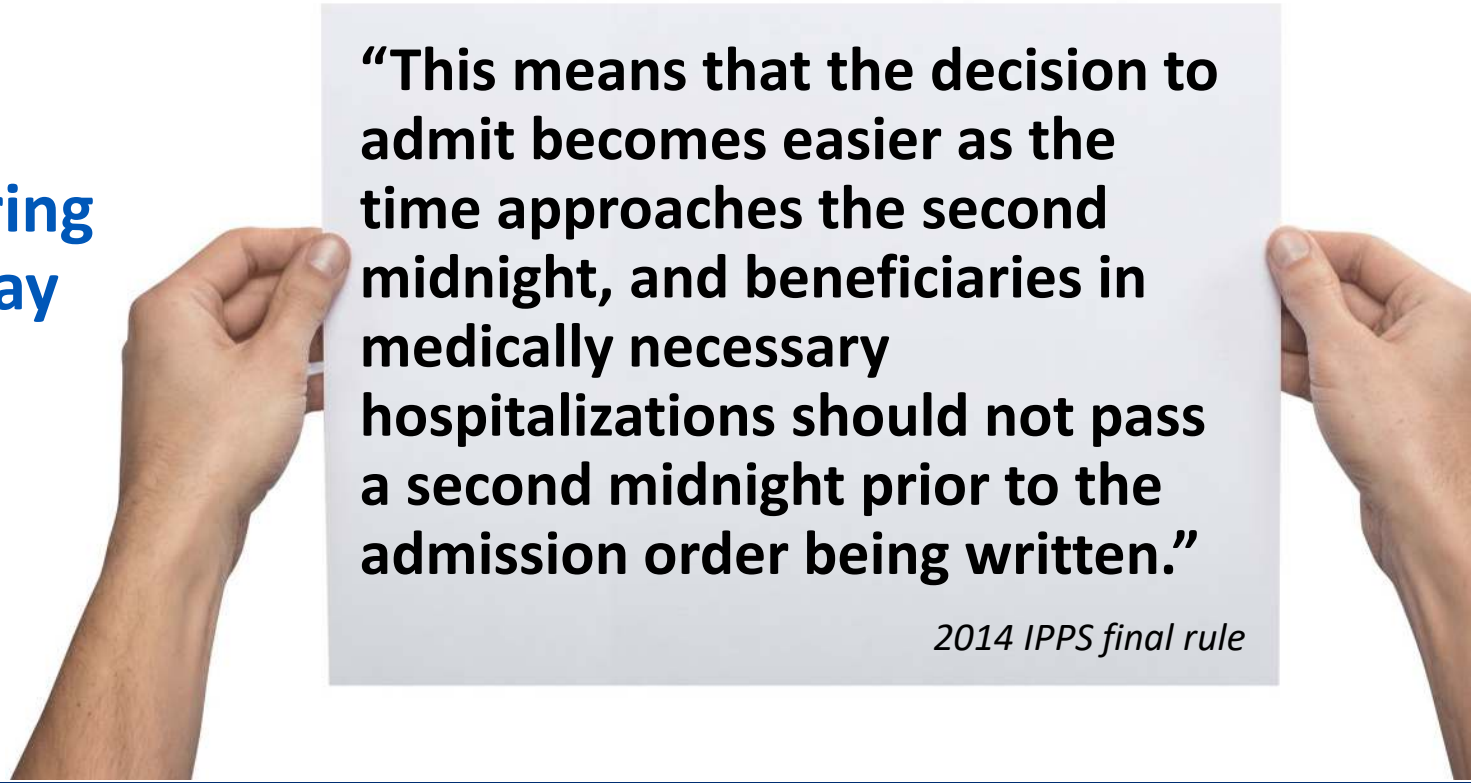
If you're not doing utilization on patients on nights and weekends, shouldn't you close the ED doors?

Medicare Inpatient v. Observation

- **Two-Midnight Rule**
  - Expectation of total hospital care duration beginning with initiation of care
    - Under 2 midnights- observation
    - 2 or more midnights-inpatient

Medicare Inpatient v. Observation

Ongoing review during hospital stay



Medicare Inpatient v. Observation

One Day Stays

- Review all one-day inpatient admissions – UR staff and physician advisor
  - Meet Two-Midnight Rule- approve and bill
  - Does not meet
    - Follow UR process

What is the Right Observation Rate?

- No two hospitals have the same payer mix
- The use of observation varies with surgical patients
- The equation used to calculate observation rate varies
- Aiming for an artificial benchmark is fraught with peril

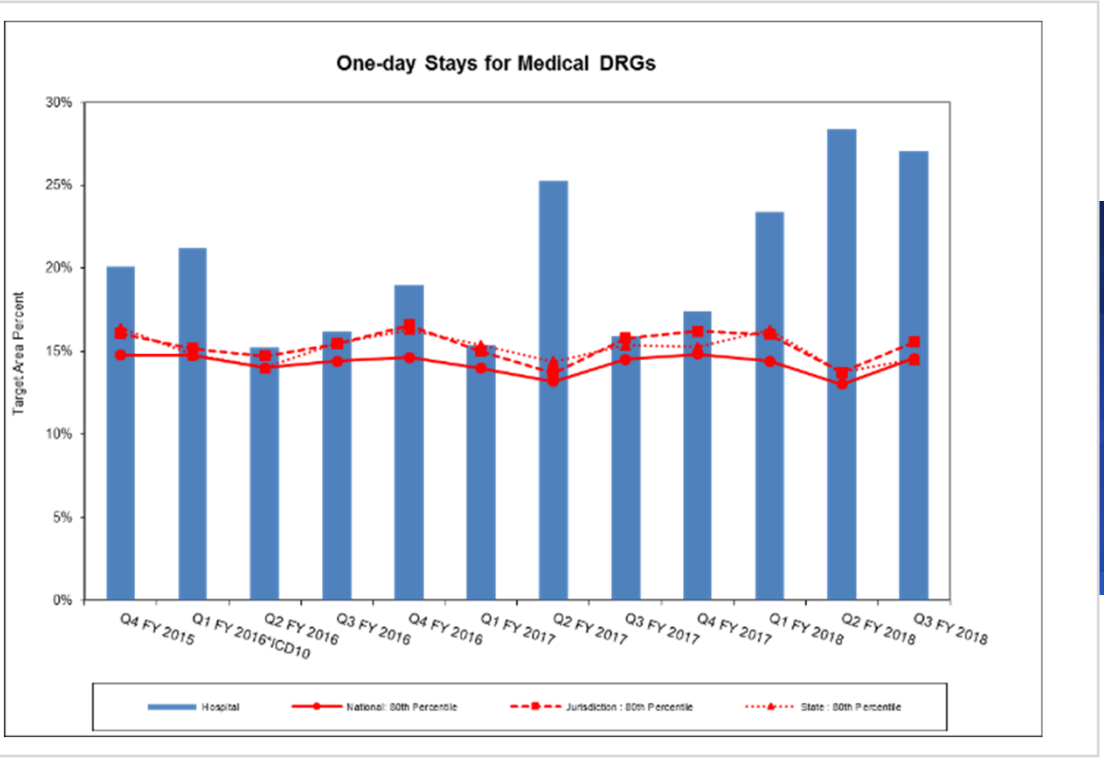
What is the Right Observation Rate?

Look at traditional Medicare medical patients only

1. If every patient is reviewed by case management with the use of a secondary physician review as appropriate for proper admission status,
2. every patient is placed in the right status,
3. observation is only ordered on the proper patients,
4. every patient goes home as soon as their need for hospital care has finished, and
5. every patient who has medical necessity for a second midnight is admitted as inpatient, then your observation rate is exactly where it should be.

- Hirsch's Law 2016

What does your PEPPER Show?



Non-Medicare Admissions

Notify Payer ASAP

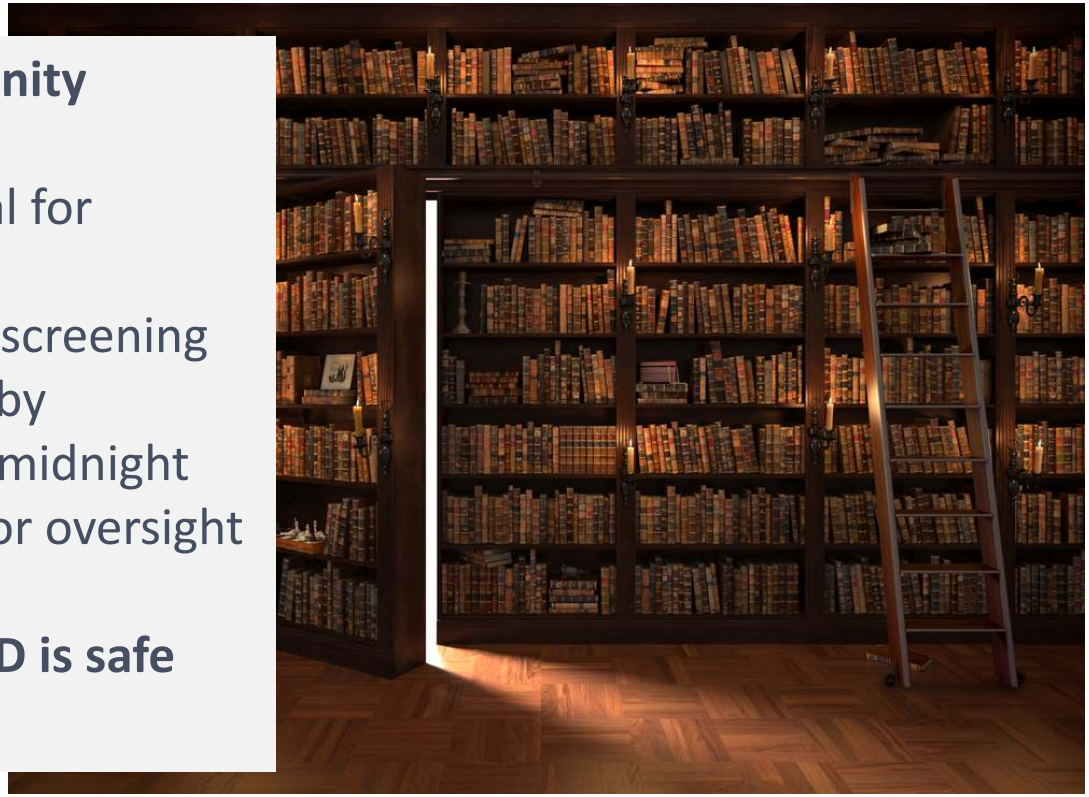
- **Provide criteria used to determine status**
- **Know payment rates- Inpt v. Observation**
  - **If Obs paid per diem or %, do the math**
- **If inpatient denied, do Peer-to-Peer**

Non-Medicare Ongoing Stays

- **Keep payer updated**
- **If observation and continued stay, get authorization for inpatient admission**
- **Look at location in hospital each day**
  - ICU/Step-down unit/Telemetry/Med-Surg unit
- **Monitor ongoing care for medical necessity**
  - Is it necessary? Is it necessary during admission?

Transfers- The Secret Door

- **“Direct admits” from community doctors**
  - Should be- “direct referral for hospital care”
  - Often used to bypass UR screening
  - All cases need screening by commercial criteria/two-midnight rule with physician advisor oversight
- **Determine if bypassing the ED is safe**
- **Check insurance/in-network**



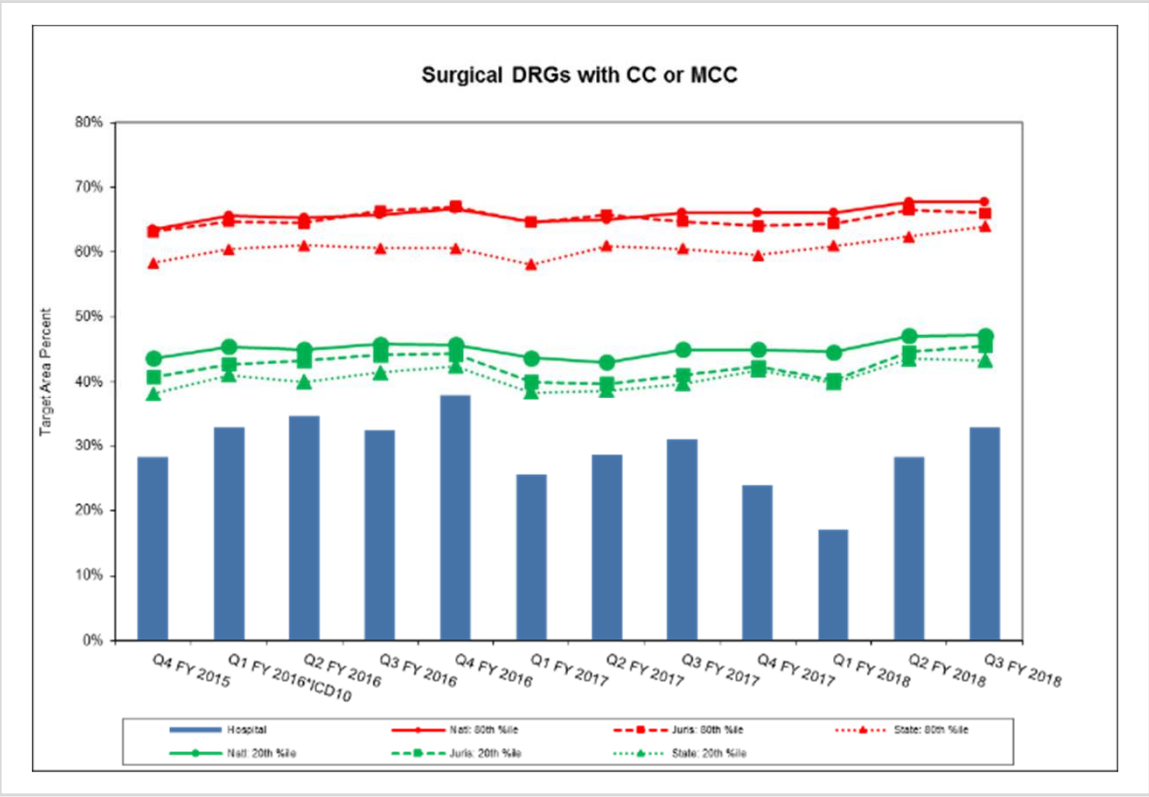
As Discharge Approaches

- Post-acute planning starts on admission
- Commercial payers often withhold approval process for SNF, LTACH, IRF until patient ready to go
- Payers reluctant to approve LTACH, IRF

Coding and Billing

- DRG validation audits increasing
- Clinical documentation integrity staff should be querying “up” and “down”

What does your PEPPER Show?



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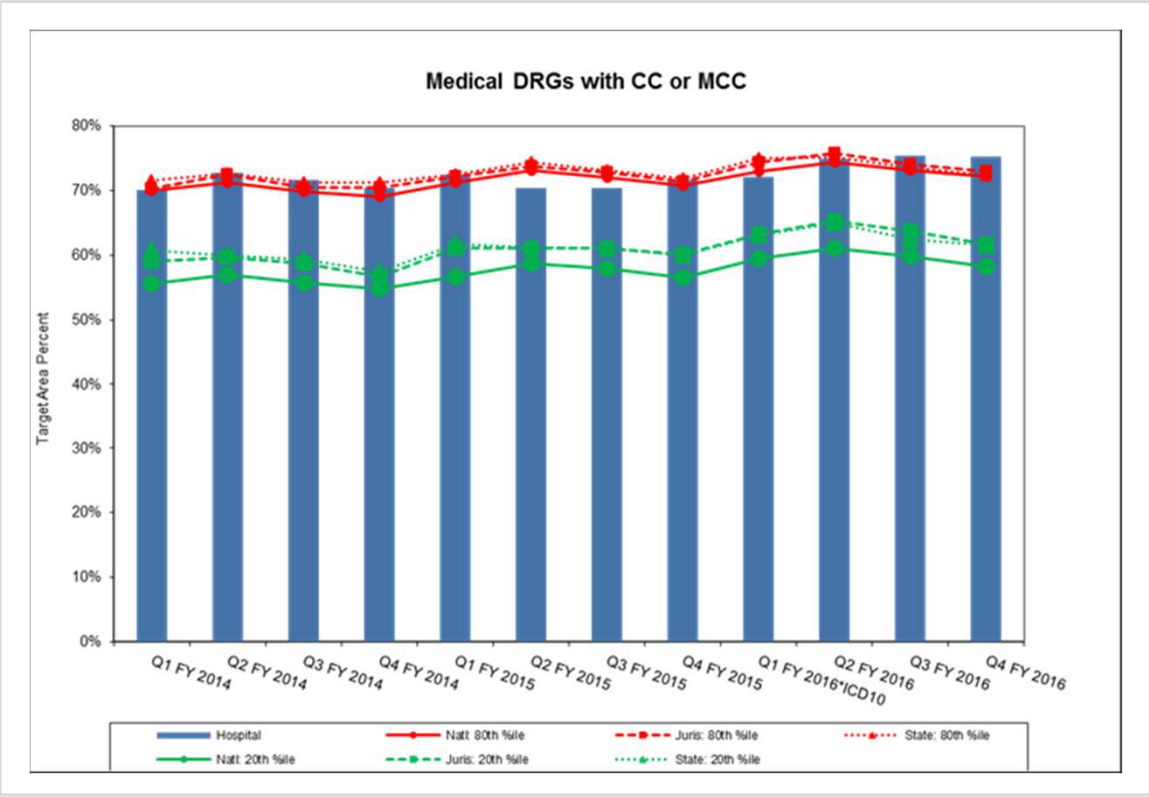

PEPPER

Program for Evaluating Payment Patterns Electronic Report

- “discharges vulnerable to improper payments”
- Expert analysis often finds more opportunity than risk
- Don’t overlook its value!

Tear Down the Silos – Data Transparency

- Your UR staff and physician advisor need to see denial and appeal data to find trends
- They can't prevent denials if they don't know what is being denied
- Doctors want to improve so give them their data

Contracting

A great contracted rate is no good if you never get to bill for it or keep it

Thanks for Listening

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