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Leadership and Clinical Denials- Best Practices

Exceptional Care. Simply Delivered

- PRIIDE Values- Guiding Principles
- Patients, Relationships, Integrity, Innovation, Dedication, Excellence
- “Patient's First”
  - Value that drives everything we do

Network Structure

- Hospitals- 6 Acute Care, 1 Psychiatric, 1 Cardiovascular Specialty and 3 IRFs
- 2 million patient encounters, 7600+ Births
- Largest Indiana Primary Care Network w/ 700K+ doctor visits year
- ~15K Caregivers

Financial Data

- Clinical Denial Recoveries-
  - 2016 $20m
  - 2017 $26m
  - 2018 $39m

History

- Revenue Cycle reporting structure
- 2 Billing Appeals specialists, Added 1 RN
- Charge Capture and Understanding of UBO4
- Focus on Commercial Payers

Present Day

- **Care Management** Reporting Structure
- Collaboration w/UR, Physician Advisors, Billing, CDI, Coding, Revenue Cycle
- **16 Member Team-** 8 RN, 8 non-clinical
  - Rac/Audit Coordinator, Behavioral Health, IP/OP, CRCC, Payor Split, 2 Follow-up, Manager

Clinical Denial? “Hard Denials” vs “Soft Denials”

- **Claim Denial-** By Remit/ Remark Code
- **Soft-** Administrative, Technical, Billing, Coding- More likely to be overturned with correction of claims, submission of medical records.
- **Hard-** Medical Necessity, Authorization, Experimental/Investigational, Level of Care- Usually require Formal Appeal

Best Practices- Across the Continuum

- Front End-
- Middle-
- Back End- “Arm Chair Quarterback” or Coach?

Denials Across the Continuum- Front End

- Prevent Authorization Type Denials (165, 173, 197,198, 210, etc) and IP Only Denials

  - **Prior Auth Team-** Hi-$$ Rad, Surgery, Short Stay, Day Beds, Infusion, IR, Cath Lab, etc
  - Screen shots from payer systems
  - Check Benefits- Number, Units, Visits

Denials Across the Continuum- Front End

- Prevent Experimental/Investigational, Non-covered Denials (55, 40, 50, 51, B5, 114)
  - **Reg/Sched/PAC-** Recorded phone calls to provide transcripts
  - Payor Specific Medical Policies Chemo/ High Dollar Drugs/NCD/LCD
  - Non-Covered Letters/ ABN's

Denials Across the Continuum- Middle

- Prevent late notification denials/penalties (197, 198, 50)
  - **CM PA Team-** Non-Clinical, Ensure timely admission notification; Status/ LOC updates
  - Know Payer timeframes; Systems
  - **Technology:** Mechanism track, index incoming outgoing calls, faxes, capture pdf for outbound

Denials Across the Continuum- Middle

- Prevent Medical Necessity and Level of Care denials (39, 50, 150, 186)
  - **UR Team-** MCG Evidence based criteria utilized/documented for every review
  - 2nd level review escalate to Physician Advisor
  - "Right status"- different things to different payors

Denials Across the Continuum- Middle

- Fight concurrent denials- Readmissions, Medical Necessity for continued stay (249, 50, 62, 197, 198)
  - **Leverage the Physician Advisor** vs. Peer to Peer
  - Relationships: Internal providers and Payer Medical Directors
  - 2 MN Rule,

Denials Across the Continuum- Middle

- Prevent Med Necessity, Clinical Validation Denials (post pay audits)
  - **Robust CDI Team** Collaboration
  - Query for Diagnosis Clarification, Avoid non-specified DX,
  - Clinical/Coding Collaboration on Mismatches, Ensure documentation supports

Denials Across the Continuum- Back End

- Appeal Claim “Hard Denials”-Clinical Denials
  - **Sub-teams** of Clinical and Non-Clinical Paired by payer split (Medicare, Medicaid, Commercial)
  - EMR- Workflows WQ driven
  - WQ routing rules create efficiency
  - Agree on hierarchy for working Hard/Soft denials to avoid burning levels of appeal

Denials Across the Continuum- Back End

- **RN Denial Resolution Specialists**
  - Inpatient, Not Med Nec (50), Exp/inv (55),
  - Any others they are consulted to assist
- **Non-Clinical Denial Specialists**
  - Outpatient, (no 50 or 55)
  - All other “hard denials”
  - Majority are No-Auth denials of some kind

Denials Across the Continuum- Back End

- **Audit Coordinator and 2 Appeals RNs**
  - Monitor, Track, Trend all audits
  - Manage and disperse correspondence timely
  - RAC, Post-Payment Integrity, Managed Care
  - Readmissions- Know contract language
  - Clinical Validation Denials vs Coding

Denials Across the Continuum- Back End

Physician Advisor Back End Role-

- Part B-Rebill/ Self-denials- Less than 2MN IP WQ
- Appeals Consult for Clinical Validation and other Med Nec review for rebill
- Argue cases at ALJ/ State
- Surgical Risk vs. Complication

Denials Across the Continuum- Back End

- **Identify Trends and Issues**
  - Take note of Payer trends, notify Contract manager to work through with payer
  - Payer Liaison Issues resolution Monthly ***Very Valuable***
  - Weekly billing team “one note” call- Corrected claims, resubmissions

Denials Across the Continuum- Back End

- **Share lessons learned and observations w/ front-end stakeholders**
  - Provide education-share screens, show and tell
  - Notify Service line of trends- Ex. Biosimilars
  - Educate Providers on impact of documentation
  - Inform Clinical Leadership of workflow issues
  - Share when large write-offs are coming

Challenges Across the Denials Continuum

- **Challenges-**
  - With Best practice is it's always changing
  - Payers adapt and find new ways to recoup
  - Medical Policy changes all the time
  - Payers want different things/ Caregivers just want to take care of patients

Challenges Across the Denials Continuum

- **Leadership Challenges-**
  - Audits are ramping up, limitations of current workflows driven by electronic remittance codes-
  - Tracking and measuring ROI for particular denials (How much time spent is too much?)
  - Keeping staff engaged and productive over time
  - Competition in the market for staff

Leadership and Clinical Denials- Best Practices

Questions?