



Addressing complex commercial denials with a clinical perspective

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Not only do commercial denials represent costly time spent by both payers and providers correcting errors and addressing disagreements, but each denial represents a reduction in revenue badly needed to support the delivery of quality care. For many hospitals, revenue lost to denials isn't about a healthy profit margin; it's about survival. Reimbursement is declining, administrative costs are rising and the promise of future incentives won't support investments in clinical transformation needed today.

These financial pressures make it more important than ever for hospitals to be reimbursed correctly the first time — without the expense of managing multiple levels of appeal. Yet commercial denials are becoming an increasing problem for hospitals as payers deny cases upstream in search of ways to buoy their bottom line amid shifting regulations, expenses and expectations.

Successfully addressing the increasing flow of commercial denials requires that hospitals infuse their utilization review (UR) and denial management processes with a clinical perspective. When a broad range of clinical experience and knowledge is applied, the support for admission decisions is strengthened and hospitals can prevent cases from being denied initially. And when payers do issue denials, this clinical perspective can further strengthen arguments at all levels of the appeal process, including peer-to-peer reviews. Elevating the quality of pre- and post-denial activities can help hospitals gain control over their reimbursement and financial integrity.

Commercial pressures

The commercial denial landscape has undergone significant change in recent years. Some of the increase in commercial denials comes from the expected source: inpatient services. But a growing number of payers are turning their focus to outpatient denials as well. For years, outpatient status was seen as a "safe" admission status, an option that traded lower reimbursement for a reduced risk of denial. But with some commercial outpatient services — such as operating room services — being denied for medical necessity 31 percent of the time,¹ this safe status no longer exists. While outpatient denials represent less revenue than their inpatient counterparts, they are plentiful and can be more difficult to successfully appeal.

At the same time, appeals are becoming more difficult to win as payers increasingly build out the teams that issue and defend denials. Between 2015 and 2017, provider success rates for commercial denial appeals declined from 56 percent to 45 percent, a decline of 19.6 percent.²



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1. Williams J. Spotlight on denials: Bringing medical necessity denials under control. Revenue Cycle Insights. revenuecycleinsights.com/news/spotlight-denials-bringing-medical-necessity-denials-under-control. Published Jan. 27, 2016.

2. Advisory Board survey and technology data, 2017. Numbers shown are for 50th percentile median performance.

The nature of denials is changing, so properly measuring denial rates requires hospitals to revisit the very definition of a denial. In the past, denials would be returned in an 835 remittance data file after claims had already been submitted via an 837 claims file. Most appeal processes are built to reflect this kind of denial. But moving forward, commercial payers are pushing denials “upstream” by communicating them at the pre-authorization and pre-payment stages or issuing denials concurrently with patient hospital stays. Many providers don’t classify these payer actions as what they are: unofficial denials that modify the billed status to reduce overall reimbursement. Hospitals that don’t track these kinds of “invisible” denials can see their reimbursement decline with no apparent cause.

For each of these challenges, payers are operating according to established principles that are directed and purposeful. Yet this level of intention isn’t matched by providers who focus their UR efforts only on Medicare cases. Without hospitals replicating the same level of oversight to commercial cases, providers are turning full management of their patient populations over to payers. This can have serious consequences to commercial reimbursement.

Provider factors

Not all factors affecting a hospital’s commercial denials challenge are payer focused; some originate within the hospital itself. Traditional UR efforts typically review Medicare cases to comply with the Conditions of Participation and as a result of historical recovery auditor activity, but often don’t spend comparable resources and time conducting commercial reviews. That lack of attention, combined with the fact that only 35 percent of providers appeal denied claims,³ deepens the commercial denial challenge.

Gathering information to analyze a denial can cost between \$50 and \$100 per case, in addition to costs in time and resources.⁴ Hospitals incur this cost regardless of whether they win or lose an appeal. Thus, each appealable denial that can be avoided produces real cost savings on the administrative side.

Additionally, denied cases provide no immediate revenue to support patient care. Even with the best outcome — a complete overturn of the denial — denials cause avoidable payment delays that can be as long as six months or more. This best outcome is far from guaranteed, though. With uncertainty looming over the appeal process, hospitals must rely on projections of overturned reimbursement that can vary wildly from reality. Each appeal a hospital successfully prevents is a dual win: reimbursement added immediately to the bottom line and an administrative cost reduction.



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3. DiChiara J. Quantify denial rates for smooth revenue cycle management. RevCycle Intelligence. <http://revcycleintelligence.com/news/quantify-denial-rates-for-smooth-revenue-cycle-management>. Published March 30, 2015.

4. Pelaia H. Hospital denials management ... In-source, outsource or both? Human Arc. humanarc.com/wp-content/uploads/2013/06/HOSPITAL-DENIALS-WHITE-PAPER-by-Holly-Pelaia-2013-05.pdf. Published 2013.

Certain learned behaviors can also reduce reimbursement in ways that mimic denials. In some cases, as case managers grow accustomed to particular health plans consistently denying inpatient authorization requests, they stop submitting these cases as their utilization review appropriately indicates. While these “self denials” are intended to avoid what case managers perceive as an inevitable denial and an unnecessary burden on the appeals team, they create yet another invisible reduction to reimbursement.

Not all costs are monetary, though. Even in ideal situations, health plans will deny at least some claims, and each denial contains the potential to damage payer/provider relations. Affecting reimbursement and medical costs, medical necessity is a sensitive subject for both payers and providers and has a disproportionately high effect on the quality of relationships that are essential to successful long-term partnerships.⁵ Poor relationships between payers and providers can inhibit contract innovations such as value-based care agreements needed to help providers compete amid the emerging industry landscape. In extreme cases, a poor payer/provider relationship can lead to the removal of a hospital from a provider network, which disrupts patient care and can spawn media attention, both of which can lead to long-term damage to the stability of both parties.

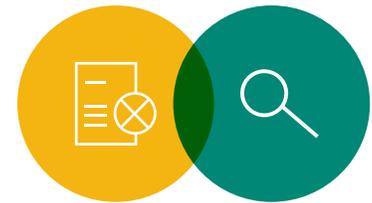
Denials occur for a variety of reasons. While some of them — such as duplicate claims or billing errors — are easily corrected once identified, others, including clinical denials, are more complicated. This latter set, including medical necessity and documentation denials, depends upon a clinical perspective for successful appeals.

Making a strong initial case: Commercial admission reviews

The most effective way to manage denials is to avoid them in the first place. Changes to the commercial denials challenge have made well-documented patient acuity and physician judgment more important than ever. Whether an inpatient claim is approved or denied by a health plan often depends upon the clarity of the documentation within the chart. Physician advisors can provide a clinical perspective to help hospitals identify the right admission status initially and to clearly document medical necessity for payer administrative and medical reviewers.

Most UR programs begin with a first-level review, during which case managers compare the case details against a criteria set, such as Milliman Care Guidelines or McKesson InterQual. That review will indicate that a case either passes or fails inpatient criteria. However, simply because a case fails first-level utilization review screening doesn't necessarily mean it should be outpatient. Did the documentation clearly point toward outpatient status, or was information missing? Payers may also use a different criteria set or apply the same criteria set differently than hospitals, resulting in denials. Likewise, with the attention of treating physicians focused squarely on patient care and not on documentation, medical records can lack vital information needed to identify the appropriate admission status. Because of this uncertainty, all cases that fail first-level screening should receive a second-level review.

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5. 2015 National Payor Survey, Catalyst Healthcare Research, May 2015.

A tiered commercial admission review process allows the UR team to continue processing those cases with clear first-level results, while sending the remainder to physician advisors for a second-level review. The added expertise of physician advisors reviewing these cases can help clarify the admission status to help secure the appropriate level of reimbursement — which can fluctuate by several thousand dollars between inpatient and outpatient — based on the medical necessity of the case.

Effective second-level reviews rely on consistency and a foundation based on medical evidence, features that can't be achieved solely through treating physician expertise. Decisions must be based on objective guidance from a variety of peer-reviewed sources and quality researchers — the evidence-based knowledge of an entire industry, not just a single physician. Physician advisors should also be able to easily reference this knowledge base, rather than requiring significant time to access. This foundation must also be kept relevant by constant curation, incorporating new research, guidance and standards as new medical evidence becomes available and medical practice evolves.

While sending every case that fails first-level screening for a second-level review is ideal, sometimes that option isn't feasible. Second-level reviews can be prioritized through the use of analytics that can reveal which payers are responsible for the majority of reimbursement and the types and quantity of denials received from each payer. When resources are limited, hospitals can use this data to prioritize case reviews based on the payers with the largest differential between inpatient and outpatient status and the largest revenue impact.

Last chance to prevent: Peer-to-peer reviews

Identifying the correct, billable patient admission status prior to patient discharge can mean the difference between a paid or denied case. However, hospitals can take advantage of this opportunity only if they fully leverage peer-to-peer discussions, an appeal step unique to commercial payers. During a peer-to-peer review, hospitals have the opportunity to speak to a payer medical director to quickly discuss the details of the case. In many cases, peer-to-peer discussions can resolve unclear aspects of a case that might otherwise result in a denial.

The success of these reviews traditionally relies upon involvement of the attending physician, which can be difficult to gain. In some cases, treating physicians may view any administrative work as a distraction from the mission of providing quality patient care. Faced with the choice of talking on the phone with a health plan medical director or treating a patient facing an emergency, the latter will always take precedence. As an added complication, attending physicians are frequently unaware of contract terms, definitions of inpatient and outpatient, and the UR process as a whole.

Fortunately, the same physician advisors who perform second-level reviews can represent hospitals during peer-to-peer reviews. The comprehensive decision-making methodology they apply to their second-level reviews provides a solid foundation for discussions with payer medical directors. As a result, physician advisors can more convincingly discuss the merits of a case at this last opportunity to avoid denials.

KEY FEATURES OF AN EFFECTIVE UR PROGRAM:



Medical necessity compliance expertise



Consistency and a foundation based on medical evidence



Review of all medical necessity claims



Analytics



Regular review of processes and standards

Peer-to-peer reviews give hospitals a chance to walk payers through case details instead of relying on health plan staff to correctly interpret the content of the medical record. Each case that succeeds at the peer-to-peer level represents improved revenue stability, lower administrative costs and fewer commercial denials, all of which would not be possible without the infusion of a clinical perspective that physician advisors can provide. By leveraging the clinical knowledge and expertise of physician advisors during peer-to-peer reviews, hospitals can transform this step from an ineffective and little-used option to a powerful resource to reduce denials.



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Crafting the strongest arguments for successful appeals

Despite the enhancements of having a clinical perspective reinforce your admission determinations and reducing denials at the peer-to-peer level, hospitals will still receive some denials. In some cases, hospitals and payers may interpret chart details differently or completely disagree about appropriate care, resulting in clinical denials. In order to maximize recovery, hospitals must support these cases with a clinical perspective after denial, just as they did beforehand.

When appealing, hospitals must argue why they believe their physicians' clinical judgment was appropriate. Simply restating the details of the case isn't sufficient to change the result. Clinicians can strengthen the appeal argument through the inclusion of commentary and medical knowledge relevant to the case. For coding and medical necessity denials, certified coding nurses and physicians, respectively, have unique professional experience that can provide context that supports the hospital's position. This context and familiarity with the industry can make the difference between a successful appeal and having to repeat the process again for another chance at the same reimbursement.



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Rather than being simply an administrative exercise necessary to complete an appeal, the crafting of the appeal letter is a highly technical exercise in clinical argumentation. While professional writers, appeal professionals and even regulatory experts may certainly be involved, the clinical perspective is essential to capturing the basis of the hospital's appeal. Consistently writing effective appeal letters depends upon deep evidence-based knowledge and expertise, a common pool of arguments, experience and research from which those involved with appeals can draw. For these reasons, the most effective clinical appeal letters will weave together successful and well-founded clinically based arguments from previous appeals, sound medical judgment and a firm understanding of the case details. This wider view allows clinicians to learn from previous experience — not only their own, but also that of as many appeal writing clinicians as possible to provide the widest pool of knowledge from which to draw.

Rather than being needed for every appeal, a clinical perspective can contribute to the kinds of appeals that need it the most, while still fitting in with a facility's end-to-end appeal solution. The clinical perspective can provide an additional layer of strength to some of the most challenging appeals to win.

Taking control of reimbursement

The escalating commercial denials challenge requires costly time to manage and threatens the reimbursement hospitals need to fund their operations. Tighter budgets and escalating expenses raise the urgency for hospitals to receive the correct reimbursement as quickly as possible by avoiding denials.

Applying a clinical perspective at critical points both before case submission and during appeal can help hospitals solve their commercial denials challenge. Through commercial admission reviews, peer-to-peer reviews and physician involvement in the appeal process, hospitals can defend their revenue integrity, reduce the length of time between service delivery and payment, and counter the trending increase in commercial denials.

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