Washington & West, LLC
Denial and Underpayment Recovery Experts

FRONT END DENIALS PREVENTION AND INTERVENTION

hfma

AAHAM
American Association of Healthcare Administrative Management
KEYSTONE CHAPTER

Regional Education Meeting AAHAM Keystone/ HFMA Philadelphia

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Discussion Objectives

- The Role of Patient Access in the prevention of administrative denials.
- Best Practice concepts for denial prevention and management.

Patient Access Goals

- Accurate verification of eligibility, benefits, and services authorized;
- Reduce denials and administrative burden of rebilling claims/appeals;
- Increase collection of patient responsibility; and
- Identify services that might result in *zero* payment prior to being rendered.

Patient Access Challenges

Cause

1. Accurate patient data not captured by scheduling or registration prior to the visit.
2. Staff members uncomfortable communicating patient financial obligation.
3. Inconsistent policies and procedures for registration and breaks in communication in departments.

Effect

1. Likelihood of clean claim decreases.
2. Longer patient wait times, decreased patient satisfaction.
3. Missed revenue opportunities, team not operating at best practice level.

Example:

Based on Kevin's email below, there is nothing I can do about this issue. We should cancel her future IVIG.

I have voiced my concern about this matter on multiple occasions in the past – with the current process, there are patients who get the treatment without having the PA approved by their insurance companies because the scheduling for service and PA are done by two teams, and the scheduling team and PA team don't update each other. The outcome seen in this pt is not the first. When a bad outcome like this occurred in the past, somehow the provider was always held responsible.

Thanks

Patient Access Solutions

- Leadership and employee education on the importance of accurate data collection and insurer requirements.
- Consistent processes across all patient access areas for insurance verification, determination of patient financial responsibilities and point of service collections.
- Push for insurers to standardize practices and make requirements clear/easily accessible.

Administrative Denials – Some Top Reasons

- Lack of Preauthorization/ Authorization
- The claim was filed late
- The Patient Didn't acquire a Referral from a Physician
- You Ran Out of Authorized Sessions
- The Authorization Expired
- The Patient Changed His or Her Insurance Plan
- The Patient's Out-of-network Benefits Differ from In-network Benefits
- The Service was Already Rendered
- The Patient has an Out-of-State Insurance Plan
- Patient's coverage lapsed
- Claim sent to the wrong administrator
- Services Were Rendered at the Wrong Location

According to a study completed by the AMA, “The current prior authorization process is extremely burdensome.”

The AMA’s report had the following findings:

- Preference for an automated prior authorization process.
- Vague prior authorization requirements.
- Long wait times with prior authorization requests.
- Difficulty obtaining approval of prior authorization requests.
- 20 percent of first-time prior authorization requests are rejected by the payers.
- Physician practices need to appeal 80 percent of payer rejections of first-time prior authorization requests.

Documentation is the key to effectively preventing and fighting denials.

Is this Clear Documentation?

"NO P REQ"

- Referring to prior auth?
- Was it not requested? Or not Required?

If I Knew Then What I Know Now…

- The information that is obtained during the admitting process is crucial to prevent and fight denials!
- Almost all technical denials can be challenged:
  - Facts
  - State and federal laws
  - Contract provisions
- Registration and Admitting staff should have access to key contract provisions and laws:
  - Prevention of denials
  - Obtain critical facts

Insurance Verification Process

- Just asking the right questions can prevent denials.
  - Verify eligibility and plan type and elicit information that is not routinely provided:
    - Specific policy exclusions
    - Pre-existing conditions
  - Opportunity to correct potential benefit problems:
    - Early registration
    - Lapses in coverage during admission/patient involvement
    - Has the patient paid their premium?

Example:

Type	Date	User
Referral Documentation Notes	03/22/2017 11:59 AM	[redacted]

Note

Note

PLACED CALL TO VT BCBS @ 800-924-3494; SPOKE WITH [redacted]

[redacted] IS CURRENTLY IN A GRACE PERIOD WITH HER INSURANCE FOR PAYMENT AND EXPRESS SCRIPTS WILL NOT BE ABLE TO INITIATE AN AUTHORIZATION FOR ENTYVIO UNTIL HER ACCOUNT IS CURRENT.

REF #[redacted]

Verify authorization prior to performing services!

- Is authorization needed for this particular service under this patient's plan?
  - Check provider website/portal and/or call to verify.
  - Even if authorization wasn't required prior, make sure nothing has changed! (ex. drugs added HCPCS code book)

If authorization was obtained:

- Does it cover this particular service?
- Is it for this date?
- Is it still valid?
  - Has it been used already?
  - Number of units and effective date?

Example:

AUTH STATUS: APPROVED - AUTH ON FILE
Insurance Verified: VT BCBS
Insurance Effective To/From Dates: 11/01/2016-CURRENT
Third Party Vendor: EXPRESS SCRIPTS
Authorization Number: [redacted]
Validity Dates: 02/28/2017 - 02/28/2018
CPT/J-Code(s): J3380
Description of Procedure: TC VEDOLIZUMAB, 1MG, INJECTION
How Many Units: 300 EVERY 4 WEEKS
Call Reference Number:
Spoke With: [redacted]
Phone Number: 800-[redacted]

Commercial vs. Medicare
Less work on the front end?

- Still need to verify benefits!
  - Does the patient have Part A and/or Part B benefits?
  - Confirm the patient has not enrolled in Part C (MAO)
  - Hospice election?
  - MSP Questionnaire

- No authorization needed for Medicare services* UNLESS Medicare Advantage Plan.
  - Requirements are plan specific
  - Contracted vs. Non-Contracted

What documentation will be needed for this service?

If the patient is being pre-registered, can we tell them what to bring with them?

Even if you've done everything right…denials happen!

Denial #1
What does this really mean?

55	**Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

The service must have been experimental, right?

This patient was admitted through the ED and had an appendectomy.

- Authorization was requested at the time of admission and was granted.
- The authorization was later denied, after clinical information was submitted. The plan indicated that the patient could have been treated at a lower level of care.
- This was not an experimental service!

Denial #2
What does this mean?

MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.

BASED ON THE FINDINGS OF PAST CLAIM REVIEWS, NOVITAS SOLUTIONS, INC. HAS IMPLEMENTED A PREPAY PROCEDURE-SPECIFIC REVIEW TO ENSURE THAT WE PAY FOR SERVICES THAT ARE COVERED, MEDICALLY NECESSARY, AND CORRECTLY CODED FOR DRG 470.

WE ARE REQUESTING THE FOLLOWING DOCUMENTATION OF SERVICES RENDERED:

1. PLEASE SUBMIT A MANDATORY ADVANCED BENEFICIARY NOTICE (ABN) IF ISSUED.
2. ADMISSION AND DISCHARGE SUMMARY
3. PHYSICIAN ORDERS
4. HISTORY AND PHYSICAL INCLUDING DOCUMENTATION TO SUPPORT THE DIAGNOSIS BILLED
5. ALL PROGRESS NOTES INCLUDING PHYSICIAN, NURSE, AND OTHER MULTI-DISCIPLINES
6. PRE-OPERATIVE PROGRESS NOTES THAT SUPPORT THE MEDICAL NECESSITY OF THE PROCEDURE, INCLUDING CONVENTIONAL THERAPY ATTEMPTED AS PRE-SURGICAL INTERVENTIONS OR CLINICAL EXPLANATION OF WHY CONVENTIONAL PRE-SURGICAL THERAPY WAS NOT DONE OR TOLERATED (E.G., X-RAY REPORT, NSAID THERAPY, PT, OT, EXTERNAL JOINT SUPPORT UTILIZATION).
7. ALL TEST RESULTS INCLUDING PRE-ADMISSION TESTING TO SUPPORT ADMISSION
8. THERAPY TREATMENT LOGS AND TREATMENT NOTES
9. DESCRIPTION OF PAIN SYMPTOMS (HOW PAIN AFFECTS ADLS, WEIGHT BEARING, RANGE OF MOTION, ETC).
10. MEDICATION LOGS
11. EMERGENCY ROOM RECORDS (IF APPLICABLE)
12. OPERATIVE /PROCEDURE REPORTS
13 CONSULT REPORTS
14. DISCHARGE ASSESSMENT/PLAN
15 DOCUMENTATION TO SUPPORT ALL SERVICES BILLED.
16. ITEMIZED BILL

Denial #2
Could this have been prevented?

- The patient was admitted for a scheduled, elective Total Knee Replacement.
- DRG 470 has consistently been targeted for pre-payment review.
- Medicare requires that certain documentation be present in the record to show that the procedure was medically necessary.
  - If the pre-operative documentation to show that the surgery was reasonable and necessary is not present, the entire hospital stay may be denied.

Denial #2
How could this have been prevented?

- What duty does YOUR Patient Access or UM have to collect documentation from external providers?

- Best practices would involve coordination between the orthopedic surgeon's office and the facility so that the documentation is provided at the time of registration.
  - Checklist of documentation requirements.
  - Packet must be submitted at the time of registration or the surgery should not be put on the schedule.

- Notify the patient during pre-registration that they can/should bring any and all documentation related to the procedure when they arrive.

Denial #3
Could this denial have been prevented?

HC 23472	LT	0360		3,769.09	0.00	0.00	0.00	0.00	CO-151	3,769.09	N362

151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

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Denial #3
How could this denial have been prevented?

- CPT Code 23472: Total Shoulder Arthroplasty
- This was an Inpatient-Only Procedure billed on an outpatient claim.
- This was an elective, scheduled procedure.
- The patient was pre-registered for the surgery.
- The facility could have an electronic “hard stop” instituted for certain surgical codes that are on the inpatient-only list. This would trigger the patient access department to pre-register the patient as an inpatient.

Can we argue this denial?

Appeal!

- It is very important to understand the appeals process for the denied claim/service.
- Can vary significantly by provider and plan type!
  - One level vs. Two level
    - Is there a reconsideration process
    - Verbal vs. Written
  - Right to external appeal?
  - Formal vs. Informal?

Appeals should include:

- Documentation of telephone conversations:
  - Name, phone #, and department of the person providing benefits and/or authorization
  - Call reference numbers
  - Authorization reference numbers
- If a procedure was not complied with, explain **the reason for the non-compliance**
- Applicable contract and/or provider manual terms
- Applicable laws

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Appeals- A Few Common Issues

ISSUE	SOLUTION
1. Untimely submission	• Matrix of appeal timeframes • Understand notice requirements
2. Submitted to incorrect address/ entity	• Know who is issuing the denial • Know type of plan • Make a call
3. Missing information	• Always include medical records • Denials team within organization

What's in Your Appeal Toolbox?

Sample Timeframe Matrix

Insurer	Claim Submission	Reconsideration	First Level	External
Aetna	Varies based on type of plan	180 days from denial	60 days from denial of reconsideration	120 days from final adverse determination
UHC	180 days from date of service	365 days from denial	365 days from denial	
Cigna	In network-90 days from date of service Out of network-180 days from date of service	n/a	180 days from denial	120 days from final adverse determination

Important Contract/ Provider Manual Provisions

- Authorization/Notification requirements?
  - Weekends and holidays?
  - Calendar days vs. business days?
- Notice requirements?
- Retrospective review requirements?

Pointing out the insurer's violation of the contract can help overcome denials

Sample of Best Practice Contract Language (Wouldn't this be nice?!)

In the event that the lack of authorization can reasonably be shown to have resulted from an action or inaction by Hospital, and Insurer determines the services to be Medically Necessary, then **Insurer shall reimburse Hospital for all Medically Necessary Covered Services rendered to the Member.**

There are federal and state laws on the following denial management topics:

- Authorization
  - Modification of authorization, delivery/newborn, emergency services
- Claims submission timeframe
- Prompt payment
  - Definition of clean claim, interest penalty
- Misverification of benefits
- Internal/External Appeals
- Retroactive denials/Retractions
- Pre-existing conditions
- Emergency Services
  - State law definition, EMTALA
- Continuation of Benefits
- ERISA
- Coordination of benefits
- Automatic newborn coverage

State vs. Federal Law - Which generally applies?

Type of Plan	Controlling Law
Fully insured (Insurance)	State
Self-funded (Claims paid by employer group)	Federal
Medicaid	State
Medicare	Federal
Medicare Advantage	Federal

Just a few Pennsylvania insurance laws that might give you PAWS?

Purdon's Pennsylvania Statutes and Consolidated Statutes Title 40 P.S.-Insurance

- 40 P.S. § 991.2166 - Prompt payment of claims
- A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

If a licensed insurer or a managed care plan fails to remit the payment within 45 days, interest at ten percent (10%) per annum shall be added to the amount owed on the clean claim.

Purdon's Pennsylvania Statutes and Consolidated Statutes 40 Pa.C.S.A. § 3803 – Retroactive Denial of Reimbursement

Chapter 38. § 3803 With limited exceptions, an insurer may not retroactively deny reimbursement as a result of an overpayment determination more than 24 months after the date the insurer initially paid the health care provider.

- Carriers can only retroactively deny reimbursement due to COB or fraud.
- If an insurer retroactively denies reimbursement for services as a result of COB, the health care provider shall have 12 months from the date of the denial, unless the entity responsible for payment permits a longer time period, to submit a claim for reimbursement for the service.

Purdon's Pennsylvania Statutes and Consolidated Statutes Title 40 P.S. Insurance - *Emergency Medical Services*

- 40 P.S. § 991.2116; 40 P.S § 3042
- Emergency Services: Any health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

Emergency Services

- Do not require authorization
- Are furnished regardless of in network or out of network status

Legal theories that may also be useful:

- Misrepresentation
- Detrimental reliance

"But for" or without the affirmative action on the part of the insurer, the provider would not have provided the medically necessary services.

Example 1

General Hospital rendered medically necessary inpatient services to John Doe. Authorization was obtained. The hospital timely submitted a claim to Insurer.

Insurance denied the claim on the basis that John Doe was not eligible for benefits during the date of service.

What is your best argument?

- Were benefits/eligibility verified?
  - Name, phone#, and department of the representative that verified benefits, or a printout of the benefits from the plan's website
  - The benefits that were quoted
  - The effective date of the patient's policy

- State Law or Legal Theories
  - Detrimental Reliance
  - Misrepresentation

- Any applicable contract terms

Example 2

St. Elsewhere Hospital rendered medically necessary inpatient services to Jane Doe. A claim is timely submitted to ABC Insurance. ABC denied the claim for lack of authorization/notification.

What is your best argument?

- Did ABC provide authorization?
  - Provide documentation of any telephone conversations or a copy of the electronic authorization
- Contract/ provider manual terms
  - Required or discretionary retrospective review?
- Applicable law
  - Did the plan do what they are supposed to do?
- Emergency services?

In summary: The Patient Access Department is the key to an optimal revenue stream.

- Ensure accurate data gathering at the time of registration.
  - Plan information-eligibility, coverage and benefit limitations.
  - Authorization-active, valid auth for the services ordered.
  - Thorough documentation will help with the appeals process.
- Decrease the incidences of denials by effective pre-screening.
  - Identify services that may be non-covered prior to them being rendered.
  - Identify services that require additional documentation development.
- Increase the rate of clean claims.

The best defense is a good offense.

A successful patient access process will

ensure that the facility has the funding it needs to carry out

high quality clinical care.

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Thank You For Your Attention!
Questions? Comments?

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Heather Holgate is an attorney and member of the legal team at Washington & West, LLC. Ms. Holgate assists and counsels hospitals, health systems, and other health care providers in disputes with commercial insurance carriers, government payers, and managed care organizations. Ms. Holgate focuses her work on resolving denied and underpaid facility claims through the administrative appeals process. Her areas of focus include a variety of commercial payers as well as government payers (TRICARE, Medicare, Medicaid, Veteran's Affairs).

Prior to joining Washington & West, LLC., Ms. Holgate represented clients at a Baltimore based firm focusing on the areas of Medicaid eligibility, Social Security Disability, and Veterans Benefits. She also volunteered with local programs providing legal advice and representation to homeless Veterans.

Ms. Holgate graduated from Rutgers University with a B.A before receiving her J.D. from Duquesne University. While in law school, she gained practical experience through the Civil Rights Clinic and an externship with the Hon. Donetta Ambrose in the US District Court for the Western District of Pennsylvania. She is admitted to practice in Maryland, the District of Columbia, and before the Board of Veterans Appeals.

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