Bringing **better** to the bedside.

Working with Payers for Effective Denial Management and Decreasing Denials Upfront

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Today's Presenters

Melissa Buchner-Mehling, MD, CHCQM, CPHYADV, FABQAURP

- Associate Chief Medical Officer, Sound Advisory
- She finished Internal Medicine Residency and began practicing as a hospitalist in 2004. As an attending hospitalist she was actively involved with many committees in the hospital, including the Patient Safety Indicator Committee, Ethics Committee, Utilization Management Committee, Readmissions Committee, and Throughput Committee. She also was the hospital ICD10 Physician Champion and CDI Physician Champion. As a hospitalist she has volunteered for medical mission trips in Honduras and Kenya. Since her first days with Sound as a Medical Director of Advisory Services, Dr. Buchner-Mehling has found innovative ways to educate providers at the hospital. She is now the Associate Chief Medical Officer with Sound Advisory Services.

Erin Boyd, MD, MBA, CHCQM, FABQAURP, ACPA-C

- Associate Chief Medical Officer, Sound Advisory
- She initially began her training in psychiatry after which she shifted her attention to full time internal medicine hospitalist work and then physician advising. Prior to joining Sound in 2019, she served as hospitalist medical director for a large hospitalist group, led the hospital utilization committee, palliative care committee, and worked collaboratively with several independent review organizations to help facilitate appeal of payor denials for numerous hospital systems. She continues to perform ongoing concurrent reviews, P2Ps, and appeals for Sound Advisory while in her Associate CMO role and enjoys physician mentorship, leadership development, and bridging clinical and non-clinical leaders. Outside of work, she is actively involved in dog rescue, running, and hiking.

Disclaimer Statement

We have no real or perceived conflicts of interest that relate to this presentation

OUR VALUES

01

UNCOMPROMISING CARE

We don’t cut corners.

02

ACCOUNTABILITY

Commitment, not lip service.

03

COLLABORATION

We’re in it together. No silos.

04

EMPATHY

People aren’t numbers.

05

INGENUITY

Care by design, not by default.

SOUND PHYSICIANS

Objectives

Learn how insurers audit charts and exactly how to make minor contract changes to prevent audits and denials in the future.

List medical necessity definitions (publicly published by payers and other definitions).

Utilization of denial data to make meaningful changes in hospital processes to prevent future denials.

Discuss the anatomy of an appeal letter and DRG dispute.

Improve provider documentation.

Background

PAYERS

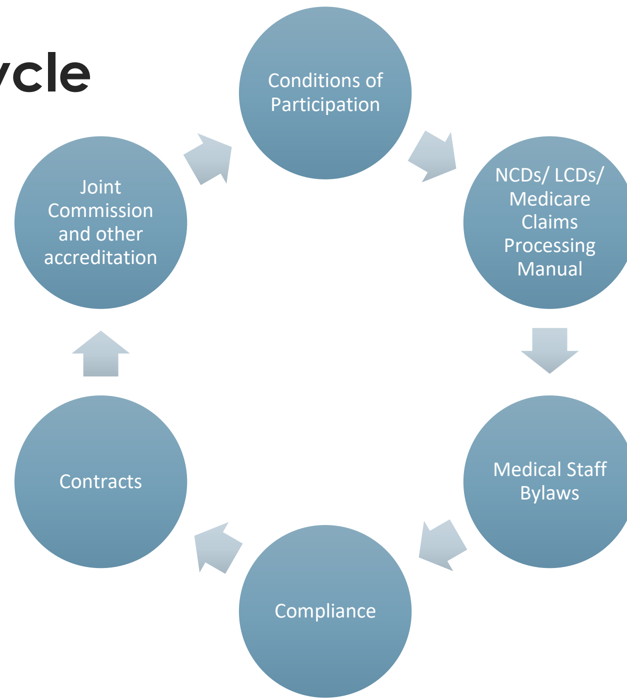
Regulatory Payer

- Traditional Medicare
- No concurrent authorization during hospital stay
- No P2P process
- Regulatory Audits

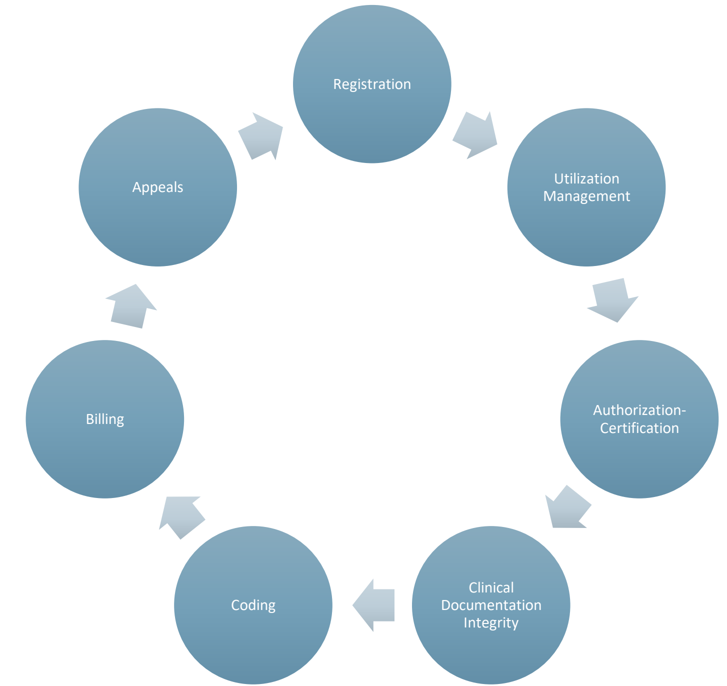
Contractual Payers

- Commercial insurance companies
- Most require timely notification of inpatient stay and provide concurrent authorization
- P2P process for most

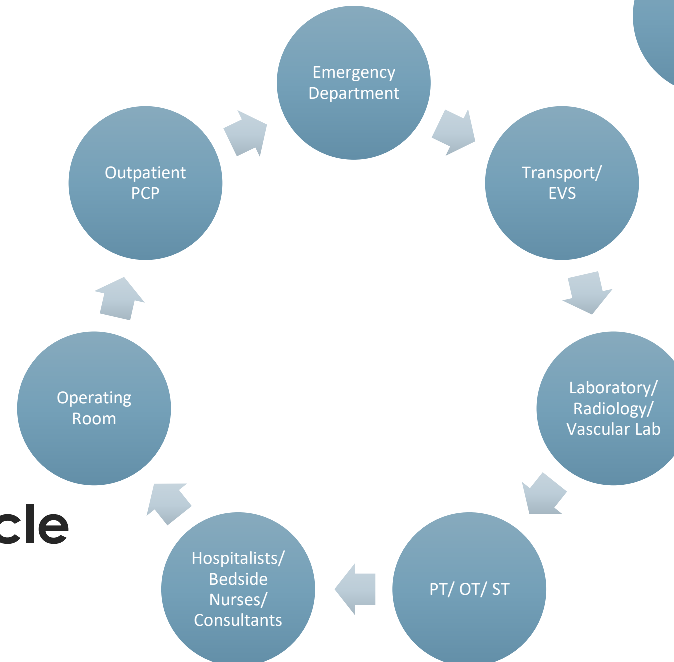
The Rules/ Regulation Cycle



The Revenue Cycle



Each department (within each cycle) in the hospital affects hospital revenue and often affect each other.



The Patient Care Cycle

What is a Denial?

Any situation in which payment is less than that which was contractually agreed upon for the services delivered:

- Complete
- Downgrade
  - Inpatient to Observation
  - ICU to Acute
  - DRG downgrade
- Carve Out

What kind of a Denial is it?

It is important to track all denials meaningfully so you can improve workflows going forward. Each department should be made aware of their denials and should be a part of a workgroup to improve the processes (or appeal).

- Administrative
- Billing Error
- Experimental/ Investigational
- Medical Necessity
- Not Medically Indicated
- Post-Acute (SNF, IRF, LTAC)
- Procedures, Medications, Level of Care, etc.
- Non-Covered Service
- No pre-authorization/certification
- Out-of-time filing
- Readmission Bridging
- Wrong provider or out-of-network

How insurers audit charts and exactly how to make minor contract changes to prevent audits and denials in the future

(including how insurers define medical necessity)

Payers Have Three Rules for Determining Status

Depends on the payer…but common element is the **quality** of the physician's documentation

Two-Midnight Rule

- Applies to **both Traditional and Advantage Medicare** patients

MCG Care Guidelines

- Requires subscription to software
- Used by about half of the commercial insurers

InterQual Criteria

- Requires subscription to software
- Usually employed as a first pass by nurse case managers

Denial for Concurrent Authorization

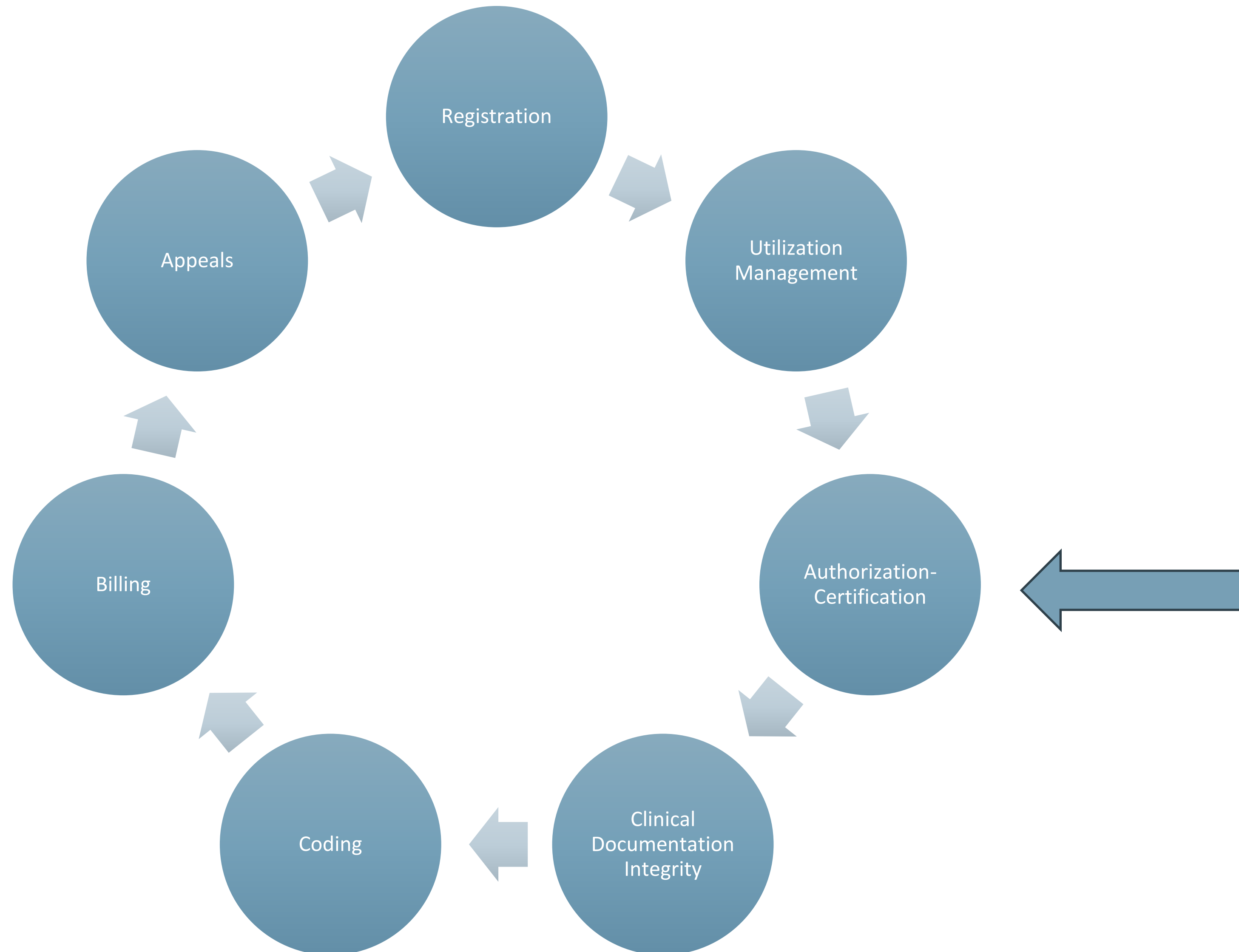
When a patient first comes into the hospital the insurer is notified of the admission and the hospital requests concurrent authorization for the inpatient hospital stay.

The payers' contract with the hospital generally states that the hospital will follow all the payer's published policies. The payer publishes how they review for inpatient medical necessity:

- Humana: MCG
- Molina: MCG
- Aetna: MCG
- Anthem/Elevance: MCG
- Cigna: MCG
- UHC: InterQual (UHC owns Optum and InterQual)
- Ambetter: InterQual
- Wellcare: InterQual
- Select Health: InterQual
- Veteran's Affairs: InterQual

If you don't want to follow the payer's policy, just make sure your policy for determining medical necessity is put into the contract (InterQual, MCG, Xsolis score, etc.)

Revenue Cycle



The hospital contacts the insurance company and requests **concurrent authorization** for an inpatient hospital stay when a patient is admitted as an inpatient to the hospital.

If this concurrent authorization is denied, you may be offered a **peer-to-peer** with the insurance medical director.

Concurrent Authorization Denials Summary

Track your concurrent authorization denials and P2Ps

Insurance company doing denial (breakdown so you can see what insurer is doing high percentage of denials in comparison to volume of total admissions with that insurer)

Decide if you are going to accept the observation payment (if you got it wrong up front) or continue the appeal process (insurer was wrong)

Make sure you can bill observation services from the initial time of admission even without an observation order (contractual insurance policy—can NOT for Traditional Medicare).

Give feedback/education so processes can improve

Can you rebill if inpatient claim is denied

Traditional Medicare

- Cannot bill observation APC as no observation order in place
- Can bill ancillary outpatient charges under Part B
  - This is a TOB 12x
  - This is where Billing will add condition code W2 (self denial of inpatient admission)
  - More information at: MLN Matters SE 1333
- This is different than a CC44 where you convert to observation during the hospital stay and CAN be paid for an observation APC as long as you accumulate at least 8 hours of observation services. A CC44 is a TOB 13x

Medicare Advantage & Commercial

- Managed Care Manual by CMS allows this to be a contractual issue
- Most contractual payers are updating their policies to state that you can NOT bill observation without an order, but you could bill just ancillary outpatient charges
- Consider getting into your contract that you can bill Observation services if inpatient is denied where possible

Rebill without Obs order? (Previously we could. Now, not so much!)

Anthem allows reimbursement for observation services when ordered by a physician or other individual authorized by state licensure law and facility staff bylaws to admit members to the hospital or order outpatient tests unless provider, state, federal, or contracts and/or requirements indicate otherwise. The member's medical record documentation for observation services must include a written order that clearly states, "admit to observation"

Humana. **Claims Payment Policy**

When an acute care hospital determines before discharge that the patient should not have been admitted as an inpatient, Humana will only accept services submitted on an appropriate outpatient type of bill (TOB) 13x or 85x claim; and will allow the provider to submit all codes that, for a normal outpatient situation, could be appropriate for that TOB; and requires condition code 44. An inpatient claim should not be submitted. When an acute care hospital or Humana determines after discharge that the patient should not have been admitted as an inpatient, Humana will only accept services submitted on an inpatient Part B TOB 12x claim.

DRG Revisions

DRG revisions: an insurance company reviews a chart and determines:

That a diagnosis that was coded out was not present (clinical validation)

OR

That a diagnosis was clinically present although not coded out correctly

OR

Changes what the principal diagnosis was (the main reason the patient came into the hospital) or DRG based on removal of secondary diagnosis

Two main types

Clinical Validation

Verifies the codes billed are supported in the medical record (must be documented by a clinician)

Coding

Verifies that all coding rules and regulations were followed correctly

Utilize denial data to make meaningful changes to hospital processes to prevent future denials

Tracking!

- **List the reason for the disputes and denials:** You can't fix what you don't know is wrong.
  - For clinical validation: track ICD10 code being denied
  - For coding issue: track DRG and reason for dispute (principal diagnosis dispute, secondary diagnosis, specific coding rule)
  - Track the SOI/ROM change if any

- **Give this feedback to all frontline teams** including CDI and hospitalists for the clinical validation disputes: this will help them improve their documentation.

- **Give this feedback to the coding team** for coding disputes to help them improve assigning the principal diagnosis and when a condition meets the definition of a secondary diagnosis.

- **Give this information to the contracting team** to address these issues during the next round of contracting (insurance companies cannot decide how to define a disease). May also want to take to Med Staff to help come to "consensus definition" of certain diagnoses to help with documentation.

Let Contracting Know

- They may have At Risk metrics in the contract.
- At Risk Metrics often include risk adjustments
  - Sicker patients (higher SOI/ROM) have a higher "expected" readmission rate, mortality rate, complication rate, etc.
  - Sometimes insurance companies do DRG revisions that only affect the SOI/ROM, but the payment remains the same (same DRG) so hospitals many not appeal these aggressively even though there is a "hidden" financial impact.
  - Ask for clinical involvement in contracting with insurers!!
  - Contract should be not only financially sound but clinically feasible
- Encourage specificity in contracts! "Hospital agrees to follow all payor published policies" could be seen as carte blanche to publish anything any time on their website and insist you follow. Need specificity! Clarify in contract that treatment "and diagnosis" decisions are deferred to the treating professionals/hospitals (most health plans defer responsibility for treatment decisions to the treating professionals/ hospitals—add to your contract "and diagnosis" to prevent DRG disputes)

Contracting Opportunities

Clearly define types of denials permissible

- Contract addendums needed to add denial types with definition
- Prevent “renaming” of denials (“short stay” audits, “claim disputes” etc.)
- Example:

Commercial Products (including Tufts Health Direct)
Effective for dates of service on or after January 1, 2025, any request for a short stay inpatient admission (48 hours or less) will be categorized as an observation stay rather than inpatient level of care. Providers will receive an administrative denial of the inpatient notification.

Put it in the contract that MA payors must follow the 2 MN rule

Allow physician advisors to speak with insurer medical director for P2Ps

Readmission policies: time frames, exclusions

Denial/Audit Prevention: Contracting opportunities

Insist that contractual payers follow Coding Clinics and Coding Guidelines (Medicare rules for DRG disputes) and cannot use any other specific definition of diagnosis

- Example: Cannot deny sepsis if patient meets sepsis 2 definition but does not meet sepsis 3 definition.
- Ensure that third parties doing DRG audits for insurer follow insurer-hospital contract

Limit time frame when cases can be re-opened for denials

Insist if concurrent auth is given for inpatient status that no further reviews for status will be done

Time frames for post-acute approvals

Consequences for payor if deadlines not met

Anatomy of an appeal letter and a DRG dispute

Example of Pneumonia Medical Necessity Denial Letter from Insurance Company

Why did we deny your request?

We denied the medical services/items listed above because:

Based on Medicare guidelines, the request for your hospital stay to be covered at an inpatient level of care does not meet the requirements for approval. Your hospital stay may be covered at an observation level of care. You can be in the hospital under an observation or inpatient stay. The observation stay can be in different areas of the hospital and may be overnight or longer. An inpatient stay must be medically necessary according to Medicare rules.

We reviewed your records and they show you were admitted to the hospital with a fever. You had blood tests. You had pictures taken of your lungs. You were given medicine in your vein. You were given fluid in your vein.

In order for your hospital stay to be covered at an inpatient level of care, you would need to have such things as:

- Abnormal blood pressure or heartbeats that do not get better with treatment (hemodynamic instability)
- An infection in the bloodstream (bacteremia)
- A very low level of oxygen in your blood (hypoxemia) that is new or worse than usual for you
- Evidence of severe organ damage (end organ dysfunction) not better with treatment

Your records do not show an infection in the bloodstream (bacteremia). If you have not been discharged from the hospital, then we may be able to approve hospital observation services. You can discuss this letter with your provider.

Under Medicare, the request for an inpatient level of care is not medically necessary. This decision was based on:

- Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, Section 10 - Covered Inpatient Hospital Services Covered Under Part A
- MCG care guidelines, 26th Edition–Sepsis and Other Febrile Illness, without Focal Infection ORG: M-160 (ISC)

Since the service your doctor asked for is not medically necessary under your Humana plan, the providers in your plan's network, such as doctors and hospitals, understand that they can't ask you to pay for those services and they can't take any action against you.

You will only have to pay any coinsurance, copayment or deductible due. You will also have to pay for services or items normally not covered by your Humana plan.

Anatomy of a Medical Necessity Appeal Letter

Clinical Summary

Begin with a synopsis of the patient's presentation.

Summarize the presentation, relevant positive findings from Vitals, Physical Examination, Labs, Imaging, and Initial Interventions done. Document the admission diagnoses. Document relevant acute findings or changes that occur daily until discharge.

Justification for Appeal

Provide a cohesive and convincing rationale for why INPATIENT care was warranted.

Summarize the overall case with key pertinent findings. Document score or criteria calculations (PSI, CURB-65, SOFA, etc.). Reference the specific guidelines the insurance company used to deny the case (MCG or InterQual). Reference Medicare rules, if appropriate. Mention any contractual language if present.

Conclusion

Standard Template.

States that INPATIENT status was appropriate for the hospitalization. Restates the key diagnoses. Ends with a request for reconsideration of the denial.

Example of Clinical Summary

Member: ***
DOB: ***
Member ID: ***
Auth ID: ***
Admit: 11/3/2024 Discharge: 11/5/2024
Hospital: ***

To whom it may concern:

Please accept this letter as an appeal for inpatient level of care reimbursement. **Patient Name** was admitted to **Hospital Name** during the above referenced dates. The admission was denied, alleging a lack of medical necessity for inpatient level of care.

Clinical Summary
Patient Name is an **-year-old female with complex comorbidities, including colon cancer with bowel resection, atrial fibrillation (managed with aspirin due to prior GI bleeds), hypertension, permanent pacemaker, cardiovascular disease, anemia, chronic obstructive pulmonary disease (COPD), vertebral compression fractures, and recurrent falls.

- **November 3, 2024:** **Patient Name** presented to the Emergency Department with a two-week history of worsening nausea, vomiting, diarrhea, inability to tolerate oral intake, and generalized weakness.
  - On arrival, she was hemodynamically unstable with hypotension (84/71), tachycardia (151 bpm), and tachypnea (31 breaths/min), **meeting two components of the *qSOFA* score (tachypnea and hypotension), placing her at high risk for in-hospital mortality.**
  - Pertinent findings included leukocytosis (10.72), hypokalemia (2.9), hypomagnesemia (1.4), and urinalysis consistent with acute UTI. Imaging revealed new fractures at L4, L5, and bilateral inferior pubic rami.
  - She received IV Zofran, IV Pepcid, a 1L fluid bolus, IV metoprolol, and IV potassium.

- **November 4, 2024:** **Patient Name** remained hypotensive (95/79), tachycardic (up to 172 bpm), and tachypneic (22 breaths/min).
  - She required multiple IV interventions, including fluids, potassium (x3), magnesium, digoxin, Cardizem, and antibiotics.
  - Elevated procalcitonin levels supported a diagnosis of urosepsis. Urine cultures were ordered.
  - Cardiology documented her history of GI bleeding and falls, precluding anticoagulation therapy and delaying evaluation for a Watchman device.

- **November 5, 2024:** **Patient Name** continued to require IV antibiotics and fluids for sepsis management.
  - Telemetry overnight documented a six-beat run of ventricular tachycardia.
  - Final urine cultures confirmed *Klebsiella pneumoniae* >100,000 CFU, resistant to ampicillin, necessitating ongoing close monitoring and treatment.

Example of Justification for Appeal

<u>**Justification for Appeal**</u>

Compliance with CMS Two-Midnight Rule

Per CMS guidelines, inpatient admission is appropriate when the expected hospital stay spans at least two midnights, supported by medical necessity. **Patient Name** condition clearly met these criteria due to:

- **Hemodynamic instability:** Hypotension (84/71) and tachycardia (151 bpm) requiring IV fluids, electrolyte replacement, and cardiac monitoring.
- **Laboratory abnormalities:** Leukocytosis, hypokalemia, hypomagnesemia, and elevated procalcitonin, consistent with sepsis.
- **Sepsis management:** Intravenous antibiotics initiated for urosepsis, later confirmed by urine culture.
- **Cardiac complications:** Persistent arrhythmias, including atrial fibrillation with rapid ventricular response and 6 beat run of ventricular tachycardia, requiring IV Cardizem, IV digoxin, and continuous monitoring.
- **qSOFA Score:** A score of **2** on presentation (hypotension and tachypnea), identifying her as high risk for in-hospital mortality per the *qSOFA* criteria, underscoring the critical nature of her condition.

These factors necessitated an anticipated stay exceeding two midnights to stabilize her condition.

Meeting InterQual Criteria for Inpatient Admission

Patient Name met multiple InterQual Acute Medical Adult criteria, including:

1. **Hemodynamic instability:** Persistent hypotension (95/79) despite fluid resuscitation.
2. **Severe tachycardia:** Up to 172 bpm, requiring IV medications for rate control.
3. **Infectious process requiring treatment:** Urosepsis confirmed with urine culture positive with *Klebsiella pneumoniae* with antibiotic resistance.
4. **Cardiac monitoring:** For arrhythmias, including nonsustained ventricular tachycardia and atrial fibrillation with rapid ventricular response.

Example of Conclusion

<u>**Conclusion**</u>

In conclusion, these factors necessitated inpatient care to stabilize her condition, mitigate **Patient Name** risk for further complications, and manage her multifactorial presentation. **Patient Name** admission required intensive inpatient-level care, including:

- **IV fluids** for persistent hypotension and dehydration.
- **IV cardiac medications** for atrial fibrillation with rapid ventricular response.
- **IV electrolyte replacement** for critical hypokalemia and hypomagnesemia.
- **IV antibiotics** for confirmed urosepsis caused by *Klebsiella pneumoniae.*

Her advanced age, significant comorbidities, and a *qSOFA* score of **2**, indicating high mortality risk, made inpatient care imperative to prevent life-threatening complications. We respectfully request reconsideration of the denial and approval of inpatient reimbursement for the referenced dates.

If the decision to deny this appeal is upheld, we request a detailed explanation citing the specific criteria from **InterQual** or **Medicare Benefit Policy Manual** that **Patient Name** case allegedly failed to meet.

Thank you for your time and attention to this matter.

Template for Dispute Letter

First Paragraph

Begin with a synopsis of the patient's presentation.

Summarize the specific diagnosis being denied, quote every provider note that documented that diagnosis and all treatment/ workup/ care the patient received for that diagnosis only (include nutrition consult, home medication continued, any consultants seen).

Second Paragraph

Address any specific details that are wrong in the DRG revision letter.

If patient did have SOFA score >=2--you will have to calculate yourself, any hypoxia readings, etc.

Third Paragraph

List standard clinical validation criteria for the diagnosis and put in red which criteria the patient had.

Fourth Paragraph

Standard template stating diagnosis was clearly present, was treated appropriately, and it would be inappropriate to code the chart out without a diagnosis that was clearly documented by 1/2/3 different physicians. Quote Coding Clinic/Guidelines that support coding out the diagnosis. Mention any contractual language if present.

Sources to Support Your Dispute Letter

- Uniform Hospital Discharge Data Set (UHDDS)
- ICD-10-CM Official Guidelines for Coding and Reporting
- Coding Clinics
- CMS Internet-Only Manuals (IOMs), Publication 100-08
- Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.3 - DRG Validation Review

Improve provider documentation

Educate physicians and CDI team on what ICD-10 codes you are getting DRG disputes for

- You need to have some clinical criteria (positive qSOFA score or Sepsis-2 criteria) BUT not everyone with those "criteria" has sepsis (a patient hemorrhaging with an incidental UTI will meet SIRS criteria in general)

- If things don't make sense, they probably aren't correct. If someone has "sepsis" diagnosed but a very short LOS or if someone doesn't meet any criteria for sepsis, there is a good chance they don't have sepsis. If someone has "acute respiratory failure" but doesn't require any supplemental oxygen, there is a good chance they don't have acute respiratory failure.

- It's likely you will get a DRG revision if a patient doesn't clinical criteria (like meeting Sepsis-2 or Sepsis-3 criteria) so make sure CDI queries the physician when clinical criteria are not present. You need to know how the physician came to the diagnosis—essentially if things don't make sense, have the attending write the DRG dispute him/herself during the hospital stay.

Example of Education for: Types of Myocardial Infarction

- **Type 1 - spontaneous MI:** MI consequent to a pathologic process in the wall of the coronary artery (e.g. plaque erosion/rupture, fissuring, or dissection), resulting in intraluminal thrombus.
- **Type 2 - MI secondary to an ischemic imbalance:** MI consequent to increased oxygen demand or decreased supply (e.g. coronary endothelial dysfunction, coronary artery spasm, coronary artery embolus, tachy-/brady-arrhythmias, anemia, respiratory failure, hypertension, or hypotension).
- **Type 3 - MI resulting in death when biomarker values are unavailable:** Sudden unexpected cardiac death before blood samples for biomarkers could be drawn or before their appearance in the blood.
- **Type 4a - MI related to PCI**
- **Type 4b - MI related to stent thrombosis**
- **Type 5 - MI related to CABG**

https://www.ahajournals.org/doi/10.1161/CIR.0000000000000617

Medical Necessity Documentation Example

Because of *(acute medical condition such as: *persistent symptomatic acute blood loss anemia, acute on chronic systolic heart failure, pneumonia, ongoing acute GI bleeding, COPD exacerbation with persistent wheezing, persistent encephalopathy, NSTEMI, acute renal failure without return to baseline, alcohol withdrawal, etc.*)* **patient is anticipated to require at least two total midnights in the hospital for appropriate medical care including** *(hospital level of services such as: *intravenous hydration, intravenous antiemetics, renally dosing all medications, electrolyte replacement, intravenous diuresis, intravenous narcotic pain medications, intravenous lorazepam per CIWA protocol, adjusting narcotic pain medications, continuous capnography, continuous pulse oximetry, adjusting supplemental nasal cannula oxygen, serial laboratory studies, intravenous antibiotics, telemetry monitoring, intravenous metoprolol, close blood pressure monitoring, hold oral antihypertensive medications with prn intravenous hydralazine as needed, intravenous Haldol, etc.*)* **Based on the expectation of the patient requiring at least two total medically necessary midnights in the hospital, Inpatient status is appropriate.**

Even better add: **Patient's** (risk score such as: *PSI, CURB65, TIMI risk score, NIHSS score, CIWA score, etc.*) **and/or the patient's risk of** (*systemic hypoperfusion, end organ damage, MI, permanent neurologic deficit, death, etc.*) **is unacceptably high, therefore, patient requires ongoing treatment with close monitoring that can only be provided in the hospital at an inpatient level of care.**

Medical Necessity Documentation Tips

The chart needs to show evolution from day to day

- Avoid Copy/Paste
- Update Exams every day and clearly delineate changes (how is the cellulitis compared to yesterday—same? Improving? Worse? If exams look the same 3 days in a row it's hard to tell WHICH day the exam was for)
- The PRESENCE of hospital-level care does NOT equate to medical necessity

  Examples:

  - Is it clear why the patient on IV steroids needs IV steroids and couldn't be on oral prednisone? (if IV steroids are continued but the patient is not hypoxic, tachypneic, or with clearly documented dyspnea on exertion today, medical necessity for IV steroids is not obvious)
  - Is it clear why the patient on IV antibiotics for cellulitis needs monitoring in the hospital or could the patient go to SNF/home with home health?

Resources

TOPIC	URL
List of DRGs, Relative Weights (Table 5)	https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page
List of all CCs and MCCs (Tables 6I and 6J)	https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page
Uniform Hospital Discharge Data Set (UHDDS)	https://stacks.cdc.gov/view/cdc/103162
Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.3 - DRG Validation Review	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c06.pdf
Medicare Claims Processing Manual	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf
Official Guidelines for Coding and Reporting	https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf

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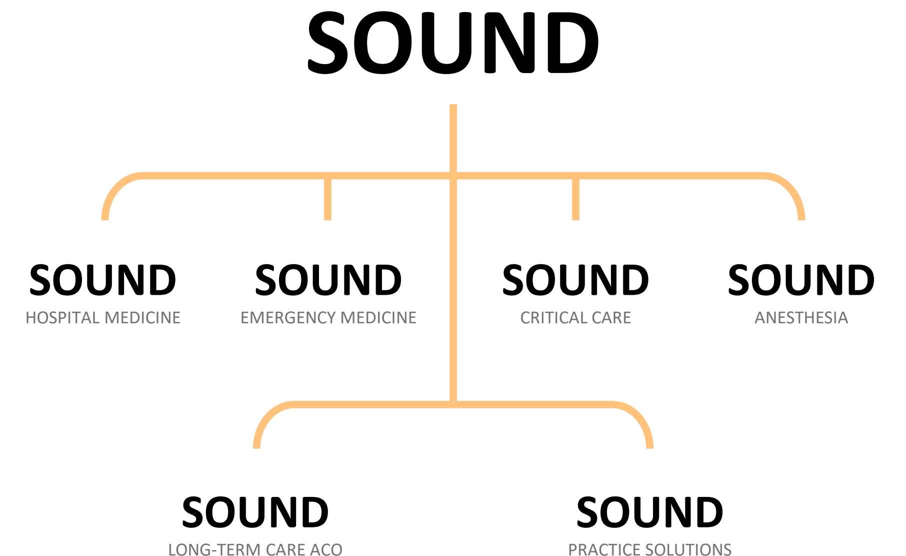

SOUND PHYSICIANS

Bringing **better** to the bedside.

Thank you

Any Questions?

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