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Getting to "Yes" When Payers Say "No" – The Importance of a Strong Denial Management Program

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Hospitals continue to lose millions of dollars each year from valid claims that are denied by third party payers due to reimbursement rules and regulations. Depending on hospital bed capacity and types of contract agreements, roughly 3% – 7% of managed care revenue, an amount that ranges between $200,000 and $500,000, is lost through payer issued denials yearly.[1] Hospitals continue to be denied reimbursement or are underpaid for care appropriately administered to patients, even when severity of illness factors and intensity of services delivered can be justified. Since healthcare costs continue to escalate, and reimbursement to providers continues to diminish, it is more crucial than ever that hospitals maximize resources to recover what is justly theirs. Most hospitals already have established mechanisms and dedicated resources to deal with payer issued denials. Yet, despite these efforts there is no substantial data to indicate that payer issued denial rates are decreasing. In fact, according to Dr. Judy Dixon, Appeals Director for Howard University Hospital, there is an upward trend in the number of denials for year 2000, with about a 4% denial rate on claims at the hospital. Generally, her department overturns 30 to 40% of the denials they appeal, with a success rate even higher on unfavorable concurrent reviews.[2] Getting payers to release information on their denial rates is difficult and is usually higher than reported. Published information on Medicare denial rates have ranged from 24% to up to 40% on selected claims.[3]

We recognize that in some instances patients may not require the intensity of care delivered at an acute care hospital and can be safely medically managed in less restrictive and less costly settings. In fact, we support the basic principles of managed care, which are meant to promote cost containment without compromising quality of healthcare. Successful healthcare delivery systems understand how to direct the right care, at the right time, to the right setting. However, despite improvements in medical management of acute illnesses in conjunction with more efficient utilization of resources, healthcare providers continue to be pressured by payer reimbursement rules to make level of care decisions that result in payment for services that are not cost justifiable. A well-known example is the debacle that exists between hospitals and payers regarding Observation level of care. We see the "Observation" or "Outpatient" level of care issue, as it is also refer to, as a dilemma about reimbursement to providers, and less about ensuring that patients are in the appropriate setting for the type of care they require and that providers are reimbursed appropriately. Ask yourself: Is there an outpatient setting that you know of where an agitated and anxious patient with acute asthma exacerbation and an O2 saturation of 90% can stay between 24 to 48 hours, receive frequent nursing and physician monitoring, IV fluids and steroids, oxygen,

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and respiratory treatments? Based on the above scenario, do you think it would it be feasible and safe to care for this patient in an "outpatient" setting at a cost well under $1,000 dollars a day? This example may be a bit extreme, but is this not a typical scenario we deal with everyday at acute care hospitals? Compared to reimbursement for an acute hospital day, Observation will be reimbursed at least 50% less than an average day in an acute care hospital.

Determining whether a patient is "Observation level of care" is an issue prone to subjectivity, influenced by time and cost containment factors, and seems less focused on the feasibility and practicality of care delivery. Struggling with payers over Observation vs. Acute level of care continues to be the nemesis for most hospitals. The bottom line is hospitals are expected to deliver the intensity of care it takes to improve health in patients with acute illnesses, use healthcare resources that have increased in cost, and do it with substantially less reimbursement. An actual example of this scenario is described below.

An 82-year-old managed Medicare patient was admitted to the hospital for acute COPD exacerbation and atrial tachycardia. The treatment plan included initial administration of an anti-arrhythmic; frequent respiratory treatments, telemetry monitoring, O2, and intravenous steroids. He also complained of chest pain and since his past medical history included coronary artery and peripheral vascular disease and insulin dependent diabetes, serial enzymes were ordered to rule out for MI. In addition, a small lower extremity ulcerative cellulitis was discovered and the patient was started on an intravenous antibiotic. Within 48 hours, the patient's respiratory and cardiac status improved, an MI was ruled out, and he was transferred to a skilled nursing facility for continued medical management. The hospital billed the payer for acute care reimbursement according to the contract agreement and was denied payment because the patient stayed *less than* 48 hours. The payer agreed to Observation level reimbursement only.

The initial decision to deny acute care reimbursement in this case was made over the telephone by a review nurse and physician advisor at the patient's health plan. The denial letter the hospital received referenced the limited amount of time the patient was treated at the hospital as justification for Observation reimbursement. These is a good example of how some payers rely heavily on diagnosis and time as drivers to reimbursement and minimize severity of illness and intensity of service factors to determine appropriate reimbursement. Sound familiar? The good news is that the case was appealed, the denial was overturned, and the hospital was eventually paid acute level of care reimbursement.

This case is one of many that continue to confuse and frustrate healthcare providers about the validity of some of the decisions made by payers. Ask yourself these questions:

- Is it reasonable for a hospital to accept a reduced rate for the first day of a patient's hospital stay, when severity of illness and intensity of services are the same on the third day?
- Should hospitals chase the clock and try to convince payers over a telephone that a less intensive setting is not practical or feasible for a particular patient?
- Is it reasonable to impose payer-developed guidelines onto hospitals, which dictate timelines for management of certain conditions? Should hospitals accept reduced reimbursement rates as a result of these guidelines?
- Should a hospital that is not within a payer's contracted network be denied payment for admitting a patient that required acute hospital level of care?

These are some of the many questions that hospitals and payers continue to struggle over and that undermine an ability to foster sound payer/provider relations. These issues are not transparent to health care consumers, and encourage the skepticism consumers feel about healthcare insurance systems.

The process to recover denied reimbursement is often complex, frustrating and time-consuming for an organization, draining valuable human resource time. Many hospitals have recognized the importance of implementing a strong denial management system and have hired staff strictly dedicated to manage and facilitate this process and work to minimize denials. Still, in other organizations multiple departments i.e. Case Management, Patient Billing, Admitting, and Medical Records, dedicate existing department FTE's to dealing with denials and are accountable to some piece of the process. In these situations, the task becomes even more daunting for staff trying to manage day to operations of their department as well as take on the additional internal and external challenges associated with denials and appeals.

Most hospitals report that the majority of the denials they receive are due to technical reasons. Some examples include i.e. lack of pre-certification or payer notification, patient eligibility issues, or billing errors. Medical necessity denials may be issued due to a lack of appropriate medical record documentation to substantiate acuity based on the payer's criteria. For example, staff from health plans that review concurrently at hospitals rely heavily on medical record documentation to determine level of care. Unless the documentation is there to justify acuity, hospitals run the risk of denied reimbursement. Or, when hospitals rely on telephonic communication with payers, delayed or inadequate clinical information also frequently results in medical necessity denials.

Set Performance Goals and Expectations

With an organized and systematic denial management program, it is recommended that hospitals can set aggressive benchmarks and target recovery goals that reflect industry best practices. One example is it to look at your hospital's total inpatient denials. Overall, denials should represent less than 1 percent of both days of care and net revenue (excluding contractual adjustments).[4] Recovery goals for technical/administrative denials should be targeted at 85% and medical necessity denials to between 70 and 80%.[5] Although the majority of denials are most often due to technical reasons, and can successfully be

overturned, medical necessity denials should be aggressively challenged and appealed as well. We recommend that hospitals look critically at each medical necessity denial case to determine reason for the denial, what decision making criteria the payer used and if it was interpreted appropriately, and the credentials of the health plan review staff involved in issuance of the denial. From our experience dealing with subjective and inconsistent interpretation of criteria by health plan review staff who demonstrate questionable clinical expertise and medical management experience, we recommend that hospitals set high expectations of health plan review staff who are responsible for making decisions regarding reimbursement to hospitals. Health plan review staff, both nurses and physicians, should have training and meet the recommended competency standards in the use of nationally recognized utilization measurement tools they use to determine reimbursement.

Success in overturning denials requires a mix of strong clinical, communication, regulatory, contract, and managed care skills. To achieve high overturn rates, there are certain key competencies we feel are critical to effectively and efficiently manage payer issued denials. These competencies include:

- Clear understanding of managed care agreements and contract language.
- An ability to foster provider/payer relationships to minimize denials.
- Strong clinical knowledge base and understanding of when alternative levels of care are not appropriate.
- Working knowledge of nationally recognized utilization measurement criteria and its application.
- Strong and effective writing and verbal communication skills.
- An ability to integrate and coordinate a denial appeals processing system with patient accounts, medical records, and coding specialists within the organization.
- Effectively track the entire denial and appeal process with dollar amounts.

Persistence is key to success in overturning denials. In fact, statistics indicate that about 25% of denials are overturned on the first appeal and another 25% are overturned on the second appeal.[6] Don't give up! Look for process improvement opportunities to your program and share best practices. Other critical success factors include, communication with staff about payer regulations and contract agreement changes, feedback on performance goals, training and fostering relationships with payers. These elements are all fundamental to an organized and systematic denial management program and will help you to set the stage to achieve high overturn success rates for your organization.

About the Authors

Jan West, RN, BSN, MHSA; Deb Girard, BA, MA, MBA; and Maura Davis, RN, BSN work together as healthcare management consultants. Together, they are a team of healthcare professionals with significant medical and case management experience in both hospital and managed care settings. Their expertise and skills have contributed to their developing a Denial Management and Denial Avoidance Program for healthcare facilities. Their mission is to assist healthcare providers in the development and/or enhancement of denial management systems for recovery of denied revenue and to identify opportunities to avoid payer-issued denials. If you are interested in learning more about this program you may contact the Center for Case Management for more details.

References:

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