Concurrent Utilization Review: Getting It Right

By Olakunle Olaniyan, MD, MBA, Iskla L. Brown RN, and Kayode Williams, MD, MBA, FFARCSI

In this article...

Take advantage of ways to improve your concurrent review process to avoid insurer denials.

Concurrent utilization review is required by virtually all Medicare payers. It is an indispensible part of the hospital revenue cycle that is controlled by clinicians. As the leader of the hospital medical management efforts, many physician executives are held accountable for the success or failure (denials) of inpatient concurrent review even though they are not directly involved in managing the process.

Having a good understanding of concurrent review will help physician executives identify opportunities to improve a process that can have a profound impact on hospital earnings.

Key areas to focus on include:

- Correctly identifying patient and insurer
- Collecting relevant medical information
- Timely and documented transfer of information to the insurer
- Daily review of the insurer's log, with proactive follow-up
- Planning for discharge
- Reducing denials through appeals and a CQI process

Many physician executives and hospitalists find themselves involved in the hospital's inpatient concurrent review process for a variety of reasons including:

1. Working with fellow hospitalists to reduce the impact of the group's denials on hospital revenue, which can be quite profound.
2. Working with the hospital case management team to minimize denials and facilitate efficient and timely discharge.
3. Working to reduce denials by high-volume admitting physicians.
4. Being charged by hospital senior management to reduce denials.

Most hospital executives lay the blame for denials squarely at the feet of physicians and their leaders, and there is often an unrealistic expectation regarding what can be done to reduce denials.

The good news is that denials can be reduced fairly significantly, but it does take time, a lot of effort. plus the buy-in and coordination of multiple stake holders. When successful, the dividends are huge for your facility and your career.

The climate for denials has worsened dramatically over the last decade. Ten years ago, only about 1 percent of reviewed cases were denied.[1] Today, 5 percent denial rates are quite common. Denials have also become routine with government programs (Medicare and Medicaid), which make up half of many hospitals' revenue stream and which did not previously issue denials. This poses a significant risk to a hospital's revenue stream.

In order to mitigate against the increasing risk of denial, hospitals must increase scrutiny of all aspects of the medical necessity justification process to ensure maximum effectiveness and efficiency. The process can be either concurrent (commercial insurers and some Medicaid insurers) or retrospective (mostly Medicare).[1]

For the vast majority of commercial insurers, each inpatient admission must go through the concurrent review process in order for payment to occur; therefore, this is an extremely important component of the revenue cycle.

There are typically two distinct components to concurrent review: the initial notification and the daily medical necessity review.

Notification

Intake admissions staff usually give notification to the insurer; this simply means the insurer has been informed by the hospital that one of its enrollees has been admitted. This is typically required within one business day of admission in order for payment to occur. However, notification alone does not guarantee payment; the medical merits of the admission must also be reviewed and deemed medically necessary by the insurer.

Concurrent review

Utilization review (UR) staff typically complete both the admission review, indicating the reasons for admission, as well as the concurrent review of the patient's progress. The insurer normally requires this review on a daily basis in order to authorize payment for each inpatient day. (Note that facilities paid based on diagnosis-related group [DRG] may not be required to conduct daily review.)

Our focus here is on the daily concurrent review completed by the UR staff. This is a critical activity that has a profound impact on earnings and would benefit from strong medical executive involvement.

Daily review process

Most hospitals generate a patient census (admission) list twice a day—once in the morning for the previous day admissions and once midday for the early morning admissions.

By the time UR obtains the census, the admissions staff should have identified the correct insurer and notified them of the admission. However, there are always patients for whom the correct insurer has not been notified for a variety of reasons, such as:

- The patient brings incorrect insurance information or none at all.
- The patient has more than one insurer and the hospital notifies the secondary insurer but not the primary insurer, or there is a question as to who the primary insurer is.
- The wrong product or location for an insurer is called.
- A patient undergoing an elective outpatient procedure that has been pre-authorized subsequently experiences complications and is admitted. The admissions staff incorrectly assumes the outpatient authorization is also good for an inpatient admission and therefore does not notify the insurer. For these patients notification is still required within one business day for the inpatient admission.

Once the hospital UR nurse has identified the patient and the primary insurer, the next step is to collect the relevant medical information necessary to ensure payment for the admission or continued stay. This allows the hospital to be proactive, not reactive, in preventing denials.

The climate for denials has worsened dramatically over the last decade.

- A patient is admitted from an observation level of care to inpatient. These patients are already inhouse and neither UR nor admissions staff are notified of the change in level of care. Notification is still required within one business day for the inpatient admission.

By the time these problems are identified, the patient is usually already on the floor and assigned to UR; this is why the UR nurse plays such an important secondary role in insurer notification.

Every patient on the census without an assigned insurer or for whom notification has not occurred should have additional scrutiny by UR in an attempt to identify a payer as soon as possible.

A simple question to a family member or the patient regarding insurance coverage may indicate that the patient has insurance. This information can then be provided to the admission staff to complete the notification process and concurrent review can occur on a timely basis. Patients who are truly self-pay should be evaluated for medical assistance.

Once the hospital UR nurse has identified the patient and the primary insurer, the next step is to collect the relevant medical information necessary to ensure payment for the admission or continued stay. This allows the hospital to be proactive, not reactive, in preventing denials.

Of vital importance in this step is the use of InterQual or Milliman criteria sets, which are used by health insurance companies. The use of one or both of these guidelines will allow the UR nurse to appropriately assess the medical necessity for the admission and determine the correct information to send to the insurer to justify medical necessity. All hospital UR staff should be trained on the use of these criteria sets. There is also tremendous value in the physician executive becoming familiar with these criteria.

If the case does not meet InterQual or Milliman guidelines, instead of waiting for the insurer to make a determination, the UR nurse should contact the treating physician to request any additional information on the case. If additional information is obtained, it should be conveyed to the insurer and the treating physician should be asked to document the additional information in the medical record.

If there is no additional information, UR should notify the treating physician that the case does not meet criteria based on guidelines and may be denied by the insurer. If the treating physician agrees that discharge can occur, UR should work with the treating physician and discharge planners to obtain a discharge even before a denial is issued.

The physician executive often plays a critical role in this process by facilitating interactions between UR and the treating physician.

Information transfer

Another essential part of the concurrent review process is the transfer of information from the hospital to the insurer. The hospital UR department should get all reviews to the insurer as early as possible—ideally before noon each day. This allows the insurer time to review each case and respond the same day. Those cases that are likely to be questioned by the insurer should be sent first so there is adequate time for the insurer to review the case and respond with a determination.

UR staff must ensure the clinical reviews are being delivered in such a way as to be able to confirm the insurer received the information submitted. The onus is on the hospital staff to have evidence of this information transfer in case the insurer denies the admission stating they did not receive the information or did not receive it timely.

Using a call tracking system to track calls and faxes would be ideal and is strongly recommended. This would ensure that in the many instances when an insurer claims no information was received, there is objective evidence from the hospital that information was sent. A tool such as this could also be useful for tracking UR nurse activity in order to assess staff loads and make recommendations for improvement.

If a call tracking system cannot be employed, the hospital may consider adding documentation to their patient account or UR system so that every call or fax to the insurer is clearly recorded, including phone number, time called, and person to whom the call or fax was made.

If none of the above options is available, the only option left is excellent documentation on hard copies of the confirmation page used to fax the cases to the insurer and/or date and time calls were made. In all of these situations it is crucial to document the phone number, time, name of person, and type of communication.

Sometimes an insurer has onsite reviewers to conduct concurrent review of their members; this removes the burden on the hospital to transfer information to the insurer on a daily basis. It also reduces denials due to no clinical information since the insurer's reviewer is onsite and responsible for obtaining the clinical information.

However, the hospital must still review cases for criteria and work with case management or social work to anticipate and plan for a timely discharge. The hospital UR department should require the insurer's onsite reviewers to provide feedback on each case reviewed before leaving for the day, especially on cases being referred to the insurer's medical director for not meeting medical necessity criteria. This allows the hospital to work proactively to prevent these denials.

Denial logs

Once the insurer receives the clinical information, it is reviewed by an insurance nurse reviewer. If the case does not meet specified criteria, it is referred to a medical director who makes the determination to approve or deny the admission or continued stay.

This determination is usually communicated back to the hospital the same day or the following day via a phone call, faxed log, or faxed denial letter. Many insurers use a log as required by both NCQA and URAC.[2]

When the hospital submits reviews to the insurer in a timely manner, the hospital must insist on a timely response back (on the same day), thus allowing the hospital to proactively take action on potential denials.

Hospital UR staff should review the insurer logs on a daily basis. This daily review can ensure a determination has been made on every case called or faxed to the insurer. If a review submitted by the hospital is not on the insurer's log, UR should contact the insurer to confirm they received the information. If the insurer states the information was not received, it should be re-sent with proof of initial timely submission. This simple step should eliminate most denials for no clinical submission.

A daily review of the insurer's logs can also prove pivotal in avoiding a denial or in expediting a discharge if the patient is meeting discharge parameters. When the response is a denial, the hospital has an opportunity either to submit additional information or request a physician peer-to-peer.

The peer-to-peer affords the treating physician or hospital physician executive the opportunity to discuss the case with the insurer's medical director and possibly avoid the denial. Taking advantage of this option allows the hospital physician executive to control the concurrent review process and prevent some denials at the time of care.

Ultimately, the discharge decision is a clinical decision that should always lie with the patient's physician. If the physician decides discharge can proceed safely, all efforts should be made to discharge the patient as soon as possible. Do not wait until the following day. The hospital should have a well-documented process for achieving evening discharges.

If the treating physician does not feel it is safe to discharge the patient, the physician should provide clear documentation in the medical record to support continued stay. In addition, the reason for continued stay should be communicated to the insurer as additional information.

If the day is still not approved, a physician-to-physician reconsideration needs to be arranged with the goal of obtaining approval for the continued hospital stay.

Finally, from the minute the patient is admitted, UR should begin planning for discharge by estimating length of stay and anticipating discharge needs. UR should then ensure any potential discharge obstacles (such as nursing home placement, major durable medical equipment needs, or home health needs) are identified early and are proactively addressed.

It is imperative that UR work closely with other entities such as floor nurses, PT/OT, case management, or social work to ensure an appropriate, swift and safe discharge plan is followed.

Insurer response

Every insurer is subject to various state, federal, and accreditation standards and mandates regarding the timeliness of UR decision making.[2] Accreditation standards are fairly consistent; however, state standards vary based on state regulations and insurance product. In general, the following standards apply:

- Once the insurer is provided with the information needed to make a medical necessity determination, the insurer must convey the determination to the hospital verbally or by fax within 24 hours or the next business day.
- Within five working days of a denial, the insurer must send a written response of adverse determination to the hospital. The response should include the denial reason and any appeal rights the patient or hospital may have.
- Many insurers also provide an opportunity for reconsideration of a denial or a peer-to-peer meeting. This time frame may vary based on accreditation and state regulations. Usually the time frame will be from 24 hours to seven days of the denial decision. This allows the treating physician or physician executive to contact the insurer and discuss the case with the insurer's medical director.

In addition to the daily concurrent review there are two other processes that can help minimize denials and maximize revenue: appealing denials and CQI.

1. Appealing denials

Every insurer affords the hospital an opportunity to appeal a denial;

however, this must be done within a predefined time frame that varies from insurer to insurer. A good appeals process can recover 30 to 40 percent of denied days.[3] The goal, however, should be to minimize the denials in the first place and thereby reduce the number of cases requiring appeal. Many hospitals currently outsource their appeals process—an effective strategy that allows the hospital to focus on maximizing revenue and minimizing denials.[3]

2. Reporting and the CQI process

The hospital should capture important indices that measure the effectiveness of different aspects of the concurrent review process. Many hospitals already do this. Important process measures include:

- Average number of cases per reviewer
- Timeliness of review submission to the insurer
- Timeliness of response from the insurer
- Number of administrative denials
- Number of peer-to-peer calls

Important outcomes measures include:

- Denial rate and number of denials
- Denials by category
- Denials by physician and by diagnosis
- Success of physician peer-to-peer

These measures should be used to identify and strengthen weaknesses in the concurrent review process. In addition, data on denials by diagnosis and physicians should be used to develop targeted educational programs to help physicians proactively prevent denials.

Where possible, key drivers of denial activity should be identified and addressed. Re-measurement then occurs to evaluate the effectiveness of the interventions. This then becomes a continuous quality improvement cycle of measurement, analysis, process improvement, and re-measurement.

Once in place, this comprehensive CQI process is the most important factor in ensuring the long-term effectiveness of the process and achieving denial reduction goals.

Olakunle Olaniyan, MD, MBA, is president of Case Management Covenants LLC in Columbia, Md.

o.olaniyan@cmcovenants.com

Iskla L. Brown, RN, is chief operations officer of Case Management Covenants LLC in Columbia, Md.

i.brown@cmcovenants.com

Kayode Williams, MD, MBA, FFARCSI, is director of Blaustein Pain Treatment Center, Department of Anesthesiology and Critical Care Medicine Division of Pain Medicine at Johns Hopkins School of Medicine in Baltimore, Md.

kwilli64@jhmi.edu

References

1. Murray, ME. Outcomes of Concurrent Utilization Review. *Nurs Econ*. Jan. 2001.
2. URAC Health Utilization Management Accreditation Guide, Version 6.0
3. Olaniyan O, Brown IL, Williams K. Managing medical necessity and notification denials. *Healthc Financ Manage*. 2009 Aug;63(8):62-7.

Get Your CME on the Go...

with ACPE's InterAct Distance Education.

Upcoming Full Sessions

InterAct: Anywhere you need it to be.

June

Ethical Challenges Jun 10–30
Managing Physician Performance Jun 24–Aug 4

July

Three Faces of Quality July 22–Sep 1

August

Advanced Topics in Health Law Aug 5–25

Other CME courses available as *Express (self-study)*. For info, visit:

www.acpe.org/interact

InterAct
ACPE Distance Education

acpe
American College of Physician Executives
The Home for Physician Leaders