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Are denials for medical necessity and notification issues eroding your bottom line? Implementing a denials mitigation process can help.

At a Glance

Hospitals should take a strategic approach to denials management. Some key areas to monitor are:

- **Prior authorization/notification**
- **Concurrent review**
- **The appeals process**

Medical necessity and notification denials represent a relatively small portion of the entire universe of denials for any hospital, yet they are the most difficult to prevent and typically have the lowest recovery rate. For these reasons, many healthcare financial managers have concluded that the recovery rates from these types of denials cannot justify the enormous time and resources typically needed to address them effectively.

Times are changing. Many hospitals have seen their medical necessity and notification denials increase significantly over the past year and can expect further increases. Further, as the cost of health care continues to rise in a bad economy, employers will demand more cost savings from commercial carriers, and many carriers will turn to increased denials to find those savings. Some commercial carriers already have denial rates as high as 20 percent of inpatient days (see exhibit).

As hospital margins continue to shrink because of escalating competitive forces, the need to reduce the financial impact of increasing denials on earnings has become significant.

The financial impact of inpatient denials on hospitals depends on many factors, with the two most critical being the hospital's total earnings (income) and the denial rate. Denials, of course, have a direct impact on earnings because the service has already been provided and the cost has been incurred. Because the costs are already on the books, any denial of that service directly affects the bottom line. The denial rate depends on both external factors (such as the regulatory environment, the degree of hospital consolidation in a given market, and the number of hospitals in close proximity to each other) and internal factors (such as the payer mix and the hospital's investment in case management and up-front authorization work).

A Strategic Approach to Denials Management

An organizationwide approach is necessary to effectively manage denials. Close cooperation among case

management, discharge planning, patient accounts, admissions, physician leadership, payer contracting, and IT is necessary.

The key components of an effective denials management strategy are:

- Minimizing denials through an effective concurrent review and notification process
- Recovering as many denied dollars as possible through an aggressive appeals process
- Effectively closing the loop between approval and payment
- Using data to identify key drivers of denials, and developing processes to mitigate these drivers, thereby further reducing denials

These components should occur simultaneously and continuously. When implemented effectively, they will lead to a steady decline in write-offs from denials. With strong denial mitigation processes in place, a denials overturn rate of 40 percent to 50 percent is possible (see exhibit).

Prior Authorization/Notification

Denials due to lack of prior authorization or notification are relatively easy to prevent and should be considered low-hanging fruit. A good denials mitigation program should have effectively eliminated most denials for this reason. The importance of a good notification system cannot be overestimated; for most payers, no notification means no payment.

All managed care payers require prior authorization at least 24 hours before elective admissions and notification within one working day of nonelective admissions. These steps are typically contractual requirements, and most payers will deny the entire claim if these requirements are not met. Once such claims are legitimately denied, few remedies remain, so it is critical to minimize their occurrence.

Prior authorization. Inpatient denials for lack of prior authorization are rare. Because elective cases are scheduled days before service is rendered, eligibility and prior authorization can easily be confirmed prior to admission. An elective admission should not proceed without the necessary prior authorization. Nonelective admissions should proceed with clear documentation of the urgent nature of the admission, and notification should occur within one business day of the admission.

When obtaining prior authorization, staff should also confirm that the patient has medical necessity clearance with the insurer. Most insurers include medical necessity review as an integral part of the authorization process.

Notification. Admissions are denied more often because of failure to notify than for lack of prior authorization. These denials occur not only because there are many more nonelective admissions than elective admissions, but also because hospitals typically have only one business day to meet this requirement. The following are some of the more common reasons for
non-notification:

- The patient brings incorrect insurance information or none at all.

- The patient has more than one insurer, and the hospital calls the secondary insurer but not the primary insurer.
- The wrong product or location for an insurer is called.
- A patient undergoing an elective outpatient surgery case that has received prior authorization experiences complications and is admitted, and an admissions employee incorrectly assumes the outpatient authorization is also good for an inpatient admission and therefore does not notify the insurer.

When notification does not occur within one business day, the hospital needs to notify the health plan as soon as possible and obtain clarification that coverage will start from the day of notification. Many carriers will agree to this either at the time of notification or through the appeals process. When an insurer cannot be identified, the hospital needs to establish a clear, concise paper trail that shows all steps taken to identify the insurer. This documentation will be useful during the appeals process.

Cases that get denied for non-notification should be reported to the hospital's notification staff for review and analysis as part of the team learning process. Blinding the cases so the team does not know who worked on them allows the process to be educational and value-added rather than punitive.

Concurrent Review

Most insurers require that hospitals provide them with medical information on all admitted cases to support medical necessity. The onus is on hospitals to justify payment for care provided.

Information transfer is a critical part of the concurrent review process because if there is no evidence the insurer received medical necessity information, the day in question is denied. Consequently, a critical step in concurrent review is collecting the correct information from the records and delivering it in such a way as to confirm receipt and capture the delivery process. When an insurer has onsite reviewers, this entire process is transferred from the hospital to the insurer.

Another important component of concurrent review is justifying medical necessity. This process is usually transparent to the hospital as the information provided will meet the insurer's medical necessity criteria and be paid most of the time. However, when there is a question of medical necessity and the day or admission is denied, the hospital should have a process for quickly identifying such cases and challenging the insurer's decision. This process, termed a reconsideration by insurers, usually includes calling the insurer's medical director with additional information. The process has the potential to prevent up to 20 percent of denials.

To challenge a denial, the hospital must be made aware of the denial in a timely manner. When insurers issue denials by mail many days after the date in question, hospitals receive them too late to challenge them and have to initiate a formal written appeal. Hospitals should insist on timely notification of all denials on the day the decision to deny the claim is made. Most insurers will comply and will typically use a daily patient log to communicate the status of each admission to the hospital.

Another controversial area of concurrent review is leveling. Leveling occurs when a bed level is downgraded to a less costly bed. For example, an insurer agrees to pay only for telemetry services for a patient in a critical

care unit (CCU) bed. Leveling allows insurers to pay for services below the usual cost. Hospitals accept leveling because they would prefer to be paid something rather than nothing. Unfortunately, the more a hospital accepts leveling, the more the insurer is encouraged to use it for that hospital. Hospitals should avoid leveling as much as possible and fight each denial aggressively. Only after the appeals process is exhausted should the leveling option be considered.

With the deployment of the federal Recovery Audit Contractor program nationally, one-day stays will receive heavy scrutiny, and hospitals can anticipate increased denials in this area. To reduce the incidence of denials for one-day stays, hospitals should have a process for reviewing as many one-day admissions as possible prior to the patient's admission. If the case management staff determine a denial is likely, dialogue with the admitting physician should occur and other treatment options explored. Ultimately, the physicians should make the decision.

Concurrent review is the most complex, most resource-intensive part of denial mitigation. Getting it right will significantly reduce denials.

The Appeals Process

The appeals process involves many interrelated steps (see exhibit) . Getting one step wrong derails the entire process. This complicated process can be broken into six subprocesses. (See Levels of Appeal Explained below)

Identifying the denial. Although this seems obvious, it is not. The denial notification process often varies by denial type and carrier preference. Medical management denials (such as medical necessity, delay in service, no clinical information provided and late notification denials) are typically first received by letter or fax. Non-notification, eligibility, and benefit denials are first received by means of the explanation of benefit (EOB). All denials are, of course, reflected in the EOB, but the initial source of notification is important because of the time frame for appeals. Insurers do not always provide timely notification. Letters are sometimes not sent, sent to the wrong address, or simply lost or not delivered. However, the onus is on the hospital to prove a letter was not received. Simply saying a letter was not received will not work. Hospitals can identify denials through:

- The concurrent review log mentioned above
- The denial letter
- The EOB or remittance advice

Denial letters should be matched with denials on the denials log. If the hospital does not have a letter to match an associated denial on the log, a call should be made to check the approval status of the case. If the case is approved, all aspects of the call should be clearly documented. If the case is not approved, the denial letter should be requested. Every EOB should also be reviewed for denials. In the case of an administrative denial where notification never happened or a benefit/eligibility denial, the EOB denial notification should be logged. For denials identified on the EOB where a letter should have been sent, the hospital should contact the insurer to request a letter and follow the steps above. The goal is to ensure that every denial is identified in a timely manner and managed appropriately.

Collecting medical necessity information and generating an appeals letter. The appeals process involves more than sending a letter to the insurer. A successful appeal depends upon two critical factors: timeliness and medical management knowledge.

Regarding timeliness, appeals must be submitted within the prescribed time frame of each insurer. The time frame varies considerably from insurer to insurer and for different products with the same insurer (see exhibit).

With respect to medical management knowledge, many appeals require the input of a nurse or physician who is well versed in the discipline of medical management because denials are often based on the efficiency of care delivery and the site of delivery, not on the medical care provided. Medical management training is often helpful in developing an overturn argument that addresses the denial reason and medical necessity as defined by the insurer.

These two factors often drive resource allocation for appeals. All appeals should be tracked and then sent by a secure traceable delivery method to the insurer for review.

Managing the insurer's appeal response process. All appeals should be tracked, using a database or other tool. Hospitals should make sure they receive a response from the insurer for each appeal.

Determining the appeal response. If the denial is upheld, the hospital needs to decide whether to pursue the appeal to level 2 or conduct an external review. More than 30 states offer an external review process; however, the appeal requirements differ significantly among states. An additional 10 percent to 15 percent of denials can be overturned at the second level.

Managing payment. Once an appeal has been approved, the hospital should continue to track it until payment has been received. It is important to have a process in place for ensuring that all overturned appeals are paid. With a vigorous appeals process, most approved claims are likely to be paid (see exhibit).

Managing data, reporting, and improving performance. One of the most important parts of a successful denials mitigation process is analyzing denials data and using the results to develop processes to reduce denials. A good denials management application and database are key to driving this process.

At a minimum, providers should regularly review denials by denial type, payer, diagnosis, and physician. Data on denial type can be used to identify opportunities for improving the notification and concurrent review process. The availability of timely data also allows providers to monitor progress regularly, which can be a powerful incentive for managers to improve their processes. Trend data on denials by payers are useful in identifying outlier payers with excessively high denial rates. This information can then be used in the contracting process or for working with payers to reduce denials. Data on denials by diagnosis and physician can be used to help reduce medical necessity denials.

Reducing Denials

Healthcare financial managers can reduce net denial write-offs to less than 1 percent of total revenue over a three-year period. For many hospitals, this accomplishment will mean reducing net write-offs from denials by more than 50 percent. The process is difficult, however, and requires a strong commitment of resources,

technology, and significant senior management oversight. Whether healthcare financial managers develop an in-house denials management process or outsource the activity to a vendor, careful attention to the various components of a successful denials mitigation process will likely reap dividends that include reduced denial rates and increased earnings.

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