Effectively Analyzing The Strength of Your Denial Management Efforts: A Simple Process To Follow

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Medical necessity denials continue to be a major drain on revenue and earnings in most hospitals. This tends to be a significant source of frustration for patients account because they often have very little control over the actual denial management process. The medical management department and physicians are the main drivers of a hospitals denial experience, yet they are often insulated from the cost implications of their activities. Therefore in order to reduce denials, it is critical that there be a strong working relationship between patient financial services and medical management.

The first step in building that relationship is having a clear and complete understanding of all denial management activities as well as the effectiveness and efficiency of these activities.

Denial management can be broken down into 5 major areas

1. Appeals management
2. Physician practice patterns
3. Concurrent review and case management activities
4. Insurance company activities
5. Regulatory activities

Each area plays a very specific role in denials generation and prevention.

Knowing the right questions to ask provides a quick and simple way to get a clear picture of what is going on in each of these areas.

In the next few paragraphs, I will discuss the specifics of each area above and which relevant questions need to be asked in order to help provide a comprehensive understanding of how effective each area is.

Appeals management

The appeal process is one of the most important aspects of minimizing denials. For many hospitals it is the only process in place because physicians have not been adequately engaged, and the concurrent review process is reactive rather than proactive. It is therefore critical that patient accounts have a clear understanding of the effectiveness of the appeals process. The following questions are important in understanding how your appeals process works and providing a clear picture of the entire process.

1. Effectiveness of the appeals process
   a. What percentage of denials are actually appealed? This is important because this is probably one of the most important indicators of how successful the appeal process will be.
   b. What percentage of appealed cases get a response back from the insurer? In other words, if 100 cases were appealed in January, how many cases do you have a response back on in April? This indicates how effectively your facility is interacting with the insurer to get a response back. Left to their own devises, insurers will respond to less than 70% of cases.
   c. What percent of overturned denials gets paid? Again this is an indication of how effective the facility is at ensuring overturned denials actually get paid correctly.
2. Outcome of the appeals process.
   a. What is the true recovery rate for appeals? This is the amount recovered over the total denied amount. Many facilities look at the amount recovered over the amount appealed. However because the amount appealed is infinitely variable, this is not reliable.
   b. What is the net recovery for appeals? This is the amount recovered less the cost of recovery. Be sure to accurately calculate how much you are truly spending. Include nurse's salaries, physician adviser costs, analysts, outreach staff to insurers, stationary and supplies, managerial oversight, benefits and overhead. **When you look at the true cost versus what is re-covered, you might sometimes find you are actually spending more than what you recover and you have a negative return on appeals.**

The effectiveness of the appeals process is critical in ensuring a strong recovery rate. It is important to make sure that every denial is accounted for. We see the best recovery rates when at least 80% of denials are appealed.

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Here is an example. Say you get 100 denials in January, your appeal department tells you their overturn rate is 50%. You then do your own analysis.

You discover 60 of the 100 denials were appealed or 60%. So 40 are closed as un-appealable for one reason or another. You then want to make sure that you get a response from the insurer on all 60 cases appealed. You typically need to have a robust team of appeals analysts calling the insurers to get the appeals back in. Left to their own devises the insurers will respond to less than 70% of appeals.

Out of the 60 cases appealed, suppose half (or 30) are overturned. You then have to make sure all 30 are actually paid. Again left to their devices the insurer will pay for less than half, so you need a strong outreach team to make sure all required documentation gets to the insurer to ensure payment.

Using the same example, even though half of your appeals were overturned, your true overturn rate is 30% not 50% because you started off with 100 appeals of which 30 were overturned. The numerator for your overturn rate is the denied amount (100) not the appealed amount (60).

Let's assume the 30 cases overturned equates to $30,000 (for simplicity sake). You now want to figure out how much it cost you to recover $30,000.00. If your cost is $20,000.00 then your net recovery is $10,000.00 and your net recovery rate is 10% not the 50% you got from your appeals department. Knowing your true net recovery rate is important because it is a critical piece of information in deciding how to best manage appeals.

Physician practice patterns, intervention and education

Physicians directly generate most medical necessity denials. It is correct that some Medical necessity denials occur due to delayed discharge, driven by social or other non-clinical issues. However by far the vast majority are driven by physician practice patterns. Almost everything that occurs with a patient requires a physician's signature. Unfortunately, physicians are not trained to provide efficient care; instead in the interest of safety and caution, they are trained to be slow, deliberate, and cautious. This is why changing physician behavior to drive more efficient care is so difficult.

There are many strategies that are used to change physician practice behavior. All take time and change is incremental. From a patient account perspective, the most important thing to know is what is being done specifically and how progress is being tracked. Strategies to improve practice efficiency include:

1. Moving more care to a hospitalist group when possible.
2. Use of clinical pathways and guidelines
3. Physician participation in case management rounds
4. Comprehensive physician peer to peer calls on denials

What questions do we need to ask in order to get a clear picture of how effective physician intervention and education is?

1. Are there any formal clinical guidelines being used by physicians?
   a. What diagnosis are being used?
   b. Criteria used to select the diagnosis?
   c. Is it a mandatory or voluntary program?
   d. What media is used to deploy the program, paper or electronic?
   e. What are the set goals for the program and how are these being tracked?
   f. Ask for results to date.
2. Are physicians participating in case management rounds?
   a. Ask for the policy and procedure that describes the program.
   b. Are all physicians involved or only high volume physicians?
   c. Is attendance mandatory or voluntary?
   d. What is the frequency of physician attendance?
3. Is there a formal physician peer to peer program with high volume insurers
   a. What percentage of denials receive a peer to peer call?
   b. Who decides what denials to call on?
   c. What is the success rate of actually reaching the insurer medical director?
   d. What is the success rate of all the calls?
   e. What is the success rate of calls where a peer to peer discussions actually occurs?
   f. What happens after the peer to peer in terms of documentation and follow up with the insurer?

The answers to these questions should give you a good idea of how robust or not your physician engagement efforts are.

For example if there is minimal or no use of clinical guidelines, then there is going to be wide variability in care and this invariably leads to higher average length of stay a more denials.

Involvement in case management rounds allows individual cases with high denial potential to be addressed proactively with the treating physician present. This is very effective because the case is discussed openly and the physician provides support for continued stay, which can be immediately relayed to the insurance company. If, on the other hand, continued stay cannot be justified, the discharge order can be initiated at or immediately after case management rounds. **In a DRG environment, this goes beyond denials and has the potential to significantly reduce ALOS.**

A well designed physician peer to peer process has the potential to reduce denials by 10 to 20%. However the process must be designed in such a way that it is easy for the physician to reach the insurance medical executive and cases are selected in such a way that the likelihood of success is high. This encourages the physician to buy into the process.

A simple measure of the success of physician intervention programs is the denials by diagnosis data. As physician intervention programs gain traction, you should see the top diagnosis drivers of denials start to drop down the list. For example if there are strong interventions targeting chest pain, abdominal pain, and cellulitis because they were number 1, 2 and

3 on your list of denials by diagnosis. Over time, however, these diagnoses should start to migrate down the list and no longer maintain the top positions on the list.

Concurrent review and case management

Most insurers still require regular transmission of clinical information from the inpatient setting in order to justify payment for continued stay. Depending on the contractual arrangement and payment methodology, this can vary from daily clinical transmission, to once per admission, to justify admission, to daily, once a certain threshold (LOS) length of stay (outlier) is reached. Regardless of the methodology, inadequate concurrent review is a major driver of denials. So what are you looking for in a strong case management program? A strong program should include the following components

1. It should be proactive rather than reactive.
2. It should include an emergency department component.
3. There should be close collaboration with the treating physicians, especially the high volume treating physicians and hospitalists.
4. There should be close collaboration and communication with the insurance companies.

Here are questions you should ask to give you a sense of the effectiveness of your program.

1. How does the clinical information retrieval process work?
   a. How early does concurrent review start retrieving information to send to the insurer?
   b. Do they proactively engage physicians for additional information if the notes in the chart is not sufficient to support ongoing stay?
   c. Do they anticipate denials and start to work to justify stay even before the insurer gets the clinical or do they wait to hear from the insurer first?
   d. What is the latest time information needs to get to the insurer?
2. How is information relayed back from the insurer to Case management and how is the information used?
   a. Does case management get a log the same day information is relayed to the insurer with status updates on the disposition of each case?
   b. If yes, how is the information on the log used?
      i. Used to make decision's regarding possible discharge.
      ii. Used to determine the need for peer to peer interactions.
   c. How soon does case management take action based on information from the log? The same day? The next day? 2 or more days later?
3. Does an ED sentinel case management program exist in your facility and how effective is it?
   a. What diagnosis were selected for pre-admission review and why?
   b. What is the schedule for coverage?
   c. What type of data was used to determine coverage?
   d. How is the effectiveness of the program monitored?
4. What type of data is used to access the effectiveness of case management?
   a. What percentage of denials are 1 day stay?
   b. What is the trended denial rate over 5 years?
   c. What is the trended ALOS over 5 years?

These questions will give a good idea of the strength of your concurrent review program. Concurrent review should be proactive not reactive. A reactive process simply collects information from the charts, transmits it to the insurer, and then awaits a decision from the insurer.

A proactive process includes a strong case management component. Not only is information collected from the chart, but at the same time case management is analyzing the case and determining if there is sufficient information to support continued stay. If there is not, then case management immediately engages the treating physician to begin the discharge process or gather the needed information to support continued stay. Once information is sent to the insurer, a response should be received the same day via a daily log. The insurer's response should not be a surprise if case management has already proactively reviewed all cases. Based on the insurer's response, ongoing discharge efforts can continue, or physician peer to peer is initiated in cases where there is a true difference between the insurer's response and what case management expected.

Sentinel ED case management is used to reduce denials by reviewing cases against medical necessity criteria before admission. Data can be used effectively to determine what diagnosis are selected for pre-admission review. Data can also be used to decide the coverage hours based on when denials frequently occur. Sentinel ED case management is extremely important in a DRG environment and should probably include review of all cases.

Insurance Company Activities and the regulatory environment

There is no question that for most hospitals, dealing with the insurer can be a stressful activity with very little perceived benefit. Because they have market power, insurers are able to dictate the terms of engagement. For most hospitals, there is little that can be done to make insurer's change their polices.

However hospitals can try to hold insurers to their own stated documented policies and procedures. Contracting should be involved in this process to make sure everyone is on the same page regarding the particular insurer's policies and procedures.

In addition, insurers can be held to medical management regulatory requirements and insurance regulations. Here are some questions you should ask to give you insight on how this process works at your facility.

1. How often does medical management meet with the top 5 insurers and what issues are being addressed? Some examples of areas worth addressing that have the potential to impact appeals results are the following.

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a. Availability of the insurer's medical director for peer to peer calls.
b. Adherence to medical necessity criteria.
c. Timely transmission of daily denial log
d. Prompt response to appeals

2. How effectively is medical management holding insurers to regulatory requirements and insurance regulations?
   a. Does medical management have a reliable way of tracking adherence by insurers to regulatory requirements?
   b. How is this done?
   c. Is there data to show if insurers are meeting timeliness requirements in terms of issuing denials, responding to appeals, timely payment and availability of a medical director to speak with physicians.
   d. If the data is available, how is it used?
   e. Is it used to get insurers to improve their process or used to actually get denials overturned.
   f. Is hospital legal department involved as needed for the most serious offenders?

Leveraging both contracting and legal as needed puts pressure on insurers to follow the rules and has a positive impact on reducing denials. However, care must be taken to make sure the process is objective and supported by strong, timely, objective evidence.

Summary

Following the above process will give you a much better understanding of how your medical management department is functioning in the different areas. Additionally, it will also provide information that drives discussions on how best to improve the effectiveness and efficiency of the medical management process. Ultimately, the most powerful measure of success is a falling denial rate over time.

About the author

Dr Olaniyan is a physician leader with over 20 years experience, with demonstrated expertise in managing escalating medical cost. As a consultant at William Mercers healthcare practice, he helped many hospitals and fortune 500 companies identify areas of opportunity for growth and profitability. As a senior executive at both United Health Care and Cigna HealthCare he helped develop cutting edge case management and disease management products that improve care for many members. He is currently the president of Case Management Covenants (CMC), a healthcare consulting firm he founded in 2005. CMC's primary focus is Physician driven denials and medical cost reduction. Dr. Olaniyan is board certified in internal medicine, a Fellow of the American college of Physicians and The American College of Physician Executives. He is also a member of The HealthCare Financial Management Association, and American Association of Healthcare Administrative Management. He has published numerous articles and lectures extensively in the area of medical management. Dr. Olaniyan can be reached at o.olaniyan@cmcovenants.com.