Denials:
Beating Payors
At Their Own Game

March 24, 2023

What to Expect

Real World Denials, Practicable Solutions, and Proven Denial Prevention!

Emerging & Prevalent Denials
Effective Resolutions
Denial Management Best Practices

Who We Are

- Experienced Team of Revenue Cycle Professionals
- Committed to Helping Healthcare Organizations Thrive
- Passionate About Solving Even The Most Difficult of Revenue Cycle Challenges!

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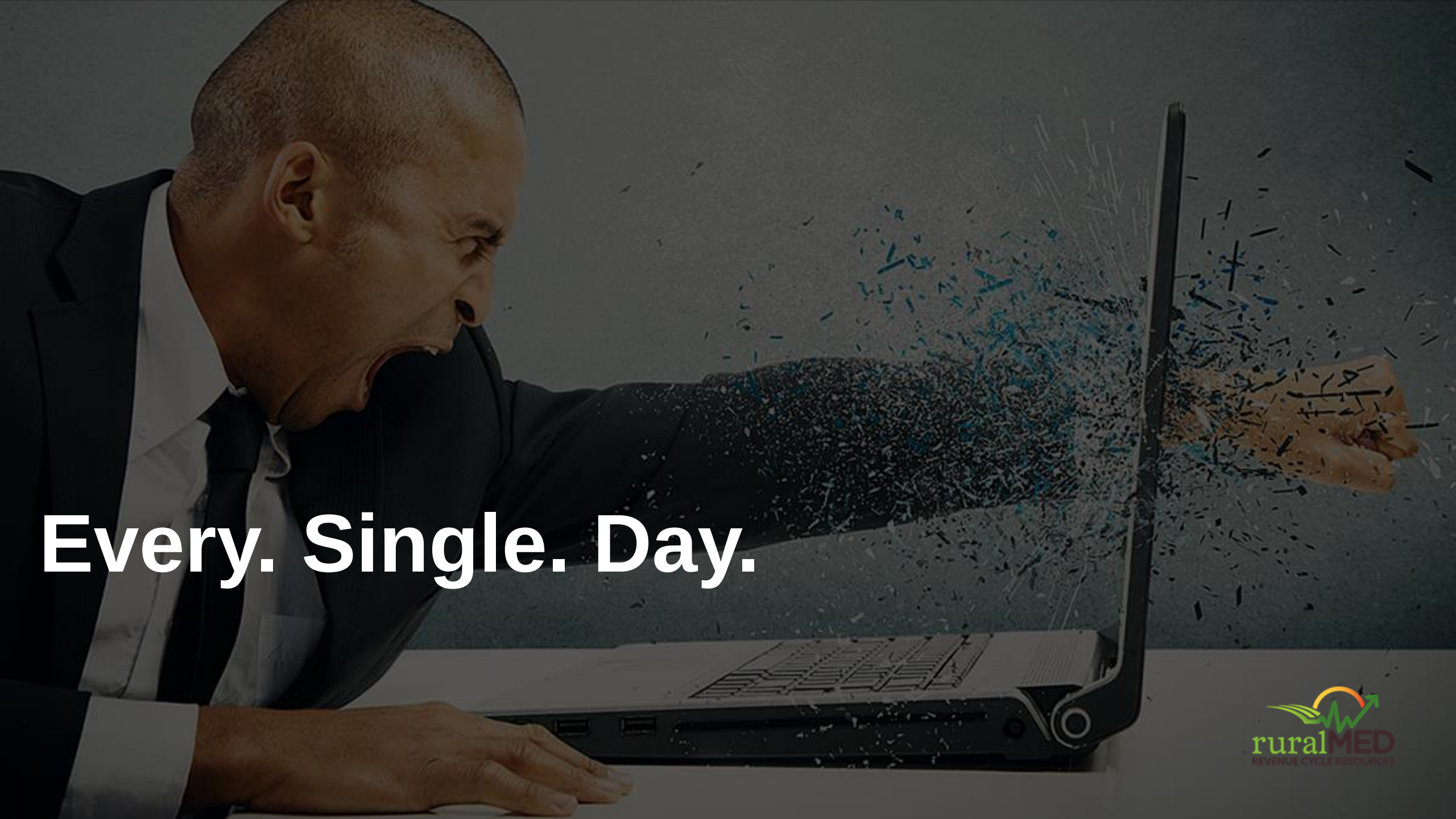
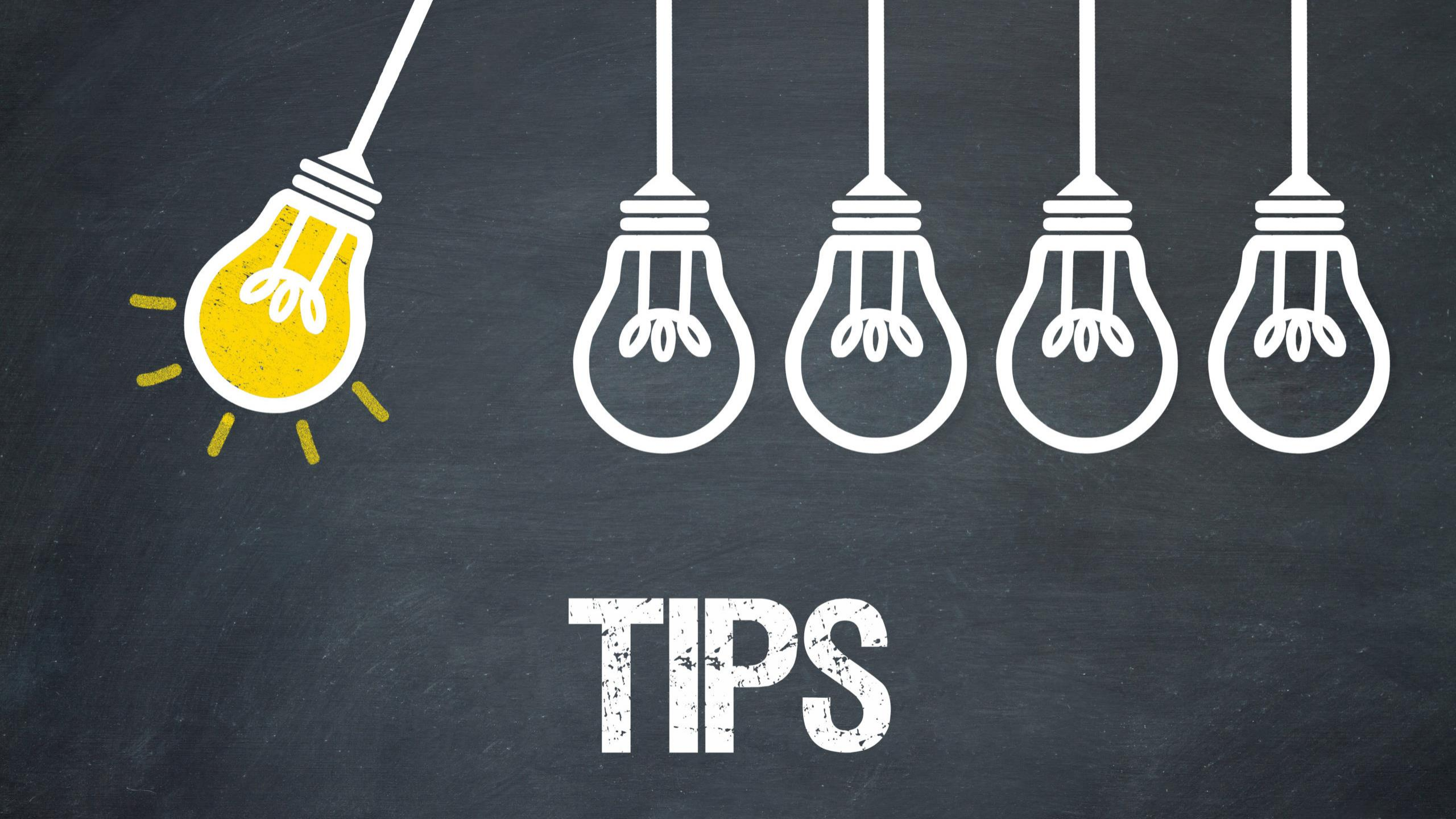
REVENUE CYCLE RESOURCES


Every. Single. Day.


TIPS

Governing Bodies

Nebraska Medicaid MCOs

- Oversite -State of Nebraska DHHS

Worker's Compensation

- Nebraska Workers Compensation Court Informal Dispute Resolution (Mediation) Request
- https://www.wcc.ne.gov/resources/court-forms-and-publications/idr-request

Nebraska Department of Insurance

- Fully Insured Plans
- https://doi.nebraska.gov/consumer/appealing-denied-health-claim

Governing Bodies

Department of Labor

- Self Insured plans
- Click on “File a Complaint” or 1-866-444-3272 to speak with an EBSA Benefits Advisor
- https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

Medicare Advantage

- General Escalation: CMS Drug and Health Plan Operations Group (DHPO)
  - 07CMHPORF@cms.hhs.gov
- Formal Appeal: Medicare MA Appeals & Grievances Processes
  - https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

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Effective Appeals

Learn the Art of An Effective Appeals!

- Written by Expert in that Area
  - Ex.-Coders or UR Draft Medical Necessity Appeals
- Concise
- References Specific Points in Record
- Provides Other Relevant Information
  - Payor Medical & Reimbursement Policies
  - CMS Publications

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Claims
DENIED

Some Old, Some New, and Some Crazy

Pre-Authorization
- Pre-Service
- Level of Care
- Missed Authorization or Notification
- Third Party Review

Medical Necessity

Payor Reimbursement Polices

Bundled Services
- Supplies
- ER/Inpatient
- Multiple Service Reductions

Incorrect Forms
- MA Professional Fees
- Medicaid CRNA Fees

No Surprises Act (Use & Abuse)

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Pre-Authorizations

Pre-Service

- Medical Necessity, Site of Service, Experimental, Other Treatment Required
- Educate on Escalation Options

Level of Care

- Timing!
- Consider Milliman/InterQual
- Payor Level of Care Matrix
- Hold Claims

Missed Authorization or Notification

- Don’t Stop Trying!

Third Party Reviews With Immediate Recoupment!

- File a Formal Appeal
- Contact Your Provider Rep
- Immediate Escalation to Governing Body

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Medical Necessity

Payor Medical Policies

- Narrowing Coverage
- Frequency Limitations
- Numerous Changes
- Predeterminations Optional
- Effective Appeals!
- Don’t Assume MA Plans Follow Medicare LCD/NCDs

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Reimbursement Policies

Hidden Denials

- Adjusted to Contractual

Bundling

- Supplies
- Infusion/Injection Admins
- Venipunctures

Lab & Radiology

- Fee Schedule/”Flat Rate”

Multiple Payment Procedure Reductions

- Therapy, Radiology, Surgery

Reimbursement Audits & Contract Language is Key!

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Contract Provisions

MA Professional Fees

- Method II
- CRNA Passthrough
- RHCs

Medicaid CRNA Fees

- State of NE “Passthrough List”

ER/Obs/IP

- 3 Day Window Bundling
- Appeal!

Contract Matrix & Language is Key!

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No Surprises Act

Low Out of Network Payments

- Payment Often Lower than Medicare or Medicaid Rates

“Hidden Denials”-Contractual Adjustments

- Payment Poster Education

ALWAYS Initiate Open Negotiation

- File 30 Days From Remit Date
- File IDR If No Response or Unable to Reach Agreement

Non-Compliant EOBs

- Report to CMS!
- https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint

Workers Compensation

NE Workers Compensation Act-48-125.02:

- Notification Required Within 15 Days If Additional Information Is Required
- Payment Must be Made Within 30 days of Receipt of All Information
- No Payment in 30 Days: FULL Billed Charges Must Be Paid NOT Fee Schedule

Lost Records?

- File a Report With the OCR

Contracts

- Carriers Taking Inaccurate or Non-Applicable Contractual Adjustments

Denial Management Best Practices

It Now Takes a Village

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Facility Wide Involvement

Revenue Cycle Steering Committee:

- Ensure Financial & Clinical Department Representation!
- KPI Review
- Report Review Examples
  - Initial Denial Trends
  - Overturned/Upheld Denials
  - Preventable Final Denials-Include $ Amounts!
  - Late Charges
  - Point of Service Collections
  - Registration Accuracy
  - MSPQ Compliance
- Discussion
  - Compliance Concerns
  - Chargemaster Items

Centralize

Authorization

- Develop Centralized Routing System
- Review of Schedules (Surgery, Radiology, etc.)
- Verify Accuracy of External Authorizations

Medical Necessity Review

- Point Person to Review Payor Policy Changes and Communicate to all Stakeholders
- Pre-Determination Process
- Internal & External Order Review
- Frequency of Service Determinations

Registration

- Cross coverage
- Consistent Accountability

System

835 ERA Routing Rules

- CARC & RARC Routing Per Financial Class/Health Plan

Denial Analytics

- Reporting to Root Cause Initial & Final Denials

Detailed Adjustment Categories

- Ex-No Authorization, Medical Necessity, Non-Covered, MUE, Credentialing, Timely Provider Sign Off

WQ Set-Up

- Escalation Parameters per Financial Class/Health Plan

Escalation

- Coding, Registration, Clinical Review
- Keep All Claim Communication Within The System

Payor Contracting Collaboration & Communication Strategy

Existing Contracts

- Get Organized and Share!
  - Payor Information Matrix
    - Timely Filing
    - Reimbursement Rates
    - Contractual Provisions Affecting Payment
    - Provider Representative Contact Information

New Contracts

- Use Decision Document
- Involve Key Stakeholders in Reviewing Contract Provisions
- Contract Interpretation
- CAH & RHC Provisions (Method II, AIR, CRNA Passthrough)
- Unique Payment Provisions
  - Ex: UHC Provision Capping Inpatient Stays at 4 days

Audits & Reports

Audits

- Find Hidden Denials- “The Sweeper”
  - Reimbursement Audits
  - Zero Balance Report
    - Review for 100% write off
  - Adjustments By User Report
    - Biller Driven Adjustments
    - Adjustment Approval Process/Threshold

Reports

- Robust Denial Reporting
  - EHR, Clearinghouse, Outside Software


Questions