Breaking the Denials Cycle:
Addressing DRG Downgrades & Ghost Denials

HFMA Mid America Summer Institute: SPARK Revenue Cycle

Meet the Presenter

Jeff Podraza, JD

President & General Manager
Denials Resolution & Prevention
Aspirion

Discussion Overview

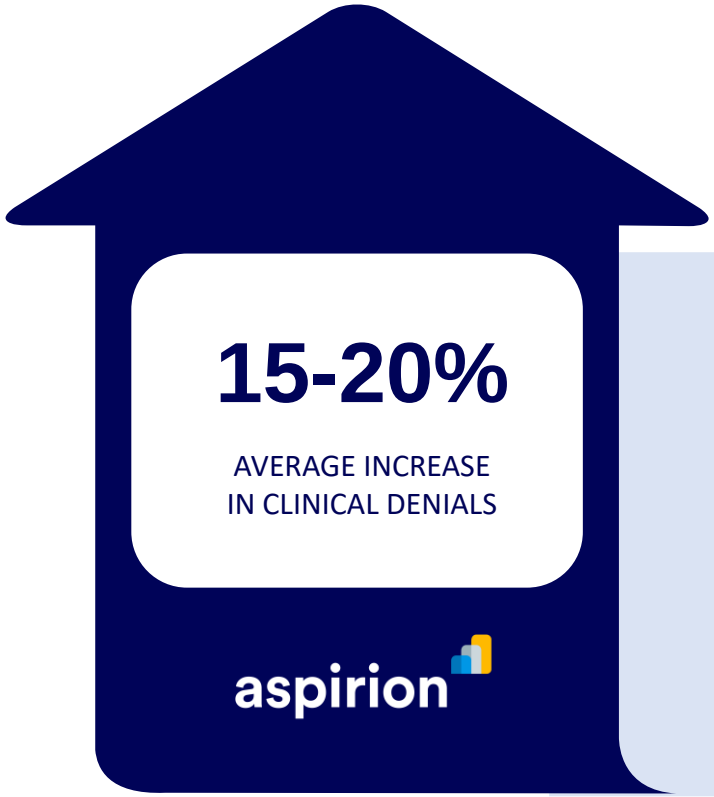
1. Today’s Complex Denials Landscape
2. Denials Team Structure & Processes
3. Tracking & Measuring Complex Denials
4. Managed Care, Contracting, & Compliance

Today’s Landscape

Complex Denials

5-Year Clinical Denials Trend: Aspirion Insights

Aspirion has seen a rise in clinical denials among its partner hospitals and health systems across the country, highlighting an escalating industry-wide issue.



Clinical Denials Have Increased

Particularly Complex Denials

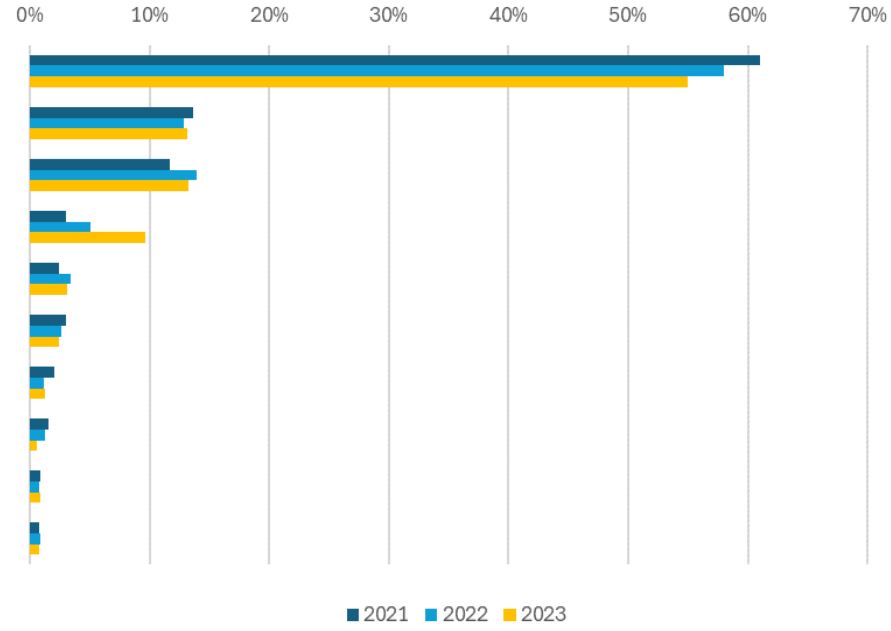
Over the last 5 years, Aspirion has seen a 15%-20% average increase in clinical denials including:

- Authorization
- Medical Necessity

3-Year Trend: Authorization Denials

Authorization Denials – by Top 10 Auth Denial Type/Issue – 3 Year Trend

Authorization - Denial Type - by Year	2021	2022	2023
AU - No Authorization	61%	58%	55%
AU - Authorization Issue	14%	13%	13%
AU - Authorization on File	12%	14%	13%
AU - Level of Care	3%	5%	10%
AU - Medical Necessity	2%	3%	3%
AU - Add On/Different Procedure Performed	3%	3%	2%
AU - No Authorization for Specific Proc Code	2%	1%	1%
AU - Number of Units/Days Exceeded	2%	1%	1%
AU - Invalid Authorization/ Dates of Service	1%	1%	1%
AU - Length of Stay	1%	1%	1%

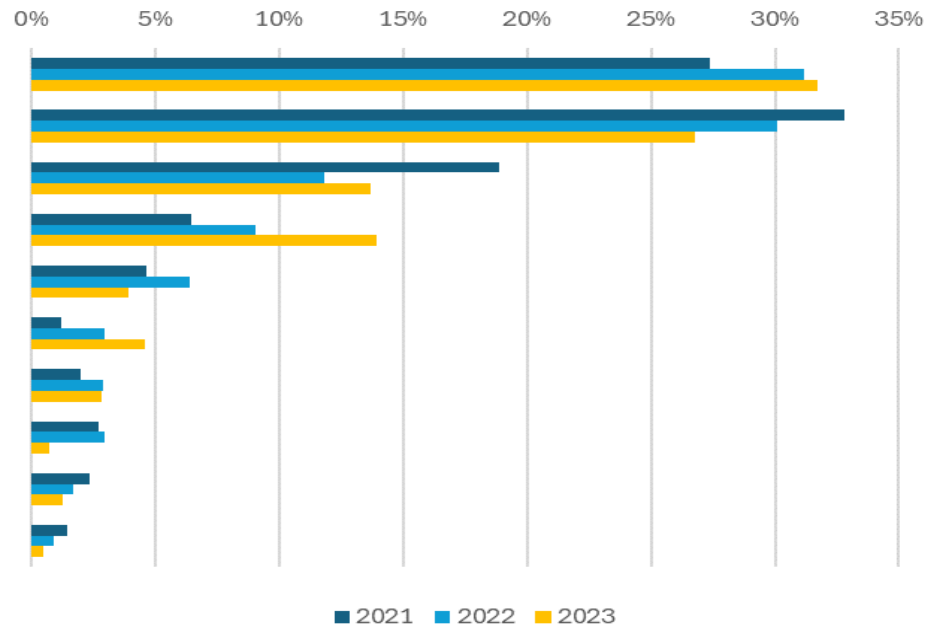


- 10% Decline in Blanket “No Authorization” Denials
- 300% Increase in “Level of Care/IP Not Authorized” Denials

3-Year Trend: Medical Necessity Denials

Medical Necessity Denials – by Top 10 Med Necessity Denial Type/Issue – 3 Year Trend

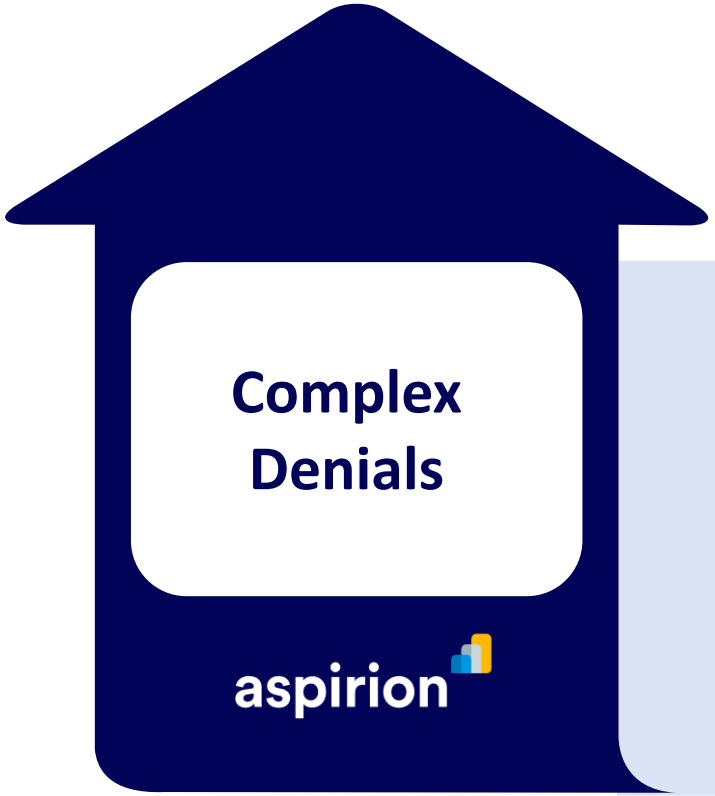
Medical Necessity - Denial Type- by Year	2021	2022	2023
MN - Level of Care - General	27%	31%	32%
MN - General	33%	30%	27%
MN - Experimental or Investigational	19%	12%	14%
MN - Payer Deemed Specific CPT Code not MN	6%	9%	14%
MN - Non-covered LCD or NCD	5%	6%	4%
MN - Number of Units Exceeds Allowed	1%	3%	5%
MN - Readmission Issues	2%	3%	3%
MN - Level of Care - Observation Issue	3%	3%	1%
MN - Length of Stay - General	2%	2%	1%
MN - Level of Care - Non Emergent	1%	1%	0%



19% Increase in "Level of Care/IP Downgrade" Denials

Uptick in Complex Clinical Denials

Swiftly resolving clinical denials enhances healthcare organizations' financial performance and ensures proper reimbursement.



Clinical Denial Types

- DRG Downgrades
- Bundling / Charge Audits
- Level of Care Downgrade Payments
  - Inpatient to Outpatient
  - Inpatient care levels
- ED Acuity Levels
- Non-Covered Services

What is a “Ghost” Denial?

Ghost Denials

Denials that are not well-defined by the payer or are unable to be accurately and quickly identified by the provider without in-depth analysis.

What does that mean?

- ✓ Not well-defined by the payer
- ✓ Unable to quickly identify

Providers across the country are no longer simply accepting these denials and are now taking more proactive approaches to limit and mitigate effects.

So, what can you do?

Breaking the Cycle: How to Overturn These Denials

aspirion

Identify the denial

- ✓Review claim, EOB, denial letter
- ✓Call payer for clarifying details

Research denial validity

- ✓Do you agree or disagree with the denial?

Assess arguments for denial overturn

- ✓Strength of argument to overturn, and likelihood of success

Craft a compelling dispute/appeal

- ✓Utilize supporting documentation, include contractual arguments and legal arguments where appropriate.

Best Practices

Denials Team Structure and Operational Processes

Best Practices: Team Members

Which team members operate as part of your denials team?

- *PFS reps, nurses, coders, billers, physician advisors – anyone else?*

Many provider systems understand the importance of having a physician advisor on the denials review team, and more systems are adopting this practice, in addition to nurses and coders.

When the clinicians work together with coders and other team members, they can dig into the actual nuts and bolts of the claim and understand what's happening with that account.

Best Practices: Team Operational Processes

Do they only work certain denials? (clinical vs. technical)

Is the team responsible for audits – pre-pay, post-pay, clinical validation, DRG, disallowed charges?

Do they work only certain payers or payer types? (Commercial/Medicare/Medicaid/Other Govt)

Breakout: Sepsis DRG Downgrade Query Checklist

15 Queries Designed to Surface Key Factors That Support Sepsis Care

1. "Was there a confirmed infection, and what was the source of the infection?"
2. "Was the patient's temperature greater than 38°C or less than 36°C at any point during the hospital stay?"
3. "Did the patient's heart rate exceed 90 beats per minute during the hospital stay?"
4. "Was the patient's respiratory rate greater than 20 breaths per minute or was the arterial carbon dioxide tension (PaCO2) less than 32 mm Hg?"
5. "Did the white blood cell count exceed 12,000/µL, was it less than 4,000/µL, or were there more than 10% immature (band) forms?"
6. "Was there evidence of hypotension, specifically systolic blood pressure less than 90 mm Hg or a reduction of greater than 40 mm Hg from baseline?"
7. "Did the patient exhibit renal dysfunction, such as an abrupt increase in serum creatinine or reduced urine output despite adequate fluid resuscitation?"
8. "Was there respiratory dysfunction, indicated by a PaO2/FiO2 ratio less than 300 or the need for mechanical ventilation?"
9. "Did the patient have liver dysfunction, with an increase in bilirubin to levels more than 2 mg/dl?"
10. "Were there coagulation abnormalities, such as a platelet count less than 100,000 µl or significant drop from baseline, or presence of disseminated intravascular coagulation?"
11. "Was there any neurological dysfunction, such as altered mental status without an alternative explanation?"
12. "Were lactate levels elevated, indicating tissue hypoperfusion?"
13. "What treatments were administered specifically for the management of sepsis and the associated organ dysfunctions?"
14. "Was there documentation of the patient's baseline organ function prior to the onset of sepsis for comparison?"
15. "Were any other causes of hypotension, besides sepsis, identified and ruled out during the patient's hospital stay?"

Best Practices: Escalation Efforts

Does your team collaborate with payers to resolve trending denials - Joint Operating Committees (JOC) meetings, payer provider relationships?

Does your team collaborate externally with other hospital systems directly, or indirectly through networking groups?

How far does your team take a denial – peer to peers, internal appeals, external appeals, arbitration/litigation prep?

Tracking & Measuring

Complex Denials

Tracking & Measuring

How are you tracking these complex denials today: within your patient accounting system, or separately?

Do you have internal thresholds for denial amounts in these categories that your health system does not pursue?

Have you established internal benchmarks regarding denial overturn rates for these claims?

Tracking & Measuring

What steps can you take to prevent these denials on a forward-going basis?

Collaboration

Managed Care, Contracting, & Compliance

Denials Feedback Loop

How robust is the feedback loop with your managed care, contracting, and compliance team with regards to these denials?

Contract Language Audits

What type of contract language do you currently have pertaining to audits?

Contract Language Wish List

What's On Your Contract Language Wishlist?

1. Right to appeal, how many levels, response time
2. Right to third-party review, IRO, and/or arbitration
3. Right to be paid in full BEFORE any audit commences
4. AR threshold limitations (by % of volume or dollars) for payer's right to audit
5. Timeframe for audits: from date of discharge, date of first payment or processing date
6. No refunds or recoups before expiration of appeal timelines
7. Require written notice of detailed audit reasoning
8. Acknowledgement that an itemized bill is insufficient to perform charge audits
9. Audits by health plan exclusively, no third-party company or vendors the health system isn't contracted with
10. Single audit allowed per claim (of any kind)
11. Defining which coding guidelines will be used (CMS, InterQual, Milliman, etc.)

For helpful revenue cycle management tips, scan here

Thank You

Jeff Podraza, JD
President & General Manager, Denials Resolution & Prevention
Direct: 571.218-7861 • jeff.podraza@aspirion.com