RevUp for CareConnect
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Managing Payer Denials

...*The devil is in the details*

A Business Office Perspective

Rudy Braccili Jr. MBA, CHFP

September 26, 2023

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Those Were the Days…

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Those Were the Days…

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Those Were the Days…

WEEKENDERS AT A GLANCE

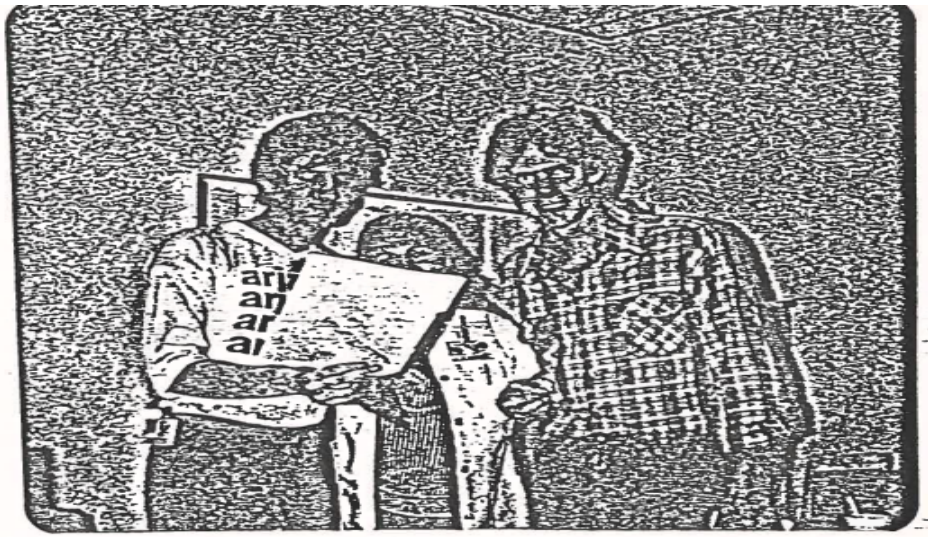
FEATURING: RUDY

JOE (AKA JOSEPH BAGADUNTS)

MUGS

ET AL

Those Were the Days…



A T T E N T I O N W E E K E N D E R S :

TO ALL INTERESTED PARTIES; A GRADUATE HOSPITAL WEEKENDERS CHORUS WAS RECENTLY FORMED. WE KNEW THERE WAS A NEED FOR THIS, WHEN WE RECEIVED A REQUEST FROM A PATIENT WHO NEEDED SOMEONE TO SING AT HIS BEDSIDE WEDDING. RUDY, JOE, AND MUGS BEING THE ONLY TRIO AVAILABLE AT THE TIM QUICKLY PRACTICED A FEW TUNES, OF COURSE THE FAVORITE OF THE PATIENT WAS "GET ME TO THE CHURCH ON TIME." AS WITH ALL HOSPITAL NEWS, WORD GOT OUT ABOUT THE TRIO'S RAVE REVIEWS (SEE THE PHILADELPHIA INQUIRER ISSUE 2/6/83 PAGE 18) AND THEY NOW ARE AVAILABLE FOR ALL PARTY FUNCTIONS. PLEASE KEEP THEM IN MIND WHEN SCHEDULING ENTERTAINMENT FOR YOUR NEXT MEDICAL SEMINARS.

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Those Were the Days…

PHOTO CAPTURING PATIENT REPRESENTATIVE RUDY BRACCILLI ("REAL PATIENT REPRESENTATIVES DO GET BLOOD ON FINANCIAL OBLIGATION STATEMENTS") AT 9:49 LUNGING FOR PHONE TO LOCATE SUPERVISER DIANE CARTER TO DISCUSS THE POSSIBILITY FOR THE WEEKEND STAFF TO TAKE A PERSONAL WEEKEND.

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Agenda

For Discussion Today:

- ❑ About Keck Medicine of USC
- ❑ The Challenges of Payer Denials
- ❑ USC's Approach to Combat Payer Denials
- ❑ Payer Denial Prevention Strategies
- ❑ Payer Denial Case Study Examples

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DISCLAIMER

- I am far from perfect!
- I'm here to share with you, and learn from you
- We are a work in progress…a continuous process improvement department
- We value:
  - Learning
  - Open exchange of ideas
  - Having fun
  - Accomplishing goals together

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About Keck Medicine of USC

Keck Medicine of USC is the University of Southern California's medical enterprise, providing highly specialized, world-class patient care at:

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Keck Hospital of USC **(401 beds)**
Surgery, Transplants, no E/D, no L&D

USC Norris Cancer Hospital **(60 beds)**
Hi volume off-site oncology clinics

USC Verdugo Hills Hospital **(158 beds)**
Community hospital with E/D, L&D

USC Arcadia Hospital **(348 beds)**
Community hospital with E/D, L&D

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About Keck Medicine of USC

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About Keck Medicine of USC

- ✓ Hospital CBO includes 3 of our 4 hospitals
  - Pt Access reports to corporate Pt Access leader
  - Pre-Arrival reports to corporate Pre-arrival leader
  - Arcadia acquired 2022 will join CBO ~ 2025
- ✓ Over 100 off-site clinics are licensed as "Hospital-based"
  - A/R managed by hospital CBO
  - Pt Access/Auth reports to clinical leader
- ✓ CBO collects ~$165M per month (excluding Arcadia)

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About Keck Medicine of USC

- ✓ 83 Patient Access representatives serving 3 hospitals…
  - 41 VHH (includes E/D, OB)
  - 28 Keck (Largest hospital has no E/D/OB
  - 14 Norris (Cancer hospital has no E/D/OB)

- ✓ Approximately 80 Pre-arrival representatives serving 3 hospitals and some clinics
  - Address all I/P accounts
  - Address most O/P > $50k accounts

- ✓ 95% of pre-arrival call center team are remote

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About Keck Medicine of USC

- ✓ Approximately 90 CBO Patient Accounting Reps:
  - Billing Mgmt, Chart audit/Coders
  - Third party Collections/credits/refunds
  - Self-pay/Customer Service
  - Contract terms & conditions
  - 95 % of CBO team work on-site five days per week

- ✓ Outsourced PFS functions:
  - Small balance insurance collection < $3k
  - Cash posting
  - Billing
  - Clinical appeal writing
  - Medicaid eligibility

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Denials Processing: Challenges

- ✓ Claims and appeal processes vary by payer
- ✓ Authorization discrepancies
- ✓ Deciphering specific underpayment reasons
- ✓ ANSI standards for payers are not enforced
- ✓ Identification of the party "at risk" for payment; DOFR

"Anthem BC HMO-Optum (HCP) (TMMC Risk)-Inpt,OPS"

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California DOFR's

I am writing to clarify billing processes for dates of service on and after January 1, 2021, for psychiatric services provided to Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal members in an emergency room (ER) setting.

Billing for behavioral health services should follow the existing processes for the terms set forth for the division of financial responsibility outlined in each IPA's network participation agreement with Blue Shield Promise.

- ER services provided to Blue Shield Promise Medi-Cal members as part of treatment for a behavioral health diagnosis that does not result in an inpatient psychiatric admission are the financial responsibility of either the member's assigned IPA or Blue Shield Promise, depending on the assignment of risk for emergency room services outlined in the IPA's agreement with Blue Shield Promise.
- ER services that result in an inpatient psychiatric admission continue to be the financial responsibility of the County mental health plan.

We appreciate the expert care you provide, and we value the opportunity to provide our members, your patients, with access to quality care.

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Denials Processing: Challenges

- ✓ Incorporating statutory requirements in collections
- ✓ Payer communication barriers; long hold times
- ✓ Identifying party accountable for where the service was performed & creating feedback relationship
- ✓ Technology challenges
- ✓ Hospitals must abide by changing payer manuals
- ✓ Understanding medical necessity

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Denials Processing: Challenges

Quoting USC's Director of Coding…

*"…RevCyc managers and staff must minimize the cliché or platitude usage of the words and terms like "**documentation**" and "**medical necessity**" and instead express literally (with the greatest specificity) what is actually required—especially when speaking or writing to non-RevCyc leaders and staff…"*

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Denials Processing: Challenges

Hire & retain the best revenue cycle professionals.

* Critical thinking skills
* Curiosity; a thirst to find answers/resolve
* A passion to win/overturn denials/get paid!
* The likeability/happy gene
* A good problem solver

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Denials Processing: Challenges

Hire & retain the best revenue cycle professionals.

Must be highly proficient in:

* The UB04/837

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* Reading payer EOB's

* Understanding/interpreting payer contracts

* Be proficient in system applications

* Know hospital/department policy

* Conversant in medical terminology

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Denials Processing: Challenges

Payers don't want to pay. It's in their nature…

How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them

Internal documents and former company executives reveal how Cigna doctors reject patients' claims without opening their files. "We literally click and submit," one former company doctor said.

"…His claim was just one of roughly 60,000 that Dopke – the Medical Director - denied in a single month last year, according to internal Cigna records reviewed by ProPublica and The Capitol Forum…"

Source: ProPublica/the Capitol forum March 2023

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USC's Approach to Combat Payer Denials

- ✓ Verification of insurance benefits pre-service or soon thereafter
- ✓ Copies of insurance cards & photo ID scanned
- ✓ POS collection of co-pays
- ✓ Electronic Notification of Admission to major payers
- ✓ Pre-arrival call center performs quality review of IP and high dollar OP accounts pre-billing

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USC's Approach to Combat Payer Denials

- ✓ **Seek authorization prior to service or soon thereafter**
  - Patient Access/Pre-arrival for O/P
  - Case Management for I/P…including peer-to-peer
  - On-line from payer/Availity web portals
  - Hardcopy authorizations are scanned
  - <u>All efforts must always be documented!</u>

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USC's Approach to Combat Payer Denials

- ✓ **Collection teams are grouped by payer**
  - One supervisor per team
  - One team lead/high dollar collector per team
  - Account balances > $3,000
  - Each collector has inventory of 300 – 350 accounts
  - Productivity target = 35 accounts per day
  - Workflow in place to refer problem accounts to team lead
  - Quality reviews performed by Supervisor
    - three collectors per month
    - five accounts reviewed per collector
  - One Plan Specialist & one Pre-Legal Specialist

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USC's Approach to Combat Payer Denials

- ✓ **Close collaboration/feedback/assistance among:**

  PFS
  Patient Access
  HIM Coding
  Case Management
  Revenue Integrity
  Clinical leaders
  Managed Care Contracting
  Legal
  I.T.

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USC's Approach to Combat Payer Denials

- ✓ Refer denials and underpayments to accountable team for validation/correction prior to appeal.

Refer To:	Underpayment/Denial Reason
Revenue Integrity	Revenue Code & Hard Coded CPT's
Billing Chart Auditor	NDC's, Modifiers & MUE's
Case Management	IP Auth, Medical Nec., OBS v IP
HIM Coding	DRG Downgrade, Dx Code
Pre-Arrival	OP Auth, Eligibility
Clinical Leaders	OP Medical Nec.: IMRT, Chemo

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USC's Approach to Combat Payer Denials

Example: Collaboration between PFS & Case management

Prior to appeal, the following denied, or underpaid inpatient cases are added by the Collector to a Case management Shared Drive LOG:

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Inpatients having a length of Stay (LOS) = 1 or 2 days

If Denied or underpaid due to Auth discrepancy, medical necessity, Inpatient should be Observation

USC Case Management professionals will review the case and either change the patient type to OP, or advise to send to clinical appeal vendor partner for clinical appeal of IP case

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USC's Approach to Combat Payer Denials

- ✓ We strive for "clean claim" submission – robust billing edits & continuous process improvement

- ✓ Account balances are netted down to = expected reimbursement amount at time of claim release to payer

- ✓ We organize our collectors by Payer; "Master your payer!"
  - Collectors do follow-up and denials/appeals
  - Proficiency with assigned payer's contract terms
  - Familiarity with assigned payer's denial reasons/issues

- ✓ Provide access to contracts to revenue cycle professionals

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USC's Approach to Combat Payer Denials

- ✓ HIPAA standard electronic responses received from payers- are auto posted to the patient accounting system
- ✓ Some responses are then mapped in the system to drive account follow-up workflow
- ✓ All are then reportable for trending analysis

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270: Eligibility, coverage or benefit provider inquiry
271: Eligibility, coverage or benefit payer response

276: Claim status provider inquiry
277: Claim status payer response (~681 possible)

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277 Claim Status Response Examples

EDI DATA	EDI DATA DESC
277	Accepted for processing.
277	Admitting diagnosis.
277	Authorization exceeded
277	Cannot provide further status electronically.
277	Charges applied to deductible.
277	Claim assigned to an approver/analyst.
277	Claim is out of balance
277	Procedure code not valid for patient age
277	Submit newborn services on mother's claim
277	Subscriber and policyholder name mismatched.

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USC's Approach to Combat Payer Denials

✓ **835: Remittance advice/EOB**

- Claim Adjustment Reason Codes (CARC) (~400+)

This is the primary reason a payer reduces payment

Each CARC is assigned to a group code

CO: contractual obligation

PR: patient responsibility

OA: other adjustment

PI: patient initiated

CR: correction and/or reversal

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- Remittance Advice Remark Codes (RARC)

Further defines the reason for the CARC

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CARC Remittance Examples

EDI DATA	EDI DATA DESC
CARC	Adjusted failure to obtain second surgical opinion
CARC	Coinsurance Amount
CARC	Expenses incurred after coverage terminated.
CARC	Late filing penalty.
CARC	Patient is enrolled in a Hospice.
CARC	Precertification/authorization/notification may be valid but does not apply to the billed services.
CARC	Revenue code and Procedure code do not match.
CARC	The time limit for filing has expired.
CARC	This payment is adjusted based on the diagnosis.
CARC	Other Adjustment
CARC	Finalized/Denial-The claim/line has been denied.
CARC	Requests for additional Information Documentation-Examples: certification, x-ray, notes.

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CARC, RARC & Claim Status Codes

Beware: Use of CARC, RARC & claim status codes by payers is anything but standard

the devil is in the details…

- ✓ Payers often do not comply with CARC-RARC requirements i.e., some CARC codes are required to be reported with a supporting RARC but are not
- ✓ Payers use ambiguous or meaningless codes
- ✓ Payers do not interpret these codes the same
- ✓ Payer-specific testing is necessary before driving workflow

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USC's Approach to Combat Payer Denials

- ✓ IP Clinical appeals are written by (vendor partner) RN's
  - USC submits & follows-up
  - If vendor determines the case to be not appealable,
  - Account is referred to Case Management for opinion

- ✓ We file level 1 (& level 2 if contractually required) appeals on all underpayments & denials balance > $250.
  - Upload to payer portal or certified mail
  - Use payers form or USC standard
  - Always include medical record
  - Never include a UB

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USC's Approach to Combat Payer Denials

If appeal is unsuccessful…Payer Escalation or Legal

- ✓ Contracted payers:
  - Account qualifies for "Payer escalation" (PE)
  - Collector adds account to shared drive PE log
  - Plan specialist sends spreadsheet to payer
  - Meet monthly with Payer Provider Rep
  - If unsuccessful at PE table, account is sent to Legal
- ✓ Non-Contracted Payers:
  - Account sent to Legal after appeal loss

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USC's Approach to Combat Payer Denials

Don't ever give up on collecting significant dollars owed from third party payers, for medically necessary services provided by our Caregivers!

When all else fails; Engage attorneys

- ✓ No cost to the hospital. Nothing to lose
- ✓ Attorneys only get paid if hospital gets paid
- ✓ Significant attorney cost to the payer to defend
- ✓ At a minimum, likely to achieve bulk settlements

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USC's Approach to Combat Payer Denials

OUR ROLE AS PARA-LEGAL

An important role played by everyone within the revenue cycle is to provide collection attorneys with the robust, concise documentation they need to win the case

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- ✓ Insurance verification/eligibility responses
- ✓ "Notification to payer" actions taken
- ✓ Attempts at authorization/pre-certification
- ✓ Interactions between clinicians (CM) and payers
- ✓ Payer statements made during collection calls
  - Example: "We are backlogged, short-staffed"

Denial Reason: Authorization Discrepancy

The term "Authorization Denial" is ambiguous

The devil is uncovered in the details:

- Full auth obtained and included on the claim
- Full auth obtained and not included on the claim
- Full auth obtained from another entity
- I/P auth obtained but some days carved out as not necessary
- I/P auth obtained but payer determines should have been outpatient
- I/P auth obtained but level of care not necessary e.g., ICU
- O/P auth obtained for CPT xxxxx but CPT yyyyy was billed
- O/P auth obtained for CPT xxxxx but not for billed Dx
- O/P auth obtained for CPT xxxxx but xxxxx & yyyyy were billed
- O/P auth obtained for CPT xxxxx 300 units but 400 units billed
- O/P auth obtained for CPT xxxxx 300 units 2 x per week but CPT xxxxx 600 units were billed 1 x per week

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Authorization Discrepancy Documentation

Documentation Specifics are Needed to Successfully Combat Payer Auth Denials

- Auth attempted: Yes or No…if not why not…
- Name of entity/organization/individual providing authorization
- Auth number
- Source/method used for authorization…payer portal, phone call etc.
- Is auth for Hospital? Physician? Surgeon? Implant? Drug?
- Date or date range authorized for services to be provided
- Location or facility authorized to provide services

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- **What specifically was authorized**
  - **For I/P** obtain specific dates authorized and level of care authorized
  - **For O/P** obtain the specific CPT codes authorized
    Is authorization for a specific diagnosis? If so document
    The quantity or units per CPT authorized
    The frequency per CPT authorized

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Authorization Related Legislation

California DMHC § 1371.8 rules state that:

"A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility"

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Authorization Related Legislation

California Title 28 CCR 1300.71 (a)(8)(T):

Defines as a prohibited payment practice any "attempt to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization"

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Federal CMS Title 42 CFR § 422.113(b)(2)

States that, "An authorization for pre-approved non-emergency care cannot be retrospectively modified or denied. This enforces the plan's financial responsibility "for post-stabilization care services obtained within or outside the MA organization that are pre-approved"

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Keep Hope Alive !

CMS and others take steps to improve prior authorization in MA and beyond

Recent developments point to an industrywide effort to ease the burden of prior authorization.

Most notably, CMS on April 5 finalized a rule that includes provisions designed to improve prior authorization in Medicare Advantage (MA) starting with the 2024 plan year.

The rule addresses prior authorization in a few ways, including by requiring MA health plans to comply with national and local coverage determinations that are applicable in Medicare fee-for-service (FFS). MA plans can apply internal coverage criteria in scenarios where no Medicare FFS guidelines are available, but they must publicly post a summary of the evidence that went into the decision.

With the new regulations looming, UnitedHealthcare, the nation's largest health insurer, is modifying its prior authorization policies. The company announced March 29 that it would remove prior authorization from nearly 20% of nonurgent items and services starting in Q3. The changes will apply to the company's commercial, MA and Medicaid managed care members.

In addition, a Gold Card Program will allow participating providers to avoid prior authorization for most procedures starting in 2024.

"We need to continue to make sure the system works better for everyone, and we will continue to evaluate prior authorization codes and look for opportunities to limit or remove them while improving our systems and infrastructure," Anne Docimo, MD, chief medical officer with UnitedHealthcare, said in a written statement. "We hope other health plans will make similar changes."

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Medicare trustees project 3 additional years of

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Keep Hope Alive !

Cigna ends prior authorization requirements for 25% of procedures
Cigna Healthcare has removed prior authorization requirements for more than 600 medical procedures…

Cigna will also remove preauthorization requirements for around 500 Medicare Advantage codes later this year, according to the release.

Other payers have also moved to limit prior authorizations.

Aetna has also moved to reduce prior authorization requirements.

The efforts come ahead of proposed regulations from CMS that would require payers to approve urgent prior authorizations within 72 hours, and within seven days for standard requests. The rule would also require payers to publicly report prior authorization denial rates and provide specific reasoning for denied requests.

(Source: Beckers Payer Issues August 24th 2023)

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USC's Approach to Combat Payer Denials

You cannot manage what you cannot measure….

- ✓ For issue trending by payer, Collectors must properly categorize the primary reason for denial, underpayment and payment delays;

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- ✓ Assign a Root Cause to all underpaid and denied claims as well as all claims not paid within 60 days of claim transmit

- ✓ Root cause answers the question: What is the primary reason the claim was unpaid, underpaid or payment delayed?

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VisiQuate Root Cause Assignments

ROOT CAUSE DESCRIPTION
AUTH DENIAL - FULL AUTH OBTAINED
AUTH DENIAL - NO AUTH OBTAINED
AUTH DENIAL - PARTIAL AUTH OBTAINED
AUTO-LIABILITY-WORK COMP DENIAL
BENEFITS EXHAUSTED
BILLING DELAY
CHARGES DISALLOWED
CLAIM NOT ON FILE
COB/COVERAGE DISCREPANCY
CODE CHALLENGE - CPT/ICD/REV/MOD/NDC
COMPLIANCE REBILL
DENIAL - OTHER
DRG DOWNGRADE

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VisiQuate Root cause Assignments

INCORRECT PAYER BILLED
INVOICE REQUIRED
ITEMIZED REQUIRED
LATE CHARGE REBILL
LATE NOTIFICATION PENALTY
MEDICAL NECESSITY DENIAL
NONE SELECTED
NOT ELIGIBLE FOR SERVICES
NOT PAID PER LOA TERMS
OVERLAP DENIAL
PATIENT INFO REQUIRED BY PAYER
PAYER RATE CALCULATION ERROR
PAYER UNRESPONSIVE-DELAY
PAYMENT POSTING ISSUE
RECORDS REQUIRED
UNTIMELY FOLLOW-UP
SERVICE EXPERIMENTAL
UNTIMELY FILING-CLAIM/APPEAL/RECORDS

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USC's Approach to Combat Payer Denials

From detailed documentation level…

…to summarization level

We use the Payer Escalation and Legal Referral Logs to summarize and highlight pertinent information for the payer and or attorneys

A dedicated Payer Plan Specialist is accountable for all Payer Escalation inventory

A dedicated Pre-Legal Specialist is accountable for the Legal referral process

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USC's Approach to Combat Payer Denials

Payer Escalation and Legal Referral Log

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Hospital Name	HOSPITAL ACCOUNT #	NAME OF PAYER OWING BALANCE	PAYER'S INITIAL DENIAL OR UNDERPAYMENT REASON

USC'S APPEAL ARGUMENT: WHY WE SHOULD BE PAID	REASON PAYER DENIED USC'S APPEAL	1ST APPEAL DATE	2ND APPEAL DATE

PAYER'S ICN/CLAIM #	PRIMARY INSURED'S LAST NAME	PRIMARY INSURED'S FIRST NAME	PRIMARY INSURED'S POLICY #

PATIENT'S DOB	FROM DATE OF SERVICE	THROUGH DATE OF SERVICE	AUTHORIZATION #	TOTAL BILLED AMOUNT

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Payer Escalation Success Example

The below cases were successfully argued at the Payer Escalation table & subsequently paid one year after service. All had been lost on appeal:

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- ✓ Health Plan denied three inpatient visits for the same patient requesting COB information/form from the patient; Sum of account balance = $136,000
- ✓ Each of the three visits had eligibility verified prior to services
- ✓ Each of the three visits were fully authorized prior to service

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Payer Escalation Success Example

- ✓ Notes from Collector's calls showed HP representative stated:

The member's HP coverage termed on 7/13/22…(which is after the dates of service for the three visits)…The claims should not have been denied for COB. All charges incurred prior to term date will be paid.

- ✓ We have documented attempts to reach the member via phone and certified mail to contact USC or HP regarding HP's COB concern. But the member never responded.

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Denial Prevention Strategies

To have effective denial prevention efforts, a thorough, retrospective analysis is required

Begin with reports of EOB CARC & RARC codes by payer

Identify highest dollar denial reasons by payer and address
A cash acceleration initiative

Identify highest volume denial reasons by payer and address
A coast savings initiative

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Denial Prevention Strategies

Using the below Claim Status & CARC codes a monthly report is generated of all payments where the payer applied a late notification penalty. Feedback is provided to Pt Access & Contracting

Payer Electronic payer denials codes:

- **eClaim Status Desc**: Pre-Certification penalty taken
  Status Code#: 100
- **CARC Status Desc**: Payment adjusted because pre-certification/authorization not received in a timely fashion
  Status Code#: 210

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Denial Prevention Strategies

A deeper, detailed dive into each payer specific denial reason is then required to separate fact from appearance

Example:

- We discovered one payer with a high volume of the CARC “Medical Records Requested”. A deep dive showed the payer was requesting records on claims where services were not authorized
- The deep dive pointed the task force to the correct root cause fix of improving the authorization process, not expediting medical record submission

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Denial Prevention Strategies

Convene a hospital-wide Denials Task Force

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- ✓ **Case Management**: readmissions, un-approved days, medical necessity, lower level of care
- ✓ **Physician Advisor**
- ✓ **Contracting**
- ✓ **Information Services/Analytics**: reporting & workflow
- ✓ **Ambulatory Care Centers** (Oncology clinics)
- ✓ **Patient Access-** notification, authorization, eligibility, COB, out of network
- ✓ **HIM:** DRG downgrades, NCD/LCD, diagnoses challenges
- ✓ **PFS:** untimely claim, untimely appeal, untimely record ADR
- ✓ **Revenue Integrity**: MUE, modifier, disallowed charges

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DRG Downgrades

Definition: A Payer determines the DRG billed by the hospital is incorrect and that a lower paying DRG should have been billed

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Underpayment Reason: DRG Downgrade

- Every inpatient discharged from an acute care hospital is assigned a Diagnosis Related Group DRG. **Some** payers reimburse the hospital based on the DRG assigned to the patient.

DRG Examples:

862 POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS **WITH MCC**

863 POSTOPERATIVE AND POST-TRAUMATIC INFECTIONS WITHOUT MCC

864 FEVER AND INFLAMMATORY CONDITIONS

865 VIRAL ILLNESS **WITH MCC**

866 VIRAL ILLNESS WITHOUT MCC

867 INFECTIOUS AND PARASITIC DISEASES DIAGNOSES **WITH MCC**

868 INFECTIOUS AND PARASITIC DISEASES DIAGNOSES WITH CC

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Underpayment Reason: DRG Downgrade

DRG assignment is a function of the following factors:

- Primary diagnosis
- All other "secondary' diagnoses
- Principal and other procedures
- Patient's sex
- Patient's age

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When a payer downgrades a DRG…they are not challenging the DRG itself, they are challenging one of the above factors (A DIAGNOSIS OR PROCEDURE) determining the DRG.

the devil is in the details…

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Underpayment Reason: DRG Downgrade

- So, when a payer advises they are changing a DRG…Collectors must ask, which specific diagnosis or procedure code is being challenged which resulted in the downgraded DRG?

- This is needed in writing from the payer so HIM coders may review the record to either agree or disagree with the payer.

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Underpayment Reason: DRG Downgrade

Dear Healthcare Provider(s) of Record,

We are responding to your claim submission for inpatient hospital services for the member listed above.

Our payment to your facility may be different from the bill you submitted
The information pertaining to the claim does not support the derived diagnosis-related group (DRG).

Based on the available information, it was determined that a DRG revision is appropriate due to the following reason(s):

- D66 cannot be validated as relevant to this admission.

The information at the time of review does not support D66 impacted the admission.

As a result, the appropriate derived DRG is 552. This may result in a reimbursement that differs from what was expected based on the original claim submission.

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Underpayment Reason: DRG Downgrade

If HIM Coders disagree with the payer's downgrade, it means all the diagnoses and procedure codes present on the claim are supported by physician documentation within the record.

APPEAL ARGUMENT

"*After re-review by our certified professional coders, no changes to coding or DRG are warranted on this claim. The codes and DRG billed to the payer originally, are supported by the physician's documentation in the patient's legal record and as such we stand by the codes billed to the payer.*"

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Underpayment Reason: DRG Downgrade

IT'S THE LAW!

Any diagnosis written, signed and dated by a physician is valid for inclusion on the UB i.e., that is the patient's diagnosis, even if someone else disagrees clinically

Other clinical opinions (CDI) are "Interesting but Irrelevant" in the reimbursement world

The DNA in healthcare reimbursement is the medical record
If it is not documented, it did not happen
If it is documented, it is so

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Underpayment Reason: DRG Downgrade

INTERESTING BUT IRRELEVANT!

Denial Description: DRG assignment incorrect

Additional Remarks: Not supported. Payment of DRG 872 is not supported. Review supports DRG 392. A review of the medical records submitted did not validate A41.9; Sepsis unspecified as the diagnosis for this admission. The principal/secondary diagnoses codes are one of the determining elements for MS DRG assignment and payment. The member presented to the hospital complaining of fever and abdominal pain. It was noted that the physician documented Sepsis in the medical record. The medical record is examined for consistent documentation of the condition and clinical evidence supporting the diagnosis. While the patient presentation warranted consideration of Sepsis as possible diagnosis there was no evidence of a rise of two or more points in the sequential organ assessment table supporting a systemic infection post hydration, per Sepsis 3 criterion followed as of 01/01/2019. Therefore, because of this review the diagnosis code has been removed. Reference for Sepsis 3: Bauer et al. (2016). The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis 3). JAMA AND Critical Care Medicine: March 2017; Volume 45; Issue 3 page 486 to 552 Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2016.

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Underpayment Reason: DRG Downgrade

Real Life Case Example:

United is downgrading DRG claims from 794 (Neonate with significant problems) to 795 (Normal newborn) because baby was not in NICU. No challenge to diagnoses.

In effect, United has decided to replace the international standard DRG calculation method with their own redefinition of how a DRG is calculated…

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Underpayment Reason: DRG Downgrade

Internal United memo inadvertently shared during a meeting with the payer…

Normal Newborn Claims/DRG Default Process…continued

Changes Made

- We are supplementing internal logic to reimburse claims more accurately based on services rendered.
- The enhanced logic will put in additional rules to have these claims default to the more appropriate DRG 795 (Normal Newborn).

Provider Related Information

- Currently, if a provider is using a DRG derivation tool that follows CMS logic exactly, (including EASYGrouper) they are accustomed to seeing their billed DRG match the DRG paid by UnitedHealthcare. Once this change is made, the paid DRG will not match the billed DRG for in scope claims. Remark codes will state that the claim was paid per the contract (UNET – D2; USP – PP0-008).
- Appeals rights apply and providers should follow the standard appeal process.
- No provider contract language changes were required to support the project deployment.

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Denial Reason: Info Required from Patient

- Collection Teams will not flip to self-pay, accounts where the insurance is liable for payment, but information is required from the patient by the third party.

  Balances > $1,000
  Call patient three “unique” times via phone
  Send at least 1 letter certified mail
  Document all efforts to reach patient

The prize money is in the hands of the insurer
This is not an opportunity to punish the unresponsive patient

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Denial Reason: Info Required from Patient

- If no response from the patient, the account will be appealed to the payer including documented attempts to contact the patient.
- Include as arguments in the appeal, all authorization documentation and insurance eligibility verification documentation obtained in advance of the medically necessary services having been provided
- These accounts remain in the third-party payer class until resolved. Even to the point of sending account to legal to pursue payment from the third party.

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Case Example: Not a Covered Service

$36,409 balance denied by Aetna as "Non-Covered"

the devil is in the details…

- Hospital surgical benefits verified in advance
- Advised pre-service no auth required
- Billed CPT 54405: Insertion penile implant
- Diagnosis code N52.9: Erectile dysfunction
- Aetna stated not covered
- Changed to self-pay based on coverage determination
- Patient called to aggressively complain blaming hospital for not advising in advance
- USC appealed the case with records

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Case Example: Not a Covered Service

Aetna's appeal response (page 1)

You have requested the Plan to retrospectively conduct a review for medical necessity on the above-referenced claim on the basis that you were verbally informed by the Plan Utilization Management staff that no authorization was required. Review of the submitted claim indicated that you billed CPT Code 54405 (Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir) with the primary diagnose of N52.9 (Male erectile dysfunction, unspecified). The claim was denied as a Plan exclusion as per page 106 of the Plan brochure (Standard Option and Value Plan), the Plan does not cover services, drugs, supplies related to sexual dysfunction, impotency or sexual inadequacy. This was not denied due to lack of pre-authorization or medical necessity.

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Case Example: Not a Covered Service

Aetna's appeal response (page 2)

CPT Code 54405 if rendered as part of gender affirming surgery is considered medically necessary if certain criteria are met and prior approval is required (page 56 of the 2023 brochure). Because the primary diagnose did not indicate gender affirming surgery in nature, the Plan would not require prior approval. However, because it's considered a Plan exclusion as the service was related to sexual dysfunction, impotency or sexual inadequacy, the Plan is unable to reconsider the above-referenced claim for benefits. You may visit our website at www.mhbp.com for an online copy of the applicable Plan brochure.

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Case Example: Not a Covered Service

- PFS referred the case to HIM coders to see if there were any gender reaffirming notes in the record which could have been coded. The answer was no.
- A savvy PFS chart auditor then found the following from a visit 3 months prior to the surgery: (HIM was able to code from physician documentation up to six months prior to the encounter)

follow up visit

History of Present Illness

This a very pleasant gentleman here for follow-up. I follow him for hypogonadism. Testosterone pellets were placed on January 8, 2022. He is here for discussion of several other issues. He is endorsing erectile dysfunction. He is in the midst of a divorce and is having some relationship stressors, he is taking depression medications. He has failed oral medications including tadalafil and sildenafil. He was using Trimix, but this no longer is adequate in order for him to achieve an erection adequate for penetration. He also does have a underlying history of diabetes. He has had a Doppler with prostaglandin that showed venous leak. He is considering penile implant. His second point of discussion today is he is experiencing gender dysphoria. He is going to start working with a counselor on this. He is interested in consulting with a urologist regarding surgical management of this as well. Finally, he is considering coming off of his testosterone long-term given the gender dysphoria.

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Case Example: Service Not Authorized

Hospital obtained prior authorization from Blue Cross for:

CPT 93458: Catheter placement in coronary artery with left heart catheterization including injection

Coder coded, & hospital billed Blue cross for:

CPT 93454: Catheter placement in coronary artery

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Winning appeal argument:

"…The initial request which was authorized under AIM #21356887 was obtained for code 93458 which is for catheter placement as well only with a more in-depth study. A review of the record by a certified coder found that code 93454 was more suitable…"

Late Notification Penalty

BC Late Notification Penalty

the devil is in the details (of the payers billing manual)…

If non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are not submitted for review and a decision rendered before the service occurs payment will be subject to a 50% penalty. Providers and Facilities must present evidence of extenuating circumstances in the event that a Provider or Facility elects to dispute these reimbursement penalties.

Payment for emergency inpatient admissions will be subject to a 50% penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities must present evidence of extenuating circumstances in the event that a Provider or Facility elects to dispute these reimbursement penalties. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

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Case Example: Late Notification Penalty

the devil is in the details (of the payers billing manual)…

Issue: The CPT scheduled does not require pre-cert…but the final coded CPT does

Issue: Patient arrives as an observation patient (which does not require Auth) but is later rolled to an inpatient (which does require Auth) We have 48 hours from the date of the physician's order to "admit to inpatient" to notify BC.

Issue: Oncology clinics where drug regimen is changed by the physician on recurring patients, but a new auth/notification request is not initiated.

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Case Example: Late Notification Penalty

the devil is in the details (of the payer's billing manual)…

Issue: Patients registered with incorrect plan codes, who may be BC members but are not on the report because of incorrect plan assignment.

BC does receive an electronic daily census of all members admitted to the hospital as I/P.

Issue: A particular surgeon scheduling Ambulatory surgery patients as Observation…to avoid authorization requirements

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Case Example: Late Notification Penalty

the devil is in the details (of the payer's billing manual)…

Attorney's weigh in: What is a provider to do?

- The answer is claim specific…
- Extenuating circumstances? Perhaps procedure needed to happen immediately, like newly discovered cancer…
- Perhaps the patient had not provided the hospital with their insurance information despite the hospital's best efforts.
- Did hospital object to the policy when it was rolled out?

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Case Example: Drug Not Paid

$15,371 balance denied by Aetna as "Paid per Contract"

the devil is in the details…

- Amount paid by Aetna was < expected reimbursement
- Electronic claim status code F1:107 "processed according to contract provisions"
- Aetna rep when called stated J9312 not paid…send medical records
- USC appealed with records. Appeal response:

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Based upon our review and information provided we are upholding the previous benefit determination for J9312 basis of determination is the documentation received <u>does not show the member has a contraindication intolerance or ineffective response to the available equivalent alternative CD20 directed cytolytic antibody agent ,Truxima…"</u>

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Case Example: Drug Not Paid

$15,371 balance denied by Aetna as "Paid per Contract"

the devil is in the details…

- A savvy Collector uncovered a document in the patient's file whereby Genentech approved the patient to receive the drug free of charge.
- 150 days later, the solution was to credit the drug charge from the patient's account.

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Denial Example: Read the Fine Print

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- ✓ Page 1 of hardcopy authorization stated authorized from xx/xx/xxxx thru xx/xx/xxxx (admit through discharge dates)…
- ✓ Page 2 stated days 1 thru 5 authorized at Med/Surg, days 6 thru 10 authorized as administrative.
- ✓ Final 10 days of stay were authorized as Admin days and paid as Admin days USC did not appeal with clinical reasoning supporting the higher loc for the final 10 days...

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Photopheresis Denials Task Force

Issue Specific Task Force Example:

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- ✓ To work collaboratively to ensure Photopheresis cases are adequately documented by a physician, to address Medicare NCD (110-4) coverage requirements
- ✓ To ascertain Medicare's clinical trial requirements for billing (condition code 30) and to ensure cases are billed accurately with or without this code as is appropriate.
- ✓ To create a feedback process whereby cases denied for medical necessity documentation may be referred for research and re-billing/appeal response
- ✓ To create a pre-service process for addressing the above to eliminate denials and re-work.

Denial Prevention Strategies

Resulted in the creation of a form embedded in Cerner

Effective for the applicable ICD-10-CM procedure codes:

- 6A650ZZ - Phototherapy, Circulatory, Single
- 6A651ZZ - Phototherapy, Circulatory, Multiple
- 36522 - Photopheresis, extracorporeal (CPT/HCPCS)

Effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid Services has expanded coverage for extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when extracorporeal photopheresis is provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Further coverage criteria is outlined in Pub. 100-03, Chapter 1, part 2, section 110.4 of the NCD Manual.

(Please document the covered indication and any supporting evidence in H&P, Operative Report, Progress Note, etc.)

INDICATIONS (*Complete Indications from Section A **AND** select any additional CED Diagnoses/ICD-10 Code applicable from Section B*):

Section A (*Select ONE indication from each Subsection*):

1. Coverage with Evidence Development (CED) when beneficiaries are enrolled in a clinical study that meets all of the criteria listed in IOM Pub. 100-03 (*Select ONE indication*):

☐ Encounter for examination for normal comparison and control in clinical research program (*Z00.6*)
☐ Other (*Non-covered, explain*): _____

2. Coverage for extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation (*Select ONE indication*):

☐ Bronchiolitis Obliterans Syndrome (BOS) (*J42*)
☐ Other (*Non-covered, explain*): _____

Section B (*Select any additional CED Diagnoses applicable*):

☐ Lung transplant status (*Z94.2*)
☐ Unspecified chronic bronchitis (*J42*)
☐ Chronic obstructive pulmonary disease with (acute) exacerbation (*J44.1*)
☐ Chronic obstructive pulmonary disease, unspecified (*J44.9*)
☐ Obliterative Bronchiolitis (*J44.9*)
☐ Lung transplant rejection (*T86.810*)
☐ Lung transplant failure (*T86.811*)
☐ Lung transplant infection (*T86.812*)
☐ Other complications of lung transplant (*T86.818*)
☐ Unspecified complication of lung transplant (*T86.819*)
☐ Other: _____

Physician Comments: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Patient Name: _____ MR#: _____ Date of Birth: _____

Performing Physician: _____ Procedure Date: _____

References:

The Middle

Questions & Discussion

Thank You for Listening Today!