Insights and actions for successful results

REVENUE CYCLE STRATEGIST

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• denials management •

4 Clinical Reasons for Denials

By Glen Reiner and Sarah Bird

Healthcare providers should think of denials as more than just back-end problems.

Hospitals are struggling to systematically identify, manage, and ultimately avoid denials to protect their revenue. With denials estimated to cost hospitals about $5 million annually and the recent Office of Inspector General report on Medicare Advantage prior authorization and claim denials stating Medicare Advantage Organizations denied 36 million claims in 2016 alone, denials remain an impactful issue for healthcare organizations ("Medicare Advantage Plans Overturn 75% of Their Own Claim Denials," *RevCycleIntelligence*, September 2018).

In fact, the claim and denials management segment of the hospital revenue cycle is expected to witness the highest compound annual growth rate during the next few years ("Revenue Cycle Management Market Expected to Boom in Coming Years," *Healthcare Finance*, February 2018).

While technical denials—those related to administrative functions—often require a volume-driven approach to management, clinical denials—those related to medical necessity or treatment—tend to be more varied and complex and are often even camouflaged by technical denials. Clinical denials require targeted upstream effort, and close partnership between clinical and business office staff.

Common Causes

Below are some of the most common causes of clinical denials and suggested solutions for each one:

Patient status (observation versus inpatient). Hospitals are expected to triage patients—effectively paving the way for diagnosis and treatment decisions—by assigning them

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Key Strategies for Performance Improvement

Ensure leadership buy-in and stakeholder collaboration. The team should include representation from across the continuum of care, including the chief medical officer, CFO, and leaders from patient financial services, care coordination, clinical staff, and health information management.

Give front-line staff a voice/seat at the table. Bottom-up buy-in is often essential for a make-or-break element to any collaborative element. Huddles or daily rounds are great engagement points.

Measure progress in key areas. Agree to key performance indicators that can be accurately displayed and tracked on a dashboard and will keep the team engaged and focused for the long term.

Report out to give the initiative momentum. Continually close the loop and drive performance. improvement circle.

a status at or before the time a service is rendered. If patients are assigned inappropriate status based on their symptoms and conditions, or the documentation does not support the assigned status, denials can result. Once initial status has been assigned, consistent review of patients' status is necessary. Particularly, observation patients must remain monitored and managed accordingly. Delays in diagnostic testing or treatment, which can occur when patients are in observation status for an extended time, may cause denials. Review admission data and focus on high-volume case types. Make diagnostic testing and initial treatment options more readily available for the most common case types to avoid denials.

Delays in diagnostic testing or treatment while patients are in observation status for an extended time may cause denials.

Level of care. Once patients have been admitted, sufficient documentation about appropriate care delivery helps providers avoid level-of-care denials. In some instances, denials can occur because of admissions decisions or a lack of documentation specificity and documentation supporting evidence. A provider also may not clearly provide the rationale through documentation for care delivered.

Using InterQual or other evidence-based criteria can help guide the decision on level of care required and decrease denial risks. Healthcare organizations should perform quality audits at a minimum of four times per year to ensure documentation adequately supports the correlation between severity of illness and level of care.

Medical necessity. In some cases, claims can be denied when payers do not interpret patients' conditions as warranting care modalities or care plans delivered. Payers may require additional documentation to support the level of service and determine medical necessity. Costly diagnostic procedures or interventions like medical resonance imaging (MRI), for example, require documentation of medical necessity.

Case managers should regularly review cases using decision support criteria to determine the best ongoing levels of care and establish discharge plans. Depending on the average daily census, these reviews should occur daily or multiple times per week. Documentation must accurately reflect patients' conditions and enable payers to understand why the chosen levels of care are warranted.

Length of stay denials for non-DRG payers or contracts. Depending on payment methodology, payers may issue length of stay denials for patients whose length of inpatient stays may not be interpreted as medically necessary. At this stage, providers should be asking whether all referrals, diagnostics, and procedures have been carried out in the right time frames to manage clinical conditions. Ongoing use of decision support criteria is also helpful here, as it provides an outline of care and expected response by day.

In addition, use benchmarks when reviewing cases to understand any risks associated with patients whose treatment or recovery varies from the norm, and document patient response and care updates in detail to avoid potential denials.

Solutions

Providers should think of denials as more than just back-end problems. They should be proactive about what may cause denials and optimize processes to prevent denials from the point of patient registrations. Capturing patients' detailed clinical conditions and continuing to track and manage them closely while documenting along the way will significantly decrease the risk of clinical denials occurring. Providers can take the following actions.

Focus on patient status assignments. Establish systems to assign appropriate patient status as early as possible. Once patients qualify for inpatient status, determine whether patients meet severity and intensity criteria for continued stays.

Support treatment decisions. As patients are treated at the appropriate levels of care, check that documentation reflects adequate rationale to support the treatment and length of stay.

Pay attention to patient journeys. Examine patient journeys from beginning to end to assess opportunities to optimize work processes. Areas to investigate include the following:

- Where and when initial level-of-care decisions are being made.
- Which patients are targeted for follow-up level-of-care reviews and at what frequency.
- Who is responsible for level-of-care changes and how they are communicated.
- How opportunities discovered by the clinical documentation team are communicated to providers.

Once these have been identified, aim to improve in a few key areas, first by setting targets and selecting and tracking metrics to measure success.

Use data. Integrate data to enable clearer pictures of patient care and to align stakeholders from leadership to case management. When emergency department patient care staff can seamlessly share information with other departments and administrative support, documentation is more consistent, and the risk of denials is decreased.

Tips to Engage Physicians in Preventing Clinical Denials

Patient care and billing staff should align on criteria for each patient status category and build documentation tools that help ensure appropriate payments for patients' care plans.

Effective clinical documentation improvement (CDI) programs incorporate physician feedback as well as regular updates to rules and regulations. CDI programs that see the most success align stakeholders on a regular basis and examine trends across departments, physicians, and service lines. They regularly review and update their clinical documentation practices with ongoing training and support, making sure to align latest practices with any updates to relevant payer policies or regulations. A strong CDI program should continually be evaluated for comprehensiveness, strengths, and opportunities.

A strong physician second-level review program can support physician documentation practices and status decisions in real time by providing a collaborative resource, such as a champion or team, that supports physician understanding of clinical outcomes and morbidity and mortality as it pertains to patients' clinical pictures.

Prevention efforts should focus upstream in the revenue cycle, starting with patient status and continuing through documentation practices, coding, CDI, utilization review, and charge capture. Identifying clinical denials and root causes is a necessary first step in driving improved clinical and documentation behaviors to avoid denials altogether. •

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