

Mastering Utilization Review and Patient Status

a NAHRI virtual event 

Understanding Clinical Revenue Cycle: Front End Approach for Denials Prevention

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Presented By



- **Tiffany Ferguson, LMSW, CMAC, ACM**, is the CEO of Phoenix Medical Management, Inc., the leading case management firm. After practicing as a hospital social worker, she was tapped to serve as director of community case management and quickly assumed leadership responsibility as system director of health and care management. Later she became the top administrator for the employed medical group. Ferguson is CMAC and ACM certified, and serves on the observation subcommittee for ACPA. She is a regular contributor for RACmonitor and *Case Management Monthly* and is a commentator for *Finally Friday*. She is a graduate of Northern Arizona University and received her MSW at UCLA.

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Presented By



- **Marie Stinebuck, MBA, MSN, ACM**, is the chief operating officer of Phoenix Medical Management, Inc., the leading case management firm. Stinebuck has practiced as a nurse for the past 25 years with 15 years in the field of case management. She has served in several roles as system director of health management with promotion to the role as the senior network director of case management. She has had leadership oversight including case management, utilization review, denials prevention, clinical documentation improvement, and medical record integrity. She has authored articles for RACmonitor, CMSA, and *Case Management Monthly*. She holds an MBA from the University of Phoenix and an MSN in Leadership from Grand Canyon University. She received her bachelor of science in nursing from Northern Arizona University.

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Learning Objectives:

At the completion of this presentation, attendees will be able to:

- Analyze the impact of patient status on denials and revenue
- Articulate strategies involving utilization review (UR) in front-end revenue cycle processes
- Explain how clinical revenue cycle plays a key part in denials prevention

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Revenue Cycle Impact on Utilization Review

Determine patient eligibility and accurate demographic collection

Certification of appropriate level of care

Reporting denials and assistance in appeals and tracking of denials

Accurate coding, tracking, and monitoring of claims

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The Dilemma

- "In order to mitigate against the increasing risk of payer denials, hospital leaders must increase scrutiny of all aspects of the medical necessity justification process to ensure maximum effectiveness, efficiency resulting in fair and complete reimbursement."
– <https://www.whistleblowerfirm.com/hospital-fraud/>
- CMS should recover overpayments of \$1 billion resulting from incorrectly assigning severe malnutrition diagnosis codes to inpatient hospital claims, ensure that hospitals bill appropriately moving forward, and conduct targeted reviews of claims at the highest severity level that are vulnerable to upcoding.
– <https://www.oig.hhs.gov/reports-and-publications/compendium/files/compendium2021.pdf>
- "Medicare Overpaid \$636 Million for Neurostimulator Implantation Surgeries." In this report, the OIG found that more than 40% of such procedures may have been medically unnecessary.
– Medicare Overpaid More Than \$636 Million for Neurostimulator Implantation Surgeries, A-01-18-00500 (hhs.gov)

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Current Denials Trends



Medical Necessity Denials: A top denial reason for providers and facilities. An appeal is required to request a consideration or change in billing status. Most frequent reason is a denial stating that inpatient criteria was not met.



Short Stay Denials: Defined as an acute hospital stay of one day or less. Medicare Recovery Audit Contractors (RAC) have targeted short inpatient stays for hospitals with high rates of this stay type. One day stays indicate that the patient may not have required hospitalization or inpatient status. RAC reviews of these inpatient stays can result in a denial and removal of funds provided by Medicare for the inpatient stay.



A focus on medical coding and hospital billing are crucial to prevent denials. Front-end prevention will assist back-end denials!!

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Denials Are Obstacles to Complete Reimbursement

Sample Data

First Pass Denial Reason	Freq
Registration/Eligibility	28%
Duplicate Claim/Service	19.20%
Service Not Covered	15.00%
Missing or Invalid Claim Data	11.70%
Medical Documentation Requested	6.50%
Authorization/Pre-Certification	5.80%
Medical Necessity	5.40%
Medical Coding	4.30%
Untimely Filing	3.10%
Coordination of Benefits	1.10%

Change Healthcare 2020 Report

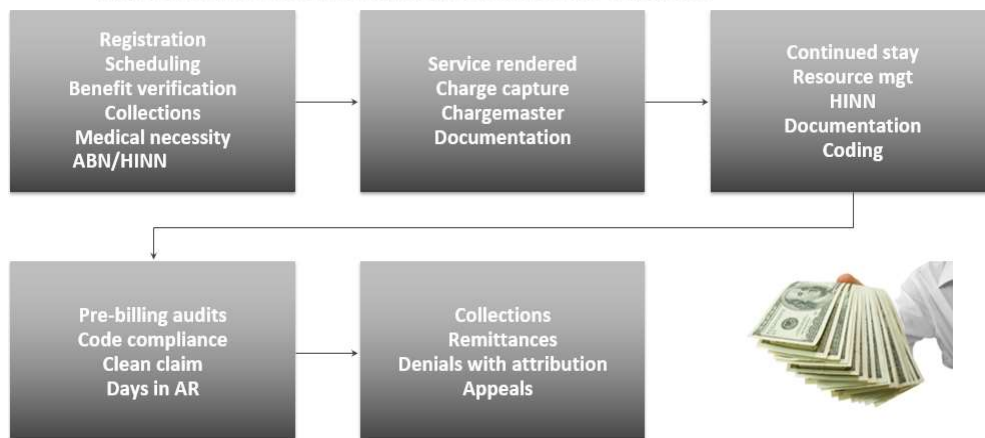
- The average denial rate from 2016 to 2020 has increased by 23%.
- ½ of all denials were identified as front-end revenue cycle issues
- 86% are preventable – “Doing it right the first time, every time.”
- Top areas:
 - Registration and Eligibility
 - Missing or Invalid Claim Data
 - Authorization Pre-Certification
 - Service Not Covered
 - Medical Necessity

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Access, UR, and the Revenue Cycle

Any break in the revenue cycle may likely result in a DENIAL of payment!



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What is Medical Necessity?

Social Security Act, section 1862(a)(1)(a) states that *“no payment may be made...for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”*

Medical necessity is required to determine whether the care provided to a patient is medically necessary, must be done in a hospital setting, and is reimbursable by the payer source. This definition can vary among insurers and government agencies.

Medical Necessity Documentation

Documentation of medical necessity justifies the necessity of acute care through complex medical decision making and should reflect:

- Patient's chief complaint
- Acuity of the patient's condition
- Any co-morbidities
- Why the nature of the patient's condition warrants hospital level of care
- The potential risks if the patient is not admitted

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Assigning Accurate Status

- There are just two levels of care: **inpatient** and **outpatient**. Observation is not a status—it is a service provided to outpatients with a physician order.
- If Medicare, apply the two-step process:
 - Does patient require hospital level of care?
 - Will that care extend over two midnights?
- Add another ½ step: Is it safe for them to be anywhere else?
- Remember, commercial payers are not bound by this rule and may still use **intensity of services** and **severity of illness**.
- Use criteria set as cited in payer contract.

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Observation Services: Outpatient Status

"Observation is an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged." The Federal Register, 11/30/01, pg 59881

Think of observation (OBS) services as an extension of the information gathering, decision-making process used in the ED to determine the need for inpatient admission.

In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

20.6 - Outpatient Observation Services
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

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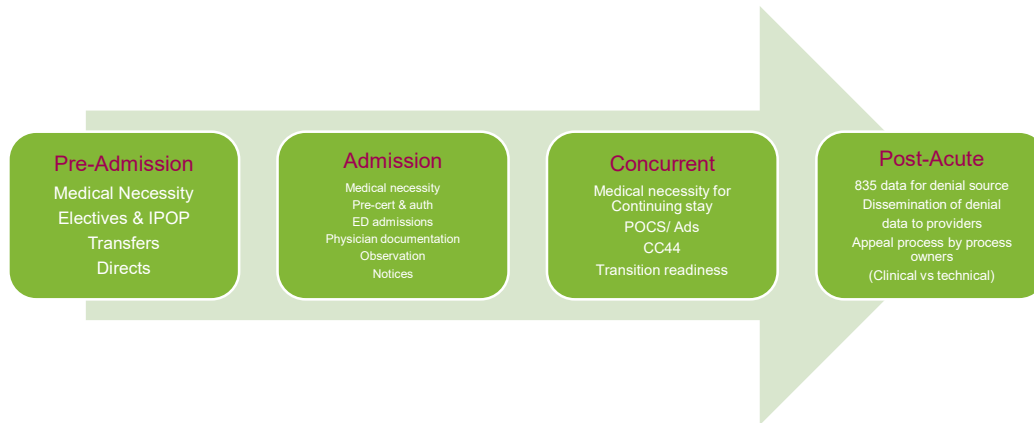
Observation Services Vs. Extended Recovery:

- Physician may not order observation for care normally included in the payment for a provided service (e.g., routine recovery following outpatient procedure as defined by physician. I&D may be 30 mins while a hernia may have 4-6 hours, and a mastectomy or prostatectomy may include an overnight recovery period).
- It is only after routine recovery ends that physicians may order observation due to some documented unexpected condition but not for convenience. If the hospital wants to extend use of bed as a courtesy to the physician/patient, the patient is in **extended recovery**, not observation.

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The UR Process



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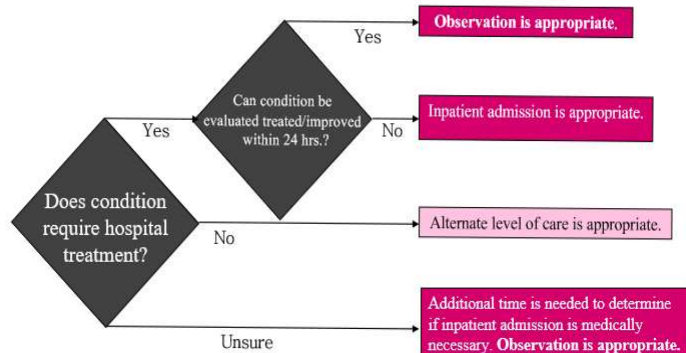
Ensuring Accurate Admission Status Through the UR Specialist

- UR is a **concurrent review** of physician documentation during the patient's hospitalization.
- UR critically reviews the completeness of medical documentation and recommends a level of care based on national guidelines.
- UR specialists work in the emergency department (ED) as real-time advisors to the clinical team with care managers, physicians, physician advisors, and nurses.
- The UR specialist works with care management, admissions, and bed management staff to review acute level of care appropriateness for direct admits, pre-admissions, and hospital transfers.
- UR contributes to the patient's clinical truth in record and revenue integrity.

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Admission Decision Tree



*The decision to admit a patient as an inpatient requires complex medical judgment, including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

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Front End Revenue Cycle



UR specialist is the access review specialist



Front door guard
Emergency room
Surgeries
Incoming transfers
Direct admits



Education

Highly proficient communication skills
Knowledgeable about access rules & regs.
Able to discern "portrait" of patient's need for hospital level of care
Understand non-coverage requirements

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Clinical Revenue Cycle: At the Front Door

Care Management	Physician Advisor	Clinical Documentation Specialist
<ul style="list-style-type: none"> • Expedite the delivery of care process. • Serve patients and transition them directly out of the ED. • Proactively coordinate the progression of care and sound the alarm for complex patients that are being admitted. • Prioritize the observation patients to confirm appropriateness of services and coordinate care in an outpatient setting. 	<ul style="list-style-type: none"> • Peer support for providing clinical resource and progression of care recourse. • Highly visible. • Perceived as credible and reliable. • Provide education and insight for effective resource management, care coordination, and regulatory updates. 	<ul style="list-style-type: none"> • In partnership with the UR specialist, provide appropriate front-end data and education regarding high query items that make medical necessity and coding difficult. Optimize potential for denial prevention. • Educate on the impact of terminology. <ul style="list-style-type: none"> • “Rule outs”that never gets resolved. • Sepsis without a source or organ dysfunction.

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Shift from Back-End to Front-End Revenue Cycle!

From a revenue cycle perspective, getting the most accurate information up front begins with patient scheduling, patient registration and confirmation of medical necessity.

Current state: Claims refilled, coding errors corrected, and rebilled, medical necessity letters written, and demographic errors remedied.

Desired state: Clean claims, all of which can be defended by medical necessity documentation.

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Transition to a Prevention Strategy



Use a comprehensive denials prevention strategy to identify where your processes are misaligned with industry best practices.

- Define change in how denials will be processed.
- Move away from a reactive process to a prevention focused strategy.
- Enlist the support of the PA and the URC.
- Find the process owner for each category of denials. Hold them accountable for process improvements within their area of responsibility.
- If teaching hospital, enlist support of teaching faculty.
- Involve hospitalist leadership.
- Prioritize remediation where it is most needed.
- Broadcast general findings to hospital associates.
- Report outcomes at each UR committee meeting—do not blind data and watch committee attendance grow.

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Denials Prevention

- Creation of a denial prevention workgroup which includes members of the revenue cycle team such as CDI, UR, contract management, patient access, HIM, central business office, and PA.
- Create mission statement of denials program related to strategy.
- Create a threshold amount for denials to appeal versus those to let pass through.
- Map out a singular system for documentation and tracking across organization.
 - Ensure all denials stakeholders are documenting in same program.

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Self Denials and Conversions

- Self denial is still a denial.
- Conversions may be the acceptance of lower payment and internal issue to avoid the denials process with the payer. (Taking observation!)
- Self denials and conversions are both important to track.

By aggressively denying over time, commercial payers have trained hospitals to self-deny cases that meet medical necessity.

Cases that could have qualified for inpatient but failed first level inpatient screening.

Observation cases that could have qualified for inpatient.

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Singular Process for Denials Across System

- Create a process for concurrent and retrospective denials management across system.
 - How are you notified?
 - Who receives the denial, and is the correct individual able to quickly address the denial or escalate it to the appropriate individual?
 - Is there a work queue in place to address, document, and track denials?
 - How is the physician advisor involved and what is the turn around time for P2Ps and appeals?
 - What is the feedback loop for tracking appeals and maintaining an aggressive follow up schedule on outstanding denials?
- Track appeals and overturns to share with leadership. Report in \$.

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Areas of Focus: Prove your ROI through Prevention

- Prioritize three top areas to focus on and develop a process improvement strategy
- Review baseline data and potential areas of greatest financial impact
- For example:
 - ED registration: Outdated insurance categories that ED is putting patients in
 - Medical necessity denials for LOC: Poor documentation from a specific surgical group
 - Payer issues: Contract states authorization/notification required within 24hrs of admission
 - Infusion denials: Commercial payer denies high-dollar claims due to place of service
 - Coding errors: Disputes between payer and hospital regarding coding definitions (clinical validation)

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Thank you!

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