

**Questions And Answers**

Bridging the Gap: Physician and Revenue Cycle Collaboration to Optimize Denial Prevention and Appeals

What is your recommendation for denials of sepsis in which our contracts do not address this? We appeal sepsis and have prior stated we adopt Sepsis-2 but payer announced Sepsis-3 criteria must be met? We lose and exhaust our appeal attempts. What should we do? We have talked with the payer via call and they state we must meet Sepsis-3 criteria for dx A41.9. Any ideas what we should do? robin.fetterly@rivhs.com

**1. Addressing Sepsis Denials When Contracts Are Silent on Criteria**

The discrepancy between Sepsis-2 and Sepsis-3 definitions has led to significant challenges in clinical documentation and reimbursement. While Sepsis-3 emphasizes life-threatening organ dysfunction due to a dysregulated response to infection, Sepsis-2's broader criteria are still widely used in clinical practice.​

Recommendations:

* **Internal Policy Alignment**: Ensure your institution has a clear, documented policy on which sepsis criteria are adopted, supported by clinical rationale and aligned with prevailing guidelines.​
* **Engage in Contract Negotiations**: Initiate discussions with the payer to clarify or amend contract terms regarding sepsis criteria. Emphasize the importance of consistent definitions to avoid future disputes.​
* **Leverage Clinical Documentation**: Strengthen documentation to clearly demonstrate the presence of sepsis under the adopted criteria. This includes detailed clinical indicators, organ dysfunction assessments, and treatment responses.​
* **Appeal Strategically:** When appealing denials, provide comprehensive clinical evidence supporting the sepsis diagnosis per your adopted criteria. Highlight any inconsistencies in the payer's application of criteria and reference authoritative guidelines.​
* **Seek External Review:** If internal appeals are unsuccessful, consider pursuing an independent external review, especially if the payer's criteria application appears inconsistent or unjustified.​

New concerns with Wellsense and Point 32 new observation policy jrivers5@mgb.org

**2. What should we do about new Wellsense and Point32Health observation policies?**

**A.** **Verify the patient’s product line.**

Wellsense and Point32Health each offer Medicaid, Medicare Advantage, and commercial plans. You must identify the product type before acting, because the regulatory and appeal strategies differ. Don’t assume - verify the plan ID or eligibility response.

**B.** **If it’s a Medicare Advantage plan (e.g., Tufts Medicare Preferred or WellSense MA**):

Use CMS's July 17 2023, memo as your appeal foundation. MA plans must follow the CMS Two-Midnight Rule.

In your appeal, cite CMS language that says the admitting physician’s expectation and documentation of a two-midnight stay qualifies for inpatient status.

If the payer refuses payment despite this, escalate to CMS using HPMS or advise the patient to call 1-800-MEDICARE.

Track each denial. If it becomes systemic, PayerWatch and AHDAM can support your efforts to report the pattern.

**C. If it’s a Medicaid plan (e.g., MassHealth via WellSense or Tufts Health Together):**

Request the full observation policy in writing.

If the denial contradicts published MassHealth guidelines or creates barriers to medically necessary inpatient care, file a grievance with the state Medicaid office.

In Massachusetts, that’s MassHealth’s Office of Medicaid Board of Hearings. In New Hampshire, contact DHHS Managed Care Ombudsman.

Make sure your appeal references any state-mandated coverage policies, if available. These vary by state.

**D. If it’s a Commercial or Exchange plan (e.g., Tufts Direct or Harvard Pilgrim PPO):**

Ask for the policy in writing. Don’t waste time appealing blindly.

If the observation policy is vague or overly strict, appeal based on InterQual or MCG criteria, and cite clinical risks (e.g., syncope, decompensation, complex comorbidities).

If the patient stayed two midnights or had risk justifying inpatient status, document that thoroughly and submit with the appeal.

For systemic issues, push your payer representative for contract review or policy modification.

**E. Share your cases.**

If you're seeing frequent denials from Wellsense or Point32 that seem out of alignment with policy or medical necessity, share redacted examples with AHDAM. We are building a working group to address exactly this kind of payer behavior across the industry.

How do you recommend handling Cotiviti's Cross Clinical Claim Review denials where they are denying based on claims data only without having seen the medical record documentation? The volume of these at our facility is high and each other these requests are labor intense to process because they require the complete medical record, DRG Coding Summary and detailed bill be sent with the appeal. nicwagn@med.umich.edu

**3. Managing Cotiviti's Cross-Claim Clinical Review Denials Without Medical Record Review**

Cotiviti's practice of denying claims based solely on claims data, without reviewing medical records, poses significant challenges.​

Recommendations:

**Challenge the Denial Basis:** In your appeals, assert that denying claims without reviewing the full medical record is inadequate and may not capture the complexity of the patient's condition.​

**Streamline Documentation:** Develop standardized templates and processes to efficiently compile and submit the necessary documentation for appeals, reducing the administrative burden.​

**Engage** with Cotiviti and Payers: Communicate directly with Cotiviti and the associated payers to express concerns about this practice. Advocate for policy changes that require comprehensive medical record reviews before claim denials.​

**Monitor and Analyze Denial Trends**: Keep detailed records of such denials, including success rates of appeals. This data can be instrumental in negotiations and in demonstrating the need for policy revisions.​

**Leverage Technology Solutions**: Consider utilizing platforms that can automate parts of the appeal process, track denials, and generate reports to support your

4. From "Architecture/Structure" slide we have lots of data - I'm a data analyst dedicated to our UR/PA team - I'm coming late into this webinar having just left a med staff UM Committee meeting where the PA is presenting case reviews reflective of data trends but how do you really change physician behaviors, these presentations almost falls on deaf ears in the meeting room. Are there other tactics for physician engagement? stephanie.slankard@baycare.org

**ANSWER**: The struggle is real.  I've spent many frustrating hours trying to convince clinicians that I care more about documentation than I do money....which is true.  However, that is also the base belief that they need to hear, and that you need to make.   Quality over Money.  Evidence Based Revenue Cycle is a term that I use (I think I might have coined it!).  If I focus on quality and documentation, then the outcome of cash "happens" and I don't have to chase money.

So, how have I been successful?

1. Start with data and specifics: Bring real accounts from your facility(s) and even better, bring real accounts that demonstrate where your care team didn't meet the burden of proof for quality.  Clinicians, I have often found, think of CODING as something that is related to reimbursement....and sure, we get paid on the codes.....but EVERY Qaulity metric uses those same codes to determine if a health outcome was favorable or not.  Hence, every code is an opportunity to prove that you are a quality clinician....or not.
2. Have a respected peer deliver the findings.  You can coach that person, but it will come better from a PRACTICING, RESPECTED peer.  The conversation will be received with more respect and from someone whom they consider to "understand" the situation.  The practicing teacher is important from my experience...where that is a Physican Advisor, CMO, or an emerging new position I love: CMO, Revenue Cycle.  The key is if that person still practices medicine, they will be better received that a retiree.
3. Don't try to conquer this all at once.  Pick a top 3 or 5 (Problem Clinicians, Problems Diagnosis, Problem CARC/RARC combos, etc) and focus on those for 1-3 months.  Put the other problems in a parking lot and escalate as you check others off the list.  A problem I see often is the "boiling the ocean" approach.....ie, trying to solve too many things at once.  Prioritization and working those priorities from root cause to completion is the key.

5. Are Medicare Advantage plans subject only to federal regs and not to the state insurance boards? cathy.seluke@mainegeneral.org

Primarily, yes.  They are supposed to comply with CMS, but are more and more operating in a nebulous manner that abides by the freedom they are normally granted in the commercial world and there are many, many examples we see where it feels like CMS is asleep at the wheel in terms of enforcement.

There are some state licensing requirements but the rules of adherence should comply with CMS policy.