Successfully Defending Inpatient Authorization Denials

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- The nation's only association dedicated to Healthcare Denial and Appeal Management.
- Our mission is to support and promote professionals working in the field of healthcare insurance denial and appeal management through education and collaboration.
- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Denise Wilson MS, RN, RRT

Senior Vice President, PayerWatch/AppealMasters; President, AHDAM

Denise has over thirty years of experience in healthcare, including clinical management, education, compliance, and appeal writing.

Denise has extensive experience as a Medical Appeals Expert and has personally managed hundreds of Medicare, Managed Medicare, and Commercial appeal cases and presented hundreds of cases at the Administrative Law Judge level. Denise is a nationally known speaker and dynamic educator on Medicare and Commercial appeals processes, payer behaviors, standards of care, appeal template development, and building a road map to drive the payer to a decision in the provider's favor. She has educated thousands of healthcare professionals around the country in successfully overturning healthcare denials.

Reggie Allen, MBA RN ACM

Chief of Clinical/Business Operations/PayerWatch

Reggie has more than 35 years of experience in a variety of healthcare positions, including staff nurse, nurse manager, Chief Nursing Officer, Chief Operating Officer, and Vice President, Clinical/Business Operations Transformation. He has been recognized nationally as an expert in care management and clinical operations. He is a results-driven leader who emphasizes operational transformation by integrating clinical and financial care aspects. He obtained a bachelor's degree in nursing from Vanderbilt University and an MBA from the University of Phoenix. He is a member of the American Case Management Association (ACMA) and the American College of Healthcare Executives.

Reggie possesses comprehensive knowledge and experience in all facets of care management, including case management, utilization management, disease management, quality management, and resource management. He has designed and implemented an enterprise-wide Clinical Appeals Unit and a clinical documentation program with success. Using six sigma and Lean principles, he is an expert in clinical and operational efficiencies that enhance clinical outcomes and financial performance through a variety of methodologies.

Preauthorization Meaning and Purpose

- Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.
- Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.
- Preauthorization isn't a promise your health insurance or plan will cover the cost.

https://www.healthcare.gov/glossary/

Preauthorization Meaning and Purpose

- The preauthorization process is utilized by health plans to ensure:
  - Necessity of services – evidence-based care
  - Effectiveness and safety of services
  - Cost efficiency
- Cons:
  - Burdensome on providers
  - Delay in or non-coverage of services for patients

Preauthorization Meaning and Purpose

- The Affordable Care Act prohibits health plans from requiring prior authorization for emergency services, regardless of whether the hospital is in-network or out-of-network.
  - *(Including some behavioral health services.)*
- Prior authorization requirements for treatment of mental health and substance use disorders cannot be more restrictive than the prior authorization requirements the plan has for other medical services.

https://www.healthinsurance.org/glossary/prior-authorization/

Preauthorization Meaning and Purpose

"Not a promise to pay"

- Managed Medicare: CFR 422.138(c) Prior Authorization
- "If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity…"

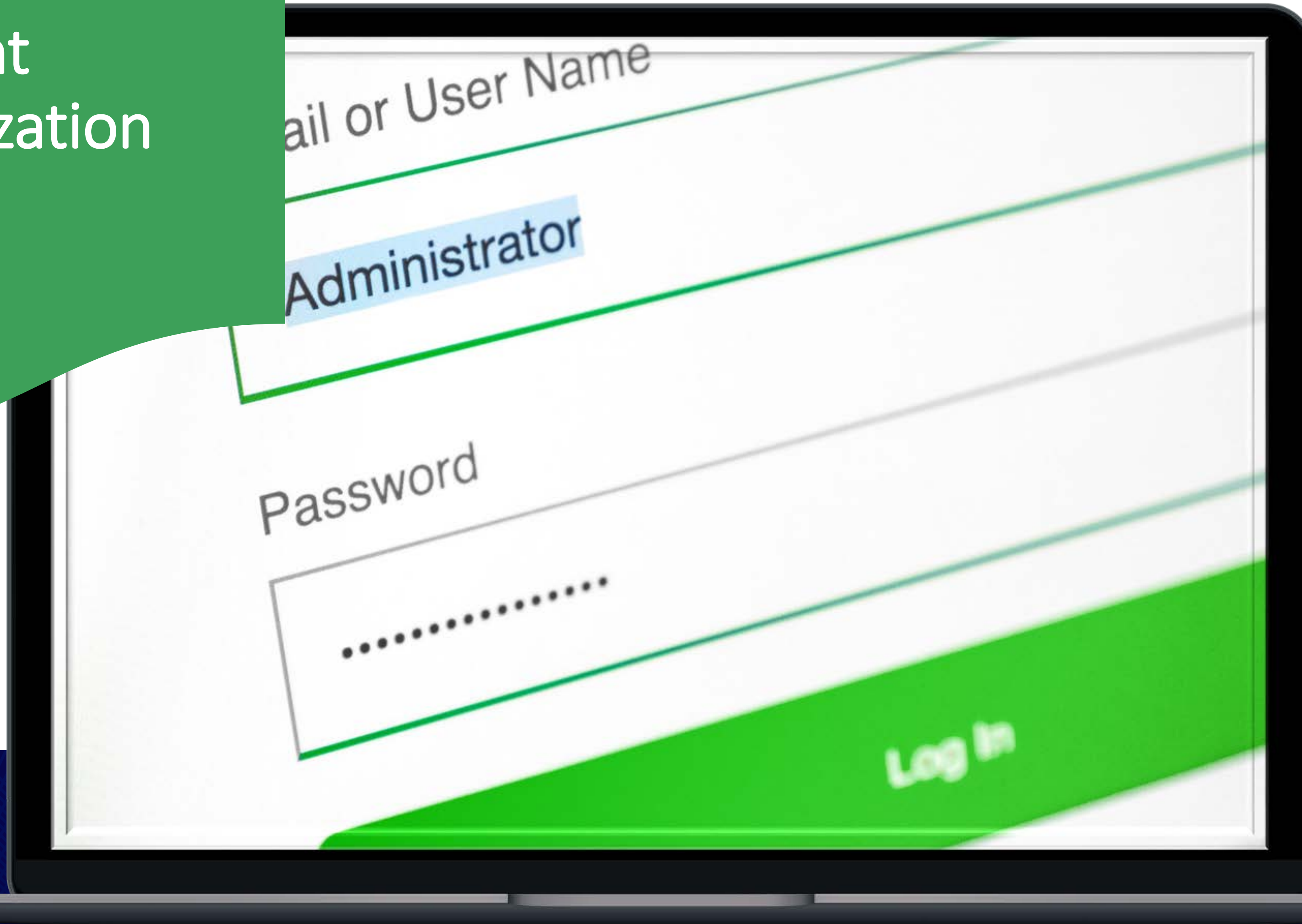
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422

As compared to Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.16 – Medical Necessity:

"Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, *chapter* 6, Section 6.1.3(A))"

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

Inpatient Authorization



Inpatient Authorization Process Flow

- Beware of the timeframes for insurance notification for services
- Consider weekend staff, if the insurance plan has 24-hour Utilization Management
- Avoid verbal authorizations (telephone, voicemail)

Challenges

- Inconsistent, ever-changing payor rules - restrictions with a payer can differ from plan to plan
- Lack of staff training – linking revenue cycle staff with the clinical team
- Lack of standards processes governing pre-authorizations – automation (Approximately 12% denials related to authorization)

Strategies

- Maintain a current master list of procedures requiring authorization, including the Medicare Inpatient Only List
- Keep track of Clinical Policy and Guidelines changes of the payer
- Create and train a consistent team (unit), both revenue cycle and clinical, to manage authorizations. This team should review all authorization denials and adjust processes accordingly.
- Maintain relationships with payer contacts to speed up authorization decisions
- Document all communication with the payer and integrate the documentation into the patient accounting system or medical record repository

Strategies, continued

- Know payers' turnaround times for rendering a decision on a request; avoid verbal approvals or denials
- Follow-up with the payer every 24 hours until a decision is rendered and provide additional clinical documentation as updated by the physician or a change in the patient's condition
- Track and trend authorization denials
- Appeal all authorization denials based on the patient's clinical condition
- Keep patient/family informed regarding the payer's decision and engage in denial prevention
- Embrace electronic authorizations – payor portals

Strategies, continued

- MA payers have no general timeframe requirement for responding to a request for prior authorization. This would need to be found in payer/provider contracts or payer policies.
  - MA payers must cover emergency and urgently needed services regardless of prior authorization and may not include instructions to seek prior authorization for such services in materials furnished to patients or providers. See 42 CFR 422.113(b)(2)(ii).
  - MA payers must cover all maintenance and post-stabilization care within one hour of a request for prior-authorization of these services and must cover all of the services requested if: 1) the payer does not respond with-in 1 hour, cannot be contacted, or the payer representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. See 42 CFR 422.113(c)(2)(iii).

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113

Track Authorization Denial Causes

DESCRIPTION	DEFINITIONS
Incorrect Patient Information	Patient information is incorrect - name, ID, date of birth, etc., as noted by the insurance card or payer correspondence.
Incorrect Primary Payer Identified	The primary payer was incorrectly identified, resulting in a later payer notification.
Failure to Obtain Authorization or Preauthorization	Failure to notify a payer of an admission or a procedure timely within the payer-specified timeframe. Example: within 24 hours or on Monday for weekend admissions
Failure to Obtain Referral for Services	Failure to obtain a referral before a procedure. Example: outpatient cases
Failure to Authorize Status Change	Failure to notify the payer when the patient converts from observation to inpatient
Auth Obtained - Incorrect Date or Place of Service	Incorrect date of service or place of service was authorized.
Authorization Obtained - Not on Claim	Authorization was obtained but not in the mainframe system or input after the case was final billed, resulting in a claim not having an authorization number listed.
Authorization Present on Claim	Authorization was obtained, found in the system, and located on the claim.
Retro-Authorization Required	Lack of authorization known at the time of admission. Example: patient premiums not paid or patient insurance was pending
Insurance Update Error	The original payer was correct, but an update to the plan afterward created an error, causing a failure to send clinical information.
Authorization Not Obtained - Payor Issue	The payer advised that authorization was not necessary for the specific services/CPT being validated and later denied for no authorization
Eligibility Update Delay	Delay in the payer updating eligibility information for the patient. This includes cases where at the time-of-service patient shows to have coverage and cases where eligibility portals fail to identify the patient has insurance coverage.

Appealing Authorization Denials

- Be knowledgeable of the payer's screening criteria
- Know the extenuating circumstances by the payer for failure to get authorization
  - Unable to Identify Coverage or Carrier (unresponsive, dementia, psychiatric, non-English speaking, patient states self-pay, other primary insurance provided, incorrect ID card, premiums not paid)
  - Unable to anticipate the need for prior authorization before service (emergent, add-on procedure, change in condition
  - Delayed Payer Notification of Approval based on their timeframes

Appealing Authorization Denials

- Craft a medical necessity appeal when authorization was not performed
  - Request a reconsideration based on the patient’s clinical condition and treatment
  - State the extenuating circumstances
  - Quote “good faith clause”
  - Thank the payor for the re-consideration

Case Study – Authorization not Requested by Provider

Extenuating circumstances existed that prevented Memorial Hospital from requesting authorization from WellCare in a timely manner.

1. The patient did not have an insurance card with him when he was sent to the Emergency Department from his cardiologist's office.
2. Hospital staff went into their portal and found an insurance card for Mr. Jones for United Health Care.
3. The expiration date on the UHC card was 12/31/9999.
4. When contacted, UHC staff provided an authorization number.

Case Study – Authorization not Requested by Provider

5. It wasn't until 8/10/22 that hospital staff realized that the patient was not covered under UHC. (IP DOS 3/3/2022 – 3/5/2022)
6. On 8/12/22, hospital staff contacted WellCare and talked to Mary, who was unable to process retro NOA over the phone.
7. Instead, as requested by WellCare, the inpatient authorization form for admission was faxed to WellCare.
8. WellCare subsequently denied retro-authorization for untimely notification.

Case Study – Authorization not Requested by Provider

Include medical necessity argument in the appeal:

78-year-old gentleman who presented to his cardiologist's office on lightheadedness and dizziness with chest pressure. He was found to have new onset atrial fibrillation with a rapid ventricular response and was sent to the hospital from the office.

At the hospital, metoprolol was started for rhythm control but resulted in bradycardia. Instead, Amiodarone was initiated. He subsequently underwent a successful radiofrequency ablation.

3. *Due to the procedural complexity, trans-septal puncture, and extensive ablation lesion set, the patient is at risk for peri-procedural complications such as cardiac tamponade, bleeding/hematoma, and thromboembolic phenomena. The patient will therefore be admitted on an inpatient basis for heparin infusion and close monitoring.*

Appealing when “Criteria Not Met”

1. Criteria WAS met; or alternate criteria WAS met
2. InterQual / MCG criteria is merely an objective tool to help guide physicians in decision-making; does not take into account specific comorbid conditions; not designed to replace the physician’s professional training and expertise
3. Care provided represented the standard of care in the medical community

Take Aways

- Preauthorization isn't a promise your health insurance or plan will cover the cost.
- The Affordable Care Act prohibits health plans from requiring prior authorization for emergency services, regardless of whether the hospital is in-network or out-of-network.
- Know payers' turnaround times for rendering a decision on a request; avoid verbal approvals or denials.
- Track and trend authorization denial causes

References

- *https://www.healthcare.gov/glossary/*
- *https://www.healthinsurance.org/glossary/prior-authorization/*
- *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422*
- *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf*
- *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.113*

Questions and Answers

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Thank you for attending today's event!

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