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

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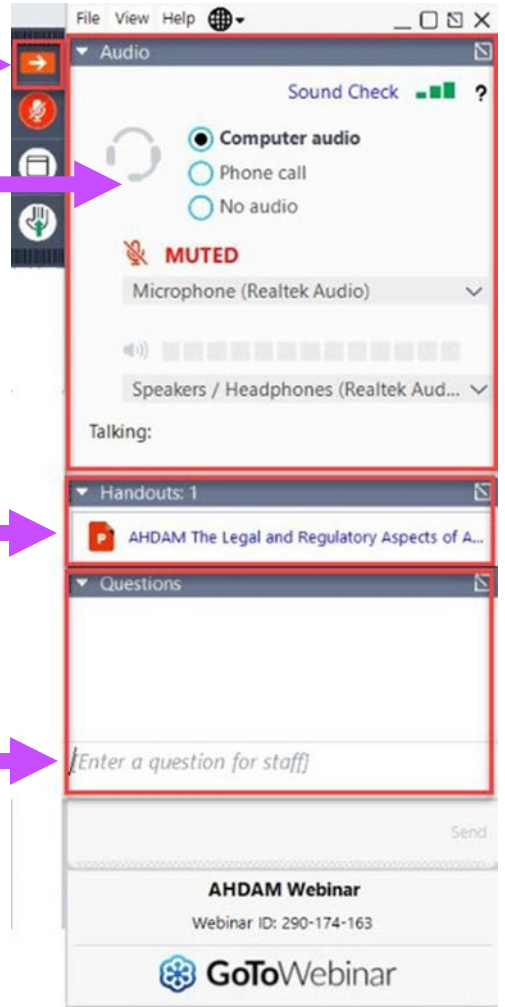

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The Association for Healthcare Denial and Appeal Management

- 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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Free CEUs are offered to AHDAM members only.

To obtain CEUs, **you must:**

- **be an AHDAM member.**
- **attend the live webinar for at least 53 minutes.**
- **complete the survey** that will pop up automatically for you at the end of the webinar.

CEU certificates will be emailed to you generally within a week of the webinar.

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From the survey you will be prompted to select desired CEUs – as many as are applicable to you:

- AMEDCO: physicians, nurse practitioners, physician assistants
- Association of Clinical Documentation Improvement Specialists (ACDIS): Certified Clinical Documentation Specialist (CCDS)
- National Association of Healthcare Revenue Integrity (NAHRI): Certification in Healthcare Revenue Integrity (CHRI)
- Commission for Case Manager Certification (CCMC): CCM board certified case managers

  This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1 CE contact hour(s). Activity Code: S00062594 Approval #: 250000888 Expiration Date: 3/26/2026

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- American Health Information Management Association (AHIMA): Certified health information management professionals

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- American Nurse Credentialing Center (ANCC): Continuing nursing education

  This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

AMEDCO: Learner Notification (for physicians)

Association for Healthcare Denial & Appeal Management

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

March 26, 2025

Online

Acknowledgement of Financial Commercial Support

No financial commercial support was received for this educational activity.

Acknowledgement of In-Kind Commercial Support

No in-kind commercial support was received for this educational activity.

Satisfactory Completion

Learners must complete an evaluation form to receive a certificate of completion. **You must attend the entire webinar as partial credit is not available**. If you are seeking continuing education credit for a specialty not listed below, it is your responsibility to contact your licensing/certification board to determine course eligibility for your licensing/certification requirement.

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Professions in scope for this activity are listed below. Amedco Joint Accreditation Provider Number: 4008163

Physicians

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Objectives - After Attending This Program You Should Be Able To

1. Identify why physician collaboration is crucial for better documentation and denial prevention.
2. Determine reasons why physicians should be involved in appeal management
3. Determine an effective way to improve cooperation between physicians and documentation specialists, case managers, revenue cycle professionals, and denial and appeals teams.

AMEDCO: Learner Notification, Continued (for physicians)

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All individuals in a position to control the content of CE are listed below.

Name	Commercial Interest:Relationship
Karla Hiravi	NA
Ryan O'Hara	Denial Research Group: Employee
Raymond Smith	NA
Jo Shultz	NA

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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.

Learning Outcomes

Learning Outcomes: At the conclusion of the webinar, the learner will be able to:

1. Identify why physician collaboration is crucial for better documentation and denial prevention.
2. Determine reasons why physicians should be involved in appeal management
3. Determine an effective way to improve cooperation between physicians and documentation specialists, case managers, revenue cycle professionals, and denial and appeals teams.

Kendall Smith, MD, SFHM, ACPA-C

Chief Physician Advisor | PayerWatch AppealMasters

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems.

He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

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Ryan O’Hara

Managing Principal, Denial Research Group

Ryan O’Hara is an accomplished healthcare executive with a wealth of experience in revenue cycle operations. Throughout his 20+ year career, Ryan has demonstrated a deep understanding of the complexities of healthcare financial management and has worked to develop strategies and solutions to drive efficiency, reduce costs, and improve patient outcomes.

He has spent the majority of his time on the healthcare provider side, working as a revenue cycle operations leader across many hospitals and health systems. He also has spent several years working on the EMR and 3rd party business partner side. This has provided for a diverse and rounded background; but one that is always rooted in being a trusted and value-add contributor for healthcare providers.

Goals Today

- **Identify why clinician and RCM collaboration is crucial for better quality and financial outcomes.**
  - Roles, responsibilities, structure, etc
  - Understand how access to payer contracts, reimbursement terms, and provider manuals provides critical leverage in disputing denials and reinforcing provider rights.
- **Better understand why clinicians should be involved in appeal management and understanding payer behavior**
  - Root cause vs. Perpetual 1-off appeals
  - Learn how to pinpoint key provisions in contracts and medical policies to craft compelling appeals that expose inconsistencies in payer determinations.
- **Improve cooperation with clinicians**
  - **The Role of Data** – Explore how tracking denial trends, payer behavior, and contract adherence through robust reporting tools can enhance appeal strategies, improve success rates, and drive systemic change.
  - What does effective communication and feedback look like?
- **Examples/case studies**
  - Clinical Validation: Documentation vs. Diagnosis
  - Medical Necessity: Payer policy vs. Physician judgement

Denial Trends

- Overall initial denial rates from 10.15% in 2020; 11.2% in 2022; 12% in 2023; this does not include takebacks (audits) from denial
- 90-day plus AR percentage is running 19 to 36% for Medicare Advantage and 27 to 36% for commercial related to denied claims
- The AHA reported 55.7% increase in denials from MA plans and 20.2% increase in commercial payers from 2022 to 2023
- Payer denials prevent from collecting the patient share of the payment
- *According to an article published by the HFMA in March 2023, 85% of denials can be avoided by implementing processes from best practices*
- Claims Denials Today ……. Audits Tomorrow

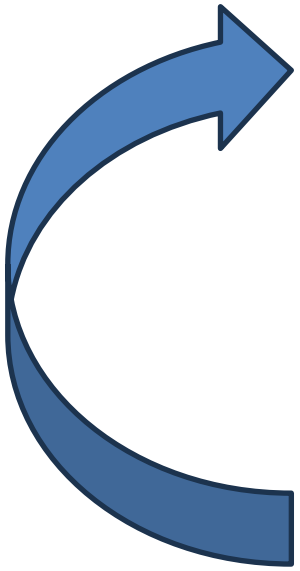
The Financial Cost of Denials

- Hospitals lose $3-5M per $100M in revenue due to denials. $262 billion annually is lost due to denied claims.
- Appeals cost $25–$118 per claim, increasing administrative burden.
- 30-40% payment reductions occur due to payer-driven DRG downgrades

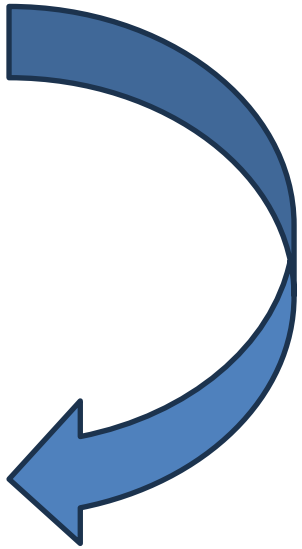
The Broader Impact of Denials

- Provider Frustration: Physicians must justify care decisions post hoc.
- Burnout & Turnover: Revenue cycle staff overloaded with appeals.
- Delayed Patient Care: Payer denials delay treatment and increase out-of-pocket costs.
- Legal Exposure: Balance billing lawsuits and regulatory scrutiny.
- Eroding Payer Trust: More hospitals dropping Medicare Advantage due to aggressive denials

Roles & Responsibilities



- **Role of Revenue Cycle**
  - Collect the **appropriate** reimbursement for services provided without delay……**at the lowest possible cost**.

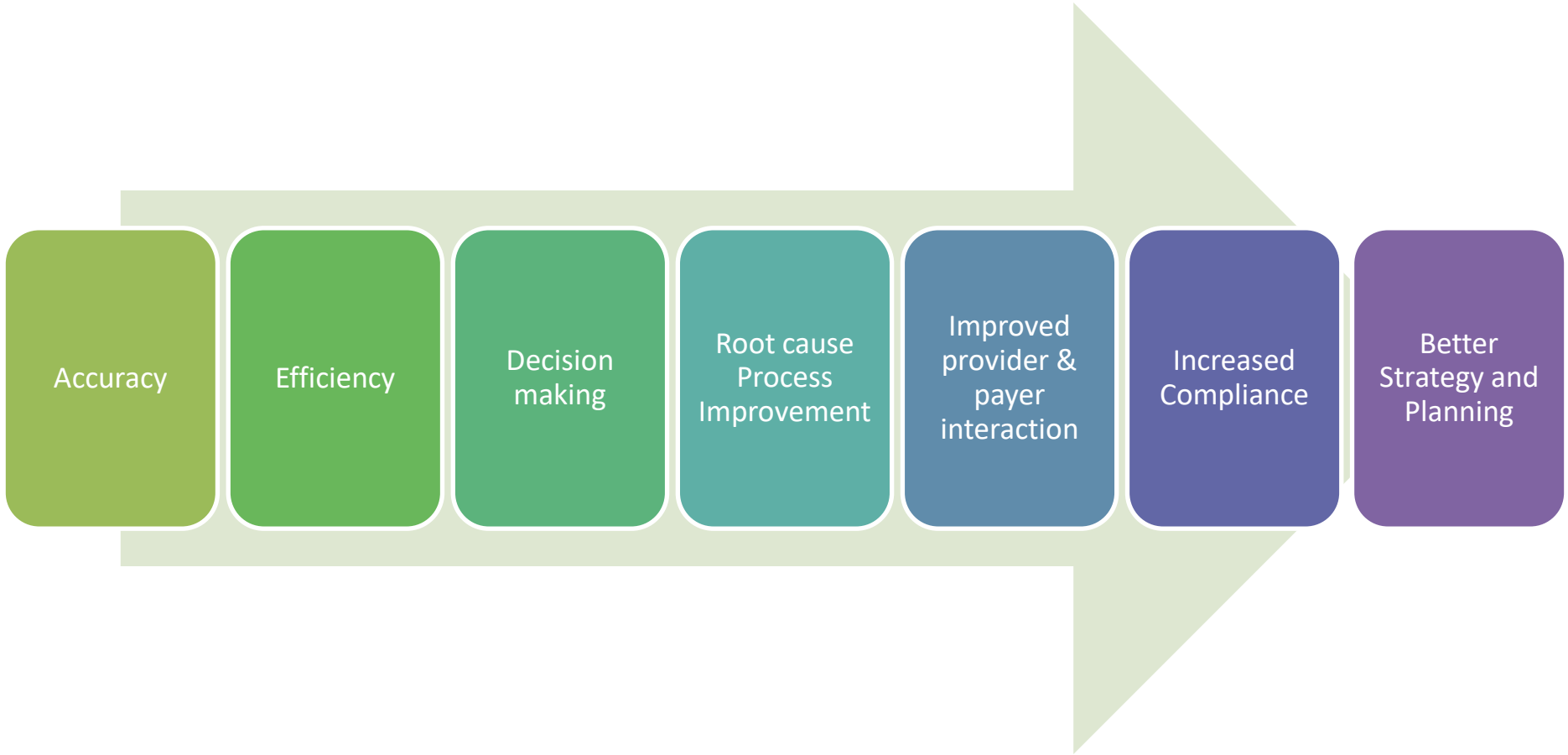


- **Role of Clinician?**
  - Deliver **outstanding** care for every customer/patient and **accurately** document in **their** medical record in a **timely** manner.

Architecture/Structure

- Focus on collaboration and outcomes vs. reporting lines
- Define escalation clearly and review examples regularly
- Keep feedback open, honest, & professional
- Align with respected, practicing physicians for feedback
- Focus on quality, not $$$$
- Have data
- Have data
- Also, have data

Benefits of employing analytics in denial management



Leveraging Analytics to Strengthen Appeal Success

- **Identify payer behavior shifts:**
  - Track denials by:
    - Payer
    - Procedure
    - Diagnosis
  - Challenge sudden changes in previously approved claims.
- **Key reports to run**:
  - **Denial Root Cause Analysis** – Identify new payer audit tactics.
  - **Payer Performance Scorecards** – Track overturn rates and escalate disputes.
  - **Clinical Validation Trends** – Detect payer DRG downgrades and shifting denial tactics.
- **Example:**
  - Implementing predictive analytics can lead to a 29% decrease in denial write-offs and a 19% improvement in clean claim rates.

The new era means.....

Moving from Clinical Documentation Integrity
to
“Payer Documentation Integrity”

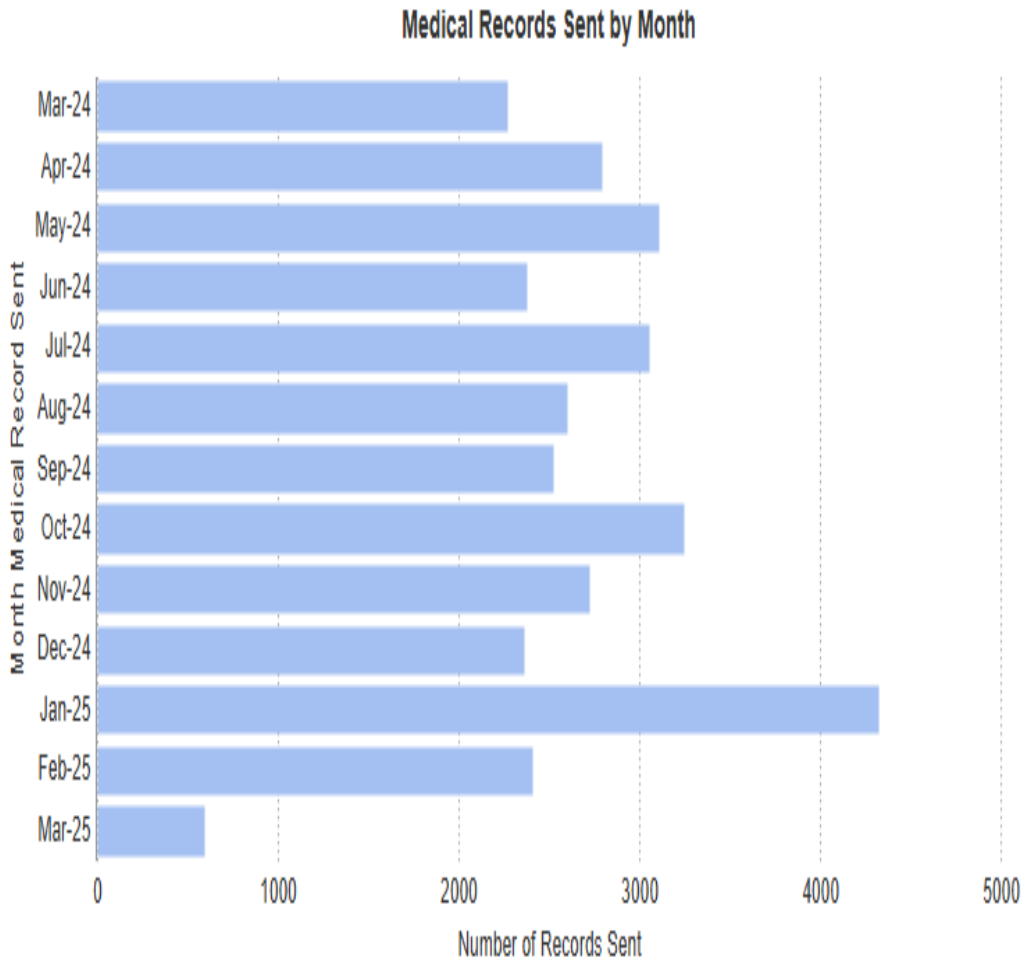
- Leverage Contract Language – Enforce provider rights in agreements to challenge denials.
- Exploit Payer Policy Inconsistencies – Identify contradictions in payer policies to dismantle denials.
- Use Data and Reporting to Build a Case – Track payer patterns to overturn and prevent denials proactively.

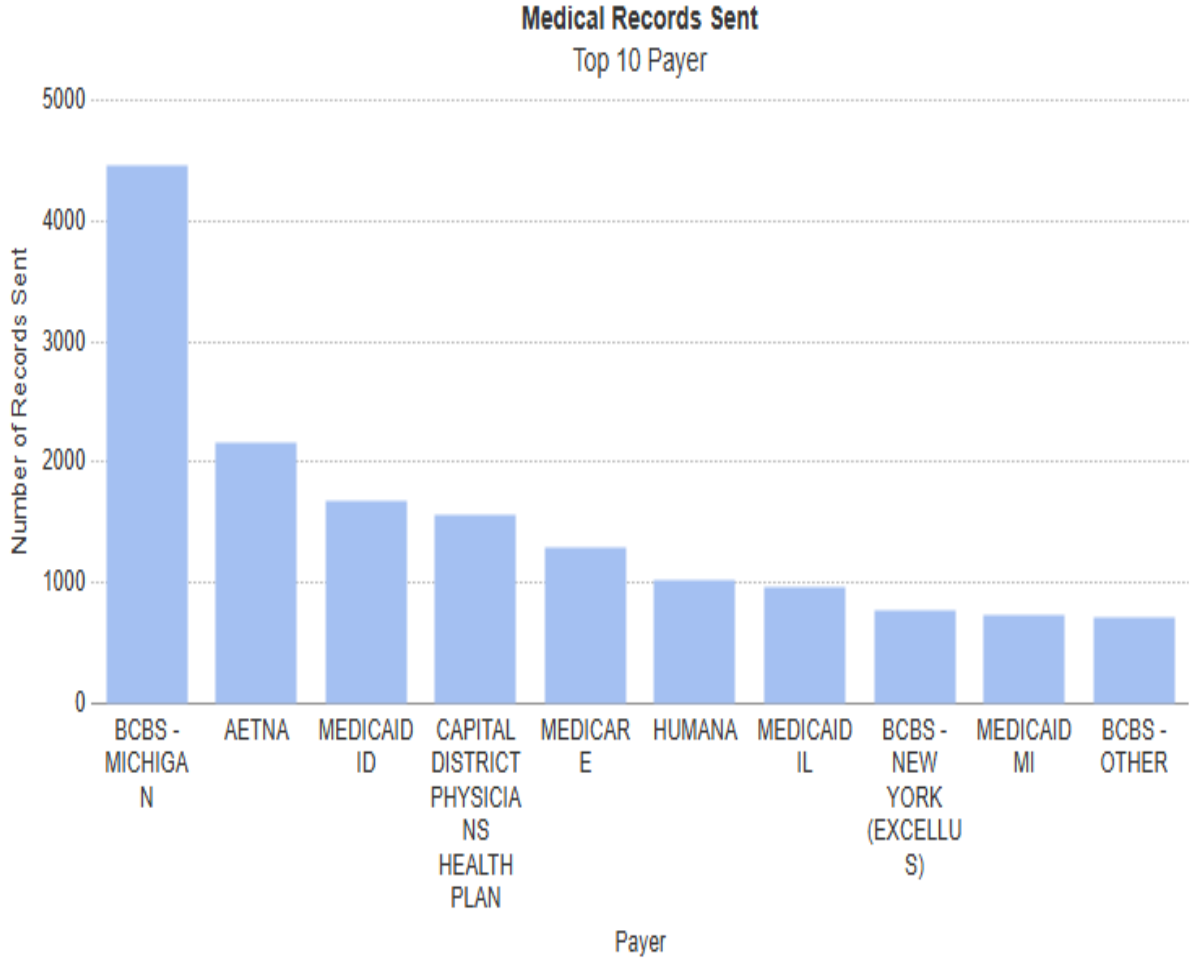
Enforcing Provider Rights Using Payer Agreements

Know the terms – Contracts define medical necessity, reimbursement, and appeal processes.

Key contract clauses to leverage:

- **Timely Filing & Audit Limitations** – Prevent retroactive denials.
- **Medical Necessity Definitions** – Payers must adhere to evidence-based guidelines.
- **Denial Reconsideration Timelines** – Enforce strict payer response deadlines.
- **Payment Dispute Resolution** – Use contract arbitration clauses to escalate improper denials.





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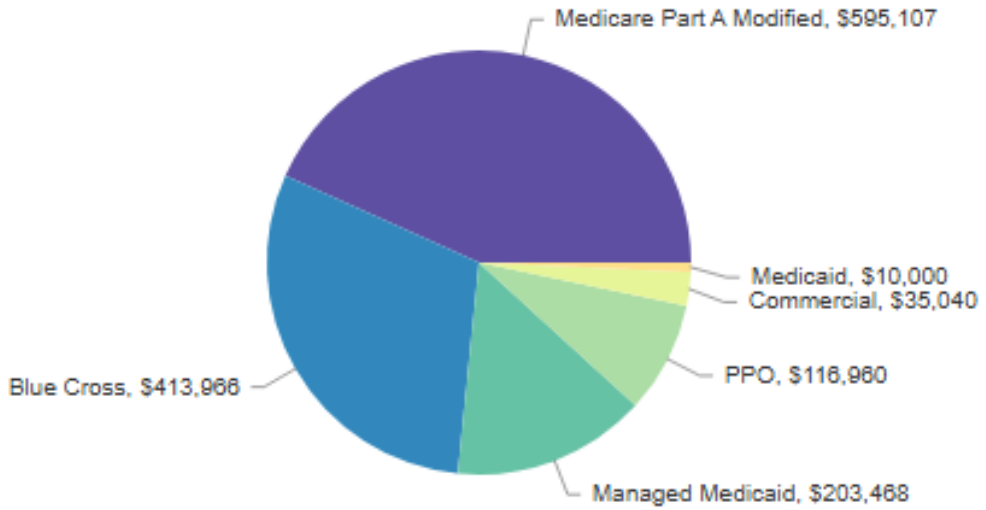
Appeal Inventory by Payer

Payer	Total Cases	Denied Dollars
Medicare Part A Modified	120	$595,107
Blue Cross	96	$413,966
Managed Medicaid	67	$203,468
PPO	16	$116,960
Commercial	3	$35,040
Medicaid	1	$10,000
Total	**303**	**$1,374,542**



Case Summary by Payer and Issue

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This report provides a case summary by Payer and Issue for the time period selected.
Overturn Rate is calculated as the number of cases won out of the number of cases appealed. Overturn rates may not be final if including Open cases in your filters.
Use Interactive Filters to narrow results by: Case Status, Case Type, Issue, Issue Category, Root Cause, Payer, Payer Plan, Closed Reason
Set Interactive Filter to Case Status = Closed for final Overturn Rates

Humana

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	979	4.89%	$7,365,062	3.24%	698	$5,060,674	147	21.06%	$1,098,124	414
DRG Validation	230	1.15%	$1,964,778	0.86%	45	$337,851	5	11.11%	$15,671	32
DRG Validation with Medical Necessity	11	0.06%	$39,707	0.02%	7	$19,385	1	14.29%	$2,704	3
Medical Necessity	1,385	6.93%	$11,629,033	5.11%	1,151	$10,151,254	313	27.19%	$2,723,032	608
Outpatient	12	0.06%	$60,047	0.03%	4	$20,812	2	50.00%	$13,734	0
Request for Records	5,357	26.79%	$55,339,529	24.32%	552	$3,415,791	110	19.93%	$480,258	194
Send Itemized Bill	1	0.01%	$13,569	0.01%	0	$0	0	0.00%	$0	0
Transfer DRG	2	0.01%	$5,343	0.00%	1	$1,498	0	0.00%	$0	1
	7,977	**39.9%**	**$76,417,067**	**33.6%**	**2,458**	**$19,007,263**	**578**	**23.5%**	**$4,333,523**	**1,252**

Medicaid

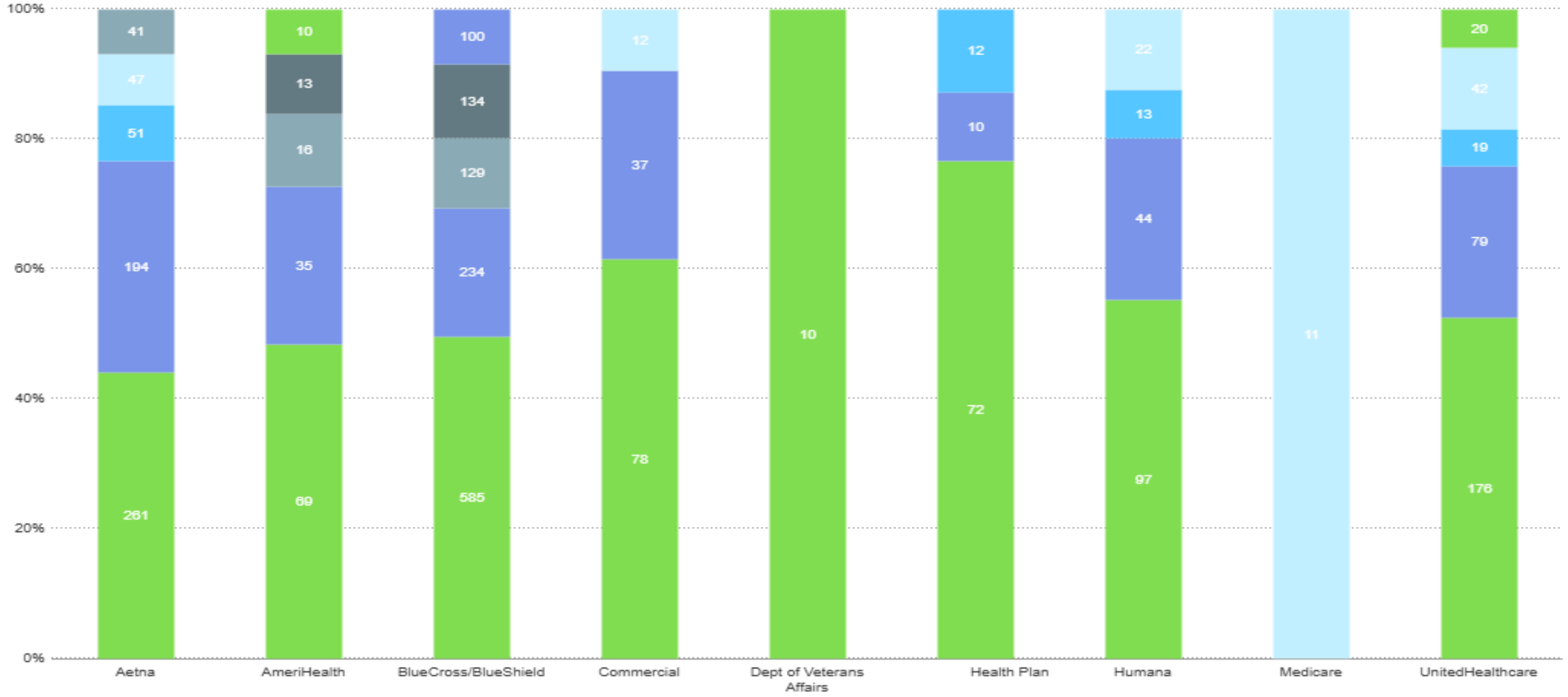
Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	12	0.06%	$654,174	0.29%	4	$33,974	1	25.00%	$5,637	2
DRG Validation	66	0.33%	$817,742	0.36%	34	$602,519	1	2.94%	$1,487	15
DRG Validation with Medical Necessity	4	0.02%	$14,373	0.01%	1	$3,010	0	0.00%	$0	1
Medical Necessity	173	0.87%	$1,769,137	0.78%	106	$824,948	12	11.32%	$148,543	66
Outpatient	36	0.18%	$81,553	0.04%	2	$3,195	0	0.00%	$302	2
Request for Records	2,497	12.49%	$22,408,036	9.85%	216	$1,882,450	21	9.72%	$267,994	158
	2,788	**13.9%**	**$25,745,015**	**11.3%**	**363**	**$3,350,096**	**35**	**9.6%**	**$423,964**	**244**

Blue Cross TX

Issue	# of Cases	% of Total Cases	Initial $ At Risk	% of Total $ At Risk	# of Cases Appealed	Initial $ Appealed	# of Cases Won	% Overturn Rate	Total Appealed $ Recovered	# of Cases Lost
No Issue Selected	284	1.42%	$2,208,802	0.97%	184	$1,386,667	53	28.80%	$347,160	85
DRG Validation	23	0.12%	$291,631	0.13%	6	$48,451	1	16.67%	$17,718	3
DRG Validation with Medical Necessity	1	0.01%	$20,904	0.01%	0	$0	0	0.00%	$0	0
Medical Necessity	765	3.83%	$10,686,052	4.70%	514	$7,772,518	112	21.79%	$1,683,153	227
Outpatient	4	0.02%	$11,921	0.01%	1	$2,616	0	0.00%	$0	1
Request for Records	1,047	5.24%	$23,694,996	10.41%	72	$620,586	0	0.00%	$9,699	19
	2,124	**10.6%**	**$36,914,306**	**16.2%**	**777**	**$9,830,838**	**166**	**21.4%**	**$2,057,731**	**335**

Top 5 Denied Diagnoses by Payer

Minimum of 10 cases per diagnosis



Clinical Validation Case Study

Case Study 1
Clinical Validation Denial

Overturned

Payer: Although the diagnosis of sepsis is documented throughout the medical record, sufficient supporting documentation was not found within the medical record to validate this diagnosis based on Sepsis 3 clinical criteria.

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Case Study 1 - Sepsis

Document Source and Date	Pertinent Information	Page(s)
ED Provider Note, 4/2/23	Significant acute erythema of the right lower leg with swelling of the calf and foot, tenderness to foot and calf, significant pain to light palpation of the foot and dorsum, tenderness to ankle as well however less so. Able to range the ankle but severe pain to foot. **Cellulitis** Medications given in ED: Vancomycin 1250 mg Lactated Ringers bolus 1000 ml **Indication for IV hydration is: treatment of sepsis.**	17, 19
H&P Notes, 4/2/23	**Sepsis 2/2 RLE cellulitis** **Presented w(ith) tachycardia and leukocytosis.** **Adtl** (additional) **1L LR bolus (received 1L already in the ED**	44

Case Study 1 - Interdisciplinary Documentation

H&P Notes, 4/2/23	**Clinical Quality Reminders**: Sepsis suspected (suspected infection with 2 of the following: RR > 20, HR > 90, T > 38°C or < 36°C, WBC > 12,000 or < 4,000): Yes - will initiate sepsis order set.	45
Discharge Summary, 4/5/23	**Sepsis 2/2 rle cellulitis** h/o mrsa Received vanc/zosyn 4/3-5, then doxycycline/Keflex for total 7-day course Heptocellular transaminitis: mild, due to sepsis vs hepatitis New Medications: Cephalexin, doxycycline hyclate	50-52

Case Study 1 - Pertinent VS and Lab Results

Vital Signs/Measurements

Vital Signs/Measurements	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
Heart Rate	4/2/23	**119** **104** **105**	≥ 90 beats/min	27 36 38

Laboratory

Test	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
WBC – Leukocytes	4/2/23	**12.2**	≥ 12 000 cells/μL or ≤ 4000 cells/μL	86

Case Study 1: Justification for Appeal

The arguments presented below justify the inclusion of sepsis as a valid diagnosis for the following reasons:

There is not consensus in the medical community as to what constitutes "Sepsis". The payer references material that appears to originate from The Third International Consensus Definitions for Sepsis and Septic Shock. As clearly shown in the Evidence Based Guideline section below, this information has not been endorsed by many members of the medical community. Thus, it remains only one possible piece of information that physicians may consider, or may decide not to consider, when evaluating and treating their patients. **Physicians are not bound by one group's opinions as to what constitutes a certain diagnosis.**

Several states (IL, NY, OH, WI) have instituted laws, regulations, or policies to improve sepsis prevention and early recognition (***https://www.cdc.gov/hai/pdfs/sepsis/VS-Sepsis-Policy-FINAL.pdf***). Because the state of New York implemented regulations in 2013 regarding early diagnosis and treatment of sepsis using the SIRS + Infection (Sepsis 2) criteria, the Greater New York Health Association confirmed in January 2019 that United Healthcare had written to both the New York State Department of Health and the New York State Department of Financial Services, stating that it would not implement Sepsis-3 criteria in its medical record audits in the state of New York. **This underscores the continued need to recognize SIRS + Infection as appropriate diagnostic criteria for the early detection of sepsis.**

Case Study 1: Justification for Appeal

There are multiple definitions of sepsis used by physicians and hospitals. In this case, it is obvious that both the hospital and physicians use sepsis 2 criteria to diagnose sepsis. Providers were clear that because of leukocytosis and tachycardia with an underlying infection of cellulitis, that sepsis was present. Documentation explicitly supports treatment for sepsis. It is also clear that the hospital endorses the use of sepsis 2 criteria as evidenced by the "Quality Reminder" found in the H&P to remind physicians of the criteria and use of a sepsis order set. Reviewers of a medical record, of unknown qualifications, should never be permitted to negate diagnoses made by the examining and treating physicians.

The CDC recognizes and endorses the early detection and treatment of sepsis in order to reduce sepsis mortality (https://www.cdc.gov/sepsis/prevention-activities/index.html).

The use of SOFA criteria as defined in The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) is not helpful for early detection of patients with sepsis.

Case Study 1: References

Cortes-Puch, I. & Hartog, C. (July 2016). Opening the Debate on the New Sepsis Definition. Change Is Not Necessarily Progress: Revision of the Sepsis Definition Should Be Based on New Scientific Insights. *American Journal of Respiratory and Critical Care Medicine.* As found on: *http://www.atsjournals.org/doi/full/10.1164/rccm.201604-0734ED*

"Despite…limitations, the SIRS criteria have been practical and widely used for quality improvement initiatives (8/9) and awareness campaigns (10) to educate clinicians and the public about the early signs and symptoms of sepsis and that delaying treatment can be lethal." [p.2]

"There is currently no test or gold standard to identify patients with sepsis…Determining the diagnostic accuracy of a new or revised definition is not feasible without a gold standard to identify patients with the clinical syndrome." [p.2]

"The decision to revise the definition should reflect unambiguous new developments in the field, rather than expert opinion. Changes in the definition should be occasioned by true breakthroughs in scientific understand or clinical evidence, and not by changes in task force members, their inclinations, or new consensus procedures." [p.1]

"The new definition, requiring the presence of organ failure, may hinder general awareness of the importance of early recognition and treatment. Ideally, patients at risk for sepsis should be identified before organ dysfunction is established to prevent organ injury from occurring…The revised definition will likely identify a sicker population and could potentially delay treatment of patients who might benefit from an early approach." [p.2]

"Early recognition and treatment of sepsis is currently accepted as a general principal, and has been deemed especially important in low and middle-income regions (11). However, the 2016 task force failed to include representatives from any of these regions where the underlying infections and the priorities for improving quality of care may differ from those in high-income regions. **Some professional societies** of emergency medicine and low and middle-income regions have already voiced this concern and **have not endorsed this new definition** ." [p.2]

Case Study 2
Technical Denial

Overturned

The request for authorization submitted by (hospital) for (patient) has been denied.

Timely notification to the health plan for inpatient care is required. The notification was not timely, so the plan did not have an opportunity to evaluate treatment options. This is an administrative decision. The member may not be billed for these services.

Case Study 2: Request and Statements of Fact

This is a request for Claim Payment Dispute on (patient's) denied claim for inpatient services at (hospital). The following is a summary of the denial from (payer A), as well as substantiation of the medical necessity that supports the need for services as provided and billed.

Statements of Fact

Extenuating circumstances existed that prevented (hospital)from requesting authorization from (payer) in a timely manner. Please consider the following:

- Hospital staff went into their portal and found an insurance card for (patient) for (payer A).
- The expiration date on the (payer A) was 12/31/9999.
- (Payer A) gave the staff an authorization number.
- It wasn't until 8/10/22 that hospital staff realized that the patient was not covered under (payer A).
- On 8/12/22, hospital staff contacted (payer B) and talked to Mary, who was unable to process retro NOA over the phone.
- As requested by (Payer B), the inpatient authorization form for admission 3/3/2022 was faxed to (Payer B).
- (Payer B) denied retro-authorization for untimely notification.

Case Study 2: Arguments

A typical medical necessity appeal was then written, followed by:

Summary:
(Patient) required inpatient status for symptomatic atrial fibrillation. As stated by his cardiologist, he was at risk for a host of complications and required drug therapy, anticoagulation, close monitoring, and ablation.

Hospital staff did their best to ascertain his insurance coverage, as noted earlier. They had no way to know at the time of admission that (payer 2) was the primary insurer, nor could they have known that (payer 1) was not active.

We are requesting that these facts are all taken into consideration, as well as the prompt and excellent care given to Mr. X and ask that retro-authorization is granted.

Case Study 3
Technical Denial

Denial letter: The admission was administratively denied due to failure to obtain prior authorization for a **planned** inpatient admission.

PANs: noted the attending's (a cardiologist) office staff stated they **had never done prior authorizations on direct admissions.** It was advised to provide medical necessity or acceptable rationale for late precertification.

H&P: (Patient) is a 73 y.o. female who presents for **planned** admission for Milrinone initiation.

Case Study 3:

Admission Information*

Admit Date/Time: 08/06/2024 1028
IP Adm. Date/Time: 08/06/2024 1054
Admission Type: Urgent
Point of Origin: Physician Or Clinic Referral
Primary Service: Cardiology
Service Area: (Hospital)
Unit: (Hospital) 3 North
Admit Provider: R.L., MD
Attending Provider: R. L., MD
Referring Provider: A. K.,MD

* Look for this information where the demographic and insurance information is found – typically at the beginning of the medical record.

Case Study 3:

(Patient) was **directly and urgently admitted to the hospital from her cardiologist's office.** Specifically, she was **directly admitted for milrinone initiation**, **as was documented numerous times** throughout the medical record.

The following information was incorporated into a typical medical necessity appeal.

Referring physician: **Directly admitted to (hospital) for milrinone initiation** (p. 30)

Presents for decompensated heart failure requiring milrinone initiation.(p. 16)

Reason for admission: acute decompensated heart failure (p. 29)

Directly admitted for milrinone initiation. (pp. 30, 75, 88, 100, 116, 127, 134)

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References

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American Health Information Management Association. (2022). *Guidelines for achieving a compliant query practice (2022 update)*. https://ahima.org/media/51ufzhgl/20221212_acdis_practice-brief.pdf

Questions and Answers

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