Best Practices for the Appeals Process

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The Association for Healthcare Denial & Appeal Management

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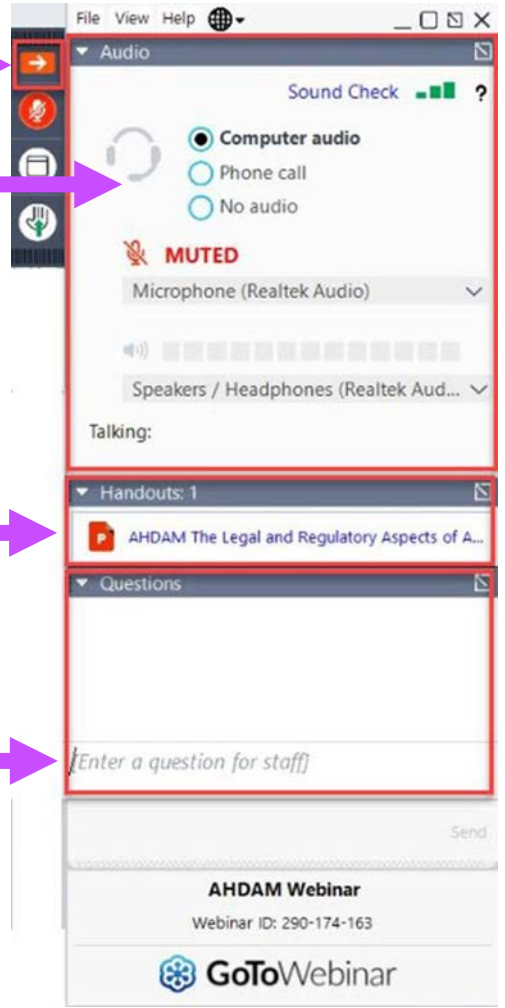

CEUs/Contact Hours

- Free CEUs are offered to AHDAM members only.
- To obtain CEUs, you must attend the live webinar for at least 50 minutes and complete the survey that will pop up automatically for you at the end of the webinar.
- CEU certificates will be emailed to you.
- CEUs are not available for watching the recording of this live webinar.
- Disclosure: No individuals in a position to control content for this
- activity have any relevant financial relationships to declare.

CEUs/Contact Hours

From the survey you will be prompted to select desired CEUs:

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

Join us for our next complimentary webinar!

Upcoming Complimentary Webinar

Total Joint Surgery Denials and Appeals

Wednesday, October 26, 2022, at 2 PM Eastern Time

CEU’s for AHDAM Members Only

Register on the homepage at www.ahdam.org

Joint PayerWatch/AHDAM Sepsis Series

Sepsis Denial/Appeal Workshop 2

Thursday, September 22, 2022 | 1PM ET

Staying the Course in Sepsis Documentation and Avoiding Sepsis Diagnosis Challenges (Dr. Agvanyan, Christi Drum, Garnette McLaughlin) This webinar will cover how to successfully manage sepsis documentation when payers try to dictate the use of a single set of criteria to clinically validate the diagnosis. Learn how to successfully challenge that practice on appeal.

Sepsis Denial/Appeal Workshop 3

Wednesday, September 28, 2022 | 1PM ET

Sepsis Current State – How to Appeal When the Payer Gets it Wrong (Dr. Hassaballa, Dr. Smith, Denise Wilson) This webinar will cover sepsis definitions, sepsis treatments, the current state of sepsis denial issues, payer-defined sepsis criteria, how to appeal for Sepsis 3 when the payer denied inappropriately, and how to appeal Inpatient Admission denials for sepsis.

Register at www.payerwatch.com

No CEUs for this series

AHDAM – 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.

www.ahdam.org

Created through the generous support of PayerWatch

Host & Presenter

Denise Wilson MS, RN, RRT, Senior Vice President, PayerWatch, 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.

Host & Presenter

Dr. Kendall Smith, Chief Physician Advisor, PayerWatch

Dr. 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.

Disclaimer

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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 Objectives

Learning Outcomes: At the conclusion of the webinar, the learner will be able to prepare an appeal letter with an argument appropriate for the level of appeal.

At conclusion of the webinar, at least 90% of participants will share on the evaluation:

- The ability to identify an appropriate appeal argument structure for an administrative hearing
- The ability to identify two informational elements crucial to preparation for a peer-to-peer discussion
- The ability to identify one circumstance when a lower-level appeal letter requires revision before filing at the next level of appeal

Best Practices in Peer-to-Peer

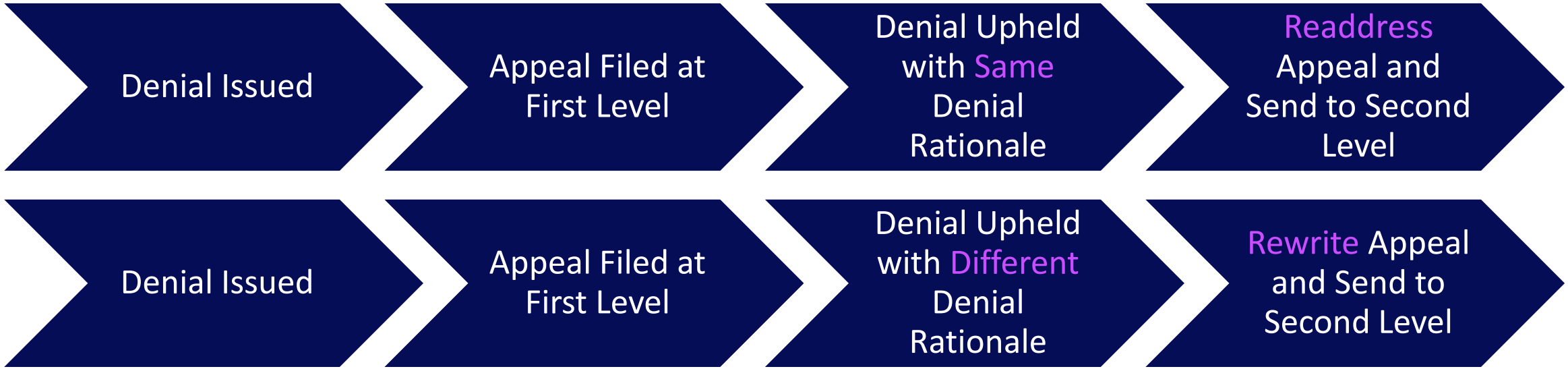
- Preparation for the P2P review is essential. At minimum, carefully review the following elements, which takes about 15-30 minutes:
  - The adverse determination letter, which explains why the requested service was denied
  - The documentation submitted with the procedure request. A request may be denied for insufficient information, so check whether the correct information was submitted.
  - The payer's medical coverage guidelines for the requested service. Refer to the insurance company's website for coverage policies. Have those guidelines on hand to refer to during the call.

Best Practices in Peer-to-Peer

- Preparation for the P2P review is essential. At minimum, carefully review the following elements, which takes about 15-30 minutes:
  - The patient's complete chart, including clinical exam notes, lab and imaging results, and abnormal vitals. Prepare talking points for the call.
  - The details (e.g., what procedure/service was done on what date) as entered in the electronic health record system
  - Evidence-based guidelines for the patient's illness or condition. Use this information to assert that services should be authorized.

Best Practices Levels of Appeal

GOAL: Move efficiently through the appeals process to get to external review



Best Practices Levels of Appeal

Payer refusing appeal due to duplicate argument

Best Practices Levels of Appeal

Payer refuses to recognize valid appeal

Per NCQA requirements/state regulations/contract terms hospital name is entitled to a full and fair review by a different reviewer not involved in the initial determination. Payer's refusal to accept our appeal as valid is in direct opposition to this entitled right. The payer's action is equivalent to an attempt to deprive the provider of the opportunity to complete the internal appeals process in order to advance the case to external review.

Best Practices Levels of Appeal

Of note, the provider was advised on 4/2/2022 via phone conversation with Ann J that the level 2 appeal had been dismissed as a duplicate because no new or pertinent information was received. Dismissing the Level 2 appeal as a duplicate deprives the provider of their right to fully avail themselves of the appeals process. Hospital requires Payer to consider the Level 2 appeal a valid appeal.

Best Practices Levels of Appeal

Here, the Appeal Level on the services for Patient was dismissed by Payer as a duplicate case with no new or pertinent information provided. However, there is no requirement in either the Agreement between Payer and Hospital or the Payer Provider Manual for subsequent provider appeals to include new information. In fact, the Provider Manual only states that providers may include additional information as part of the appeal. But regardless of whether additional documentation is supplied, Payer still is obligated to “provide a full and fair review of the appeal.”

Best Practices Levels of Appeal

Denial issued with lack of clarity of denial rationale, or no denial rationale provided

Best Practices Levels of Appeal

Legal Argument for No Denial Letter-Unclear Reasoning

Example from Illinois

In this case Payer Name failed to provide a reasonable and accurate explanation for why the services provided were denied. According to Illinois Administrative Code title 50 § 4520.70(c), Payer Name must, when denying or under paying a claim, provide a reasonable written explanation of the basis of the underpayment or denial. This explanation shall clearly set forth the policy definition, limitation, exclusion or condition upon which denial or underpayment was based.

Here, insert the specific information the denial letter lacked.

Payer Name's denial letter violates Illinois law by not including this information. Retrospective authorization is appropriate when Payer Name's letter of denial does not conform to the notice requirements set forth in Illinois law.

Payer's use of Screening Criteria

The auditor indicated the decision to deny inpatient level of care was based on InterQual/MCG criteria. InterQual/MCG criteria is merely an objective tool to help guide physicians in decision-making regarding whether a person's medical condition is severe enough to warrant inpatient status. This criteria does not consider specific comorbid conditions that place a patient at a greater risk of adverse outcomes. The decision to admit to inpatient was a complex decision that went far beyond general InterQual/MCG guidelines. The attending physician was charged with evaluating the entire presentation, including acute and chronic comorbidities, to determine the appropriate setting for the patient. InterQual/MCG was one tool to help in the decision-making process. It was not designed to replace the physician's professional training and expertise.

Payer's Mis-use of Screening Criteria

Although it is ultimately the provider's decision to admit patient's name as an inpatient based on his/her professional judgment, InterQual/MCG is an established means to assist the Provider in making that decision. Hospital name employs InterQual/MCG as a screening tool to review patient's name's need for inpatient status. Based on the established review process set forth by hospital name, patient's name met medical necessity criteria for inpatient status. (Insert guideline/reasoning)

Arguing for/against Criteria Use

When faced with a denial based on screening criteria that were misapplied, my appeal methodology is:

5% Argue that screening criteria were misapplied

22% Argue standards of care support inpatient admission

70% A little of both

3% Something else

Payer’s Misrepresentation of the Documentation

What if the payer makes erroneous statements in their denial?

“Patient was afebrile” when in fact patient had a presenting temperature of 101F.

- Refute every erroneous statement with facts from the documentation
- Sets the argument that the payer is not conducting a fair and honest review of the case

Traditional Medicare Level 3

Hearing in front of an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA)

- Educating the ALJ
  - Explaining the medical necessity in simpler terms
  - Connecting the dots between medical record documentation and payer policy
  - Explaining how the payer did not consider:
    - Standards of care
    - Coding guidelines
    - Widely accepted diagnosis validation methods
    - Extenuating circumstances

Mediation/Arbitration/External Review

- Include statements refuting the payer's behaviors early in the appeals process
- Connecting the dots between medical record documentation and payer policy
- Explaining how the payer did not consider:
  - Standards of care
  - Coding guidelines
  - Widely accepted diagnosis validation methods
  - Extenuating circumstances

Payer's use of Clinical Payment Policies

- Primarily relate to outpatient services or procedures
- Payer-specific policies
- Consider creating a checklist of required documentation/diagnosis codes
  - Use as education for providers
  - Incorporate into appeal letter templates
  - Explain the 'outliers' in the appeal
    - "As a long-distance truck drive, Mr. Jones was unable to complete a course of physical therapy prior to his total knee replacement surgery. He did practice strength-training exercises while on the road as prescribed by his physician."

Payer’s use of Clinical Payment Policies

National Coverage Determination (NCD) Hyperbaric Oxygen Therapy

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one man unit) and is limited to the following conditions:

- Acute carbon monoxide intoxication,
- Decompression illness,
- Gas embolism,
- Gas gangrene,
- Acute traumatic peripheral ischemia. *(etc.)*

Payer's use of Clinical Payment Policies

National Coverage Determination (NCD) Hyperbaric Oxygen Therapy

"The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 –days of treatment with standard wound therapy and must be used in addition to standard wound care."

"Standard wound care in patients with diabetic wounds includes: assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, etc."

- Where is that ⬆ documentation?
- Wound center? Physician's office? Home care?

Takeaway points

- Appeal work must be efficient as well as effective
- Don’t be afraid to stand up for your rights – legal/regulatory arguments
- Be thoughtful in arguments for/against screening criteria
- Educate your ALJs and other non-clinical adjudicators
- Don’t be a stranger to clinical policy bulletins – make friends with the keepers of the documentation

Q&A

Thank you to our support team at the corporate office!

AHDAM

The Association for Healthcare Denial & Appeal Management

Thank you for joining us for today's event!

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PayerWatch