HCPro's
Medicare Compliance Training Handbook

Denials Management

Tanja Twist,
MBA, HCM

HCPro's
Medicare Compliance
Training Handbook

Denials Management Training Handbook

Tanja Twist, MBA/HCM

HCPro

Table of Contents

About the Author

Tanja Twist, MBA/HCM

Tanja Twist, MBA/HCM, has more than 25 years of experience in healthcare revenue cycle management, with a focus on reimbursement and denials management. She has held the position of director of patient financial services, as well as overall operations officer for large and small hospital facilities, professional providers, and provider groups. Twist currently works for the University of California Los Angeles (UCLA) Health Systems. She advocates for hospitals and providers nationwide, providing revenue cycle management services supported by a deep knowledge of state-specific issues and unparalleled expertise in Medicare, Medicaid, and commercial reimbursement.

Twist has a bachelor's degree in business management and a master's degree in business administration with a certification in healthcare management. She is a nationally recognized speaker on governmental recovery programs, commercial denials, and best practices to avoid audits. Twist is on the board of the Western Region chapter of the American Association of Healthcare Administrative Management (AAHAM), was a board member for the Workgroup for Electronic Data Interchange (WEDI), and is an active member of the Southern California chapter of the Healthcare Financial Management Association (HFMA).

CHAPTER 1

Understanding Denials

Denials management is a frequent discussion topic among revenue cycle professionals. Yet despite the continued focus, most industry statistics reveal that, on average, providers write off between 3% to 5% of their net revenue to denials every year. These providers are not ignoring their denials; in fact, most would likely say they have a denials management process in place. However, few have a program that not only tracks and trends denials but also uses that data to identify the root causes of their denials or takes the necessary corrective actions to prevent them from occurring in the future. Without such a program, the revenue bleed will continue to repeat itself year after year.

Today's revenue cycle leaders are struggling to maintain positive financial margins in an audit-heavy environment. The number of audited claims has increased substantially over the past 10 years as government programs and commercial payers have placed an increased focus on their own financial viability through aggressive, and often overwhelming, audit programs that providers may struggle to comply with. This has led to what can be viewed as a reactive or even passive environment instead of a proactive environment, often due to resource and budgetary constraints. Most providers pull and submit records for the pre- and post-payment audit probes, and many file appeals for denied claims

either internally or through a vendor. However, most fail to formally identify and correct the root causes of the claim issues triggering the probes and denials. In doing so, they subject themselves to continued and likely increased audits and denials. The bigger concern, however, in not correcting the systemic problem is that the provider can be targeted for focused pre-payment or post-payment medical reviews by CMS, Medicare Administrative Contractors (MAC), Recovery Audit Contractors (RAC), Comprehensive Error Rate Testing (CERT), or other claim review contractors. If the results of these reviews identify potential fraud, the provider can then be referred to the appropriate Medicaid Zone Program Integrity Contractors (ZPIC) for further investigation.

The purpose of this handbook is to illustrate the process by which providers can effectively decrease the percentage of revenue being written off to denials each year, as well as significantly decrease compliance risks. This is not a promise to stop the appeal programs from probing your facility, but rather to provide proven methods to not only manage but also prevent repeat denials and ultimately decrease your denial write-off percentage. While this method does require additional resources and time in the beginning, it will pay for itself in the end by making your organization smarter in identifying and correcting the key issues that are driving your current denials, and in ultimately preventing future audit requests for those claims. It is important to remember that auditing firms learn from the organizational data they gather. During a probe, if they find any issues, you can be sure that additional audit requests will follow. However, once the data you provide in response to these probes or audit requests demonstrate that the issue is no

longer occurring, they will stop auditing those claims. While they may shift their focus to other areas, if you take the necessary steps to move your organization from one that merely manages denials to one that proactively identifies and prevents them, you will stay one step ahead of the auditors.

Basic Types of Denials

The first step in any effective denials management program is to develop an understanding of what constitutes a denial, as well as the different types of denials and their contributing causes. Once this knowledge has been established, providers can begin to capture and categorize denials by their specific reason and dollar value, allowing a deep dive into the type(s) of services being denied, the type of claim, and the physician, payer, department, person, or situation that caused the denial. Although there are a large number of denial reason codes used throughout the industry, all of them generally tie back to a few basic denial types: medical necessity or clinical denials, technical denials, and beneficiary coverage or benefit denials.

Medical necessity or clinical denials

Medical necessity or clinical denials are typically a top denial reasons for most providers and facilities. They are also known as hard denials, in that they require an appeal to request reconsideration. Denial reasons that fall under this category include:

- Inpatient criteria not being met

- Inappropriate use of the emergency room

- Length of stay

- Inappropriate level of care

The primary causes of medical necessity denials are the:

- Lack of documentation necessary to support the length of stay

- Service provided

- Level of care

- Reason for admission

Providers must ensure that their physician and nursing documentation clearly supports the services billed for and that the physician's admission order clearly identifies the level of care. One of the most effective means of ensuring compliance is through the implementation of a clinical documentation improvement (CDI) program. This can either be an internal program or outsourced to a qualified vendor. A successful CDI program facilitates the accurate documentation of a patient's clinical status and coded data.

Implementing a successful CDI program is typically one of the most challenging pieces of the denials management process, but it is the most important for long-term success. The first step is to obtain the support of the executives and physician leadership within the organization. Second, but equally important, is identifying a physician champion or physician advisor role. This role is critical, as he or she will be the liaison to the physicians,

reviewing chart documentation and providing feedback on how to prevent denials moving forward.

Utilization management issues

Another of the most common categories of denials is authorization issues, which includes:

- Lack of authorization

- Failure to notify a health management organization (HMO) or at-risk medical group of an admission from the emergency room

- Authorizations for a different level of service

- Lack of, or inconsistent, daily certification

Providers should ensure that all scheduled procedures or non-emergent admissions are authorized or certified prior to services being rendered. For unscheduled or emergent admissions, HMOs require authorization of services and notification of admissions from the emergency room once the patient has been stabilized. Preferred provider organizations (PPO) may also require an authorization or initial certification for the service or admission, along with daily clinical certification throughout the stay. Failure to do so can prompt a denial of the noncertified days billed or the level of care provided. These denials require appeals, which result in a significant delay in account balance resolution, as well as an increase in staff resources needed to resolve an account.

Technical denials

Any nonclinical denial can be categorized as a technical denial. Technical denials are also known as preventable denials. Causes of technical denials can range from contract terms and/or language disputes, coding-related errors, data entry or registration errors, charge entry errors, and charge data master (CDM) errors. Other technical denials may be caused by claims submission and follow-up deficiencies and denials pending receipt of further information, such as medical records, itemized bills, an invoice for an implantable device or drug, or receipt of the primary explanation of benefits (EOB) for a secondary payer claim.

It is imperative that your claims are submitted in adherence with federal, state, and individual health plan requirements and that your claims are submitted timely. Other claim submission errors can be caused by claims being sent to the wrong address or even the wrong payer. Technical denials are known as soft denials because they can usually be reprocessed by providing a corrected claim or other additional information to the payer.

Coverage/plan denials

The majority of coverage or incorrect plan denials are the result of process failures during the registration of the patient's account. These denials include:

- Incorrect demographic information

- Lack of coverage at time of service, patient plan benefit restrictions

- Limitations and misdirection of the claim when an HMO is involved

Demographic denials can be eliminated by verifying the patient's address and ensuring that the name and date of birth received and entered into your computer system match that of the insurance company. Date of birth errors are often due to a typographic error by the provider but can also be caused by data entry errors on the part of the insurance company. To prevent name mismatch errors, it is important that the patient and subscriber names entered into the provider's computer system match those found on the insurance card. Most common problems are the result of using a patient's familiar name instead of his or her legal name (for example, Pat versus Patricia) or the lack (or inclusion) of a middle name or initial.

Benefit denials are most commonly the result of a provider's failure to verify the patient's specific plan benefits during the insurance verification process. Verifying benefits can identify coordination of benefit issues, beneficiary plan coverage or out of network coverage restrictions, and eligibility termination due to lack of premium payment. With the expansion of coverage as a result of the Affordable Care Act (ACA), it is not only imperative to verify eligibility and benefits at the time of admission or service, but also to develop a process for re-verification at the first of each month for hospital stays and other services that span from month to month. This process should not be a new concept for providers, as employer group health insurances have historically presented these types of issues. However, post-ACA, the industry has noticed a dramatic increase in coverage denials due to plan termination.

Initial claim submission issues

Many initial claim submission or payer rejection errors can be eliminated by ensuring that the claim submission (bill scrubber) software or vendor uses robust, current edits, specific to each payer and type of service being billed. It is equally important for providers to routinely audit reports that capture edits that their billing staff are encountering and either correcting or overriding. This data should be used to correct the root cause of the issue causing the edit to fire.

Misdirected claims for managed care health plans, resulting from a provider's failure to follow the division of financial responsibility (DOFR) between the health plan and their contracted medical groups or capitated hospitals, usually make up the majority of technical denials. The DOFR defines the at-risk entity (where the claim should be submitted) for the specific types of services provided. Providing education and cheat sheets or copies of the individual DOFRs to both the registration department and the billing departments, as well as ensuring staff are educated on correctly identifying the true responsible entity, is the best mechanism of defense.

Account follow-up denials

Denials can also be received for failure to provide information requested by the insurance company, such as medical records, itemized bills, or copies of invoices. Ensuring timely, thorough follow-up on correspondence with the insurance company will help to eliminate these denials. For payers who require that the documentation be submitted with the claim, a good prevention technique is to create a billing edit that holds applicable claims

until the documentation necessary for submission has been obtained and submitted with the initial claim.

Regulatory Impacts

The logic behind most denials can be traced back to language in payer contracts or various regulatory statutes. Although the impact on claims submission and reimbursement are obvious in some cases, such as CMS' specific guidance on claims submission and billable services, there are many state and federal regulations that may ultimately impact claims and denials. An understanding of the major regulations will aid in appeals and guide efforts to prevent denials on the front end.

Regulatory statutes

Regulatory statutes are a large contributor of denials due to an increased focus on fraud and abuse. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established a national healthcare fraud and abuse program, which has led to the introduction, or ramping up, of a number of federal and state audit programs, such as CMS' RAC program (CMS, Medicare Fee for Service Recovery Audit program, 2016), CERT program (CMS, Comprehensive Error Rate Testing, 2016), ZPIC (*MLN Matters,* 2012), the Medicaid Integrity Program's (MIP) Audit Medicaid Integrity Contractors (Audit MIC) (CMS, Medicaid integrity program, 2015), the Payment Error Rate Measurement (PERM) audits (CMS, Payment error rate measurement, 2016), and the Office of Inspector General (OIG) (OIG, 2016) just to name a few. Each of these programs has unique nuances regarding their scope

of service and provider response and appeal process. It is imperative that providers continually monitor these programs, ensure compliance, and establish response policies for each one.

CMS guidelines

CMS publishes coverage determinations for items and services at both a local and national level. While the majority of these are local coverage determinations (LCD), occasionally CMS determines the need to publish a national coverage determination (NCD), which applies to all Medicare providers regardless of their Medicare Administrative Contractor (MAC). Compliance with both applicable MAC-published LCDs and the NCDs is a critical element for a provider to effectively manage and prevent denials for Medicare and Medicare Managed Care claims. Each MAC will publish a database containing open (current) and closed (archived) LCDs on their respective websites (CMS, NCDs Alphabetic Index, 2016).

Recovery Audit Contractors

Most providers have experienced audits and denials resulting from CMS' RAC program, now also known as Recovery Auditors (RA). In its Fiscal Year 2014 Executive Summary to Congress (CMS, 2014), CMS reported that $2.3 billion dollars was collected in RAC-identified overpayments during fiscal year 2014. The following three primary areas were identified as the causes of the most common improper payments:

- Payment is made for services that do not meet Medicare's coverage and medical necessity criteria

- Payment is made for services that are incorrectly coded

- Payment is made for services where the documentation submitted does not support the ordered service

The total amount of overpayments collected by the RAC program, from fiscal year 2010 through fiscal year 2015, was a staggering $9.6 billion (CMS, 2015). Although CMS outlined the three primary reasons for improper payment, providers must still be diligent about monitoring CMS' RAC website, as well as the website for their assigned regional Recovery Auditor, to stay up to date on additional areas of concern (CMS, Medicare fee for service recovery audit program, 2016). The top causes of denials vary from year to year. For example, the CMS 3rd quarter 2016 RAC data identified the top issues nationally causing provider denials as MS-DRG coding validation for sepsis and infections, as well as outpatient therapy claims that registered above the $3,700 threshold for both skilled nursing facilities and outpatient hospitals (CMS, Quarterly newsletter, 2016). These data reflect different areas of concern from the data reported in 2014, and 2017 data will likely highlight other areas of concern.

References and websites related to the Medicare RAC program can be found in Appendix B.

On October 31, 2016, CMS announced the award of the new Medicare Fee-For-Service RACs:

- Region 1: Performant Recovery, Inc.

- Region 2: Cotiviti, LLC

- Region 3: Cotiviti, LLC

- Region 4: HMS Federal Solutions

- Region 5: Performant Recovery, Inc.

The RACs in Regions 1 through 4 will perform post-payment reviews to identify and correct Medicare claims that contain improper payments (either overpayments or underpayments) that were made under Medicare Part A and Part B for all provider types other than durable medical equipment, prosthetics, orthotics, supplies (DMEPOS), and home health/hospice. The Region 5 RAC will be dedicated to the post-payment review of DMEPOS and home health/ hospice claims nationally (CMS, News & announcements, 2016).

A sample RAC tracking dashboard is available on the downloads page for this book at *www.hcpro.com/downloads/12561*.

Medicare Outpatient Observation Notice (MOON)

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act was signed into law August 6, 2015, and becomes effective March 8, 2017. The NOTICE Act requires hospitals and critical access hospitals to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours. The written notification must take the form of a document called the Medicare Outpatient Observation Notice (MOON). Initially, the Medicare Advantage population was excluded from MOON; however, as of August 6, 2016, Medicare Advantage patients are included in the MOON requirements.

The written notice must be delivered no later than 36 hours after observation services are initiated and must include:

1. The reason the individual is receiving observation services

2. An explanation of the implications of receiving outpatient observation service

    a. Cost sharing

    b. Post-hospitalization eligibility for Medicare coverage of skilled nursing facility services

The hospital must obtain the signature of the individual or individual acting on behalf of the patient. Hospitals must deliver a hard copy of the MOON to beneficiaries and enrollees. Hospitals must retain a copy of the signed MOON and may store the MOON electronically. The beneficiary must be given a paper copy of the signed MOON— even if the signature is captured digitally. Hospitals are permitted to give the MOON by telephone provided a hard copy is delivered to the representative (CMS, 10611, 2016).

Compliance with the NOTICE Act and the MOON requirement will likely prove to be the source of future probes and/or audits by CMS. Failure to produce a countersigned copy of the completed MOON form for an observation claim spanning more than 24 hours upon request would find the hospital in violation of the NOTICE Act. Hospitals must ensure that they have developed policies and procedures to incorporate accurate and timely completion of the MOON form into their processes for observation cases spanning more than 24 hours for both Medicare-fee-for service and Medicare

Advantage populations beginning no later than March 8, 2017. More information on the MOON, including a blank MOON form, is available on the downloads page for this book at *www.hcpro.com/downloads/12561*.

Federal guidelines

A number of federal guidelines contain language that directly impact provider billing. Sometimes, this language may exist as a subsection of a law that, on the surface, has little to do with medical billing or beneficiary rights and limitations. Organizations that are unaware of the full scope of federal guidelines put themselves at an unnecessary risk of increased denials and noncompliance.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA), a federal law that applies to many private employers, establishes minimum standards for retirement (pension plans), health, and other welfare benefit plans (including life insurance, disability insurance, and apprenticeship plans) to protect employees and employers. ERISA applies to private (nongovernment) employers offering employer-sponsored health coverage and some other benefits to their employees. It does not require employers to offer any specific types of insurance or retirement plan but does set minimum standards for some of the benefits that an employer does offer to employees. ERISA laws do not apply to privately purchased, individual insurance policies or benefits (USDL, 2016).

The Benefit Claims Procedure Regulation (BCPR), a subsection of

ERISA (29 *CFR* 2560.503-1), stipulates how benefits are determined when an employee files a claim. It controls how claims, appeals, and decisions can be made, as well as discloses rights for employees who make claims. The BCPR regulation created important new patient protections to ensure that group health plan participants in the managed care environment have access to a faster and fairer process for benefit determinations (USDL, Fact sheet, 2000).

At face value, ERISA appears to be unrelated to provider or facility operations. This could not be further from the truth. ERISA and the specific stipulations outlined in the BCPR are directly applicable to healthcare provider claims. The regulations refer to an "authorized representative." When a claim involves urgent care, a plan must, without regard to the plan's procedures for identifying authorized representatives, permit a healthcare professional with knowledge of the claimant's medical condition (e.g., a treating physician) to act as the authorized representative of the claimant. This exception is intended to enable a healthcare professional to pursue a claim on behalf of a claimant under circumstances where, for example, the claimant is unable to act on his or her own behalf (USDL, Group health and disability plans, 2012).

State regulations

Managed care denials are complicated by the division of financial responsibility. In some cases, the service is the financial responsibility of the health plan, and in others it's the responsibility of the medical group. One of the largest issues contributing to managed care denials is the failure of the provider/facility to provide timely notification to the plan or medical group of an

admission. Establish-ing a process for ensuring timely notification will significantly reduce denials or delays in payment. Often, payers or medical groups will not respond to the provider's initial notifi-cation in a timely fashion and then deny post-stabilization care.

In California, guidelines for timely notification and payer response are outlined in the California Health and Safety Codes, Article 5, otherwise known as the Knox-Keene Healthcare Service Plan Act of 1975 (California, 2016). Section 1371.36(a) states:

> *A health care service plan shall not deny payment of a claim on the basis that the plan, medical group, independent practice association, or other contracting entity did not provide authori-zation for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized, if all of the following Article 5, §§1367—1374.195 Knox-Keene Act 2016 277 conditions are met: (1) It was medically necessary to provide the services at the time. (2) The services were provided after the plan's normal business hours. (3) The plan does not maintain a system that provides for the availability of a plan representative or an alternative means of contact through an electronic system, including voice-mail or electronic mail, whereby the plan can respond to a request for authorization within 30 minutes of the time that a request was made. (b) This section shall not apply to investi-gational or experimental therapies, or other non-covered services.*

Section § 1371.4(d) states:

> *If there is a disagreement between the health care service plan*

and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

While the regulations cited above are specific to the state of California, there may be similar statutes in other states. I encourage readers to research and understand their own state regulations and not to accept a payer or medical group's denial in blind faith.

Contract Language and Payer Manuals

Contract terms can be a large contributor to a provider's denials. This can be caused by a misinterpretation of the intent of a contract's terms. This is often seen in the calculation of stop-loss and exclusions (carve-outs) within the rate structure of a contract. Other areas that can cause underpayments are the language within the body of a contract and a health plan's provider billing or operation's manual. Providers must use caution when negotiating

their contracts to ensure the intent and language are clear. It is also equally important that providers download and understand payer-specific billing and appeal requirements outlined in both the contract and the payer's billing and operations manuals.

References

Centers for Medicare & Medicaid Services (CMS). (2016). Medicare fee for service recovery audit program. Retrieved from *www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/.*

CMS. (2012). The role of the zone program integrity contractors (ZPICs), formerly the program safeguard contractors (PSCs). *MLN Matters,* SE1204. Retrieved from *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1204.pdf.*

CMS. (2014). Recovery auditing in Medicare for fiscal year 2014. Retrieved from *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.pdf.*

CMS. (2015). Medicaid integrity program. Retrieved from *www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram/.*

CMS. (2015). National program total corrections. Retrieved from *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/National-Program-Total-Corrections.pdf.*

CMS. (2016). Comprehensive error rate testing. Retrieved from *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/.*

CMS. (2016). Details for title CMS-10611. Retrieved from *www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10611.html.*

CMS. (2016). National coverage determinations (NCDs) alphabetic index. Retrieved from *www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=AgAAAAAAAAAAA%3d%3d&.*

CMS. (2016). News & announcement. MLN connects provider enews. Thursday, November 3, 2016. Retrieved from *www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-11-03-eNews.html#_Toc465834795.*

CMS. (2016). Payment error rate measurement. Retrieved from *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html?redirect=/perm.*

CMS. (2016). Quarterly newsletter. Retrieved from *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/MedicareFFS-Recovery-Audit-Program-3rd-Qtr-2016.pdf.*

Office of Inspector General (OIG). (2016). Fraud. Retrieved from *https://oig.hhs.gov/fraud/*

State of California Department of Managed Health Care. (2016). Regulations applicable to California licensed health care service plans. Retrieved from *https://wpso.dmhc.ca.gov/regulations/docs/16CCRp.pdf.*

United States Department of Labor (USDL). (2016). Frequently asked questions. Retrieved from *http://webapps.dol.gov/dolfaq/go-dol-faq.asp?faqid=225.*

USDL. (2000). Fact sheet. Retrieved from *www.dol.gov/ebsa/newsroom/fs112000.html.*

USDL. (2012). Compliance assistance: Group health and disability plans. Retrieved from *www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/programs-and-initiatives/outreach-and-education/hbec/CAGHDP.pdf.*

The process for dealing with claim denials and appeals can be time-consuming. Confusion around complex regulations may unnecessarily prolong the process and negatively impact a hospital's revenue cycle.

An effective denials management program requires clear goals and a mission that results in value to the hospital. A denials management program is not only a key part of revenue integrity, it can provide valuable data hospitals can use to analyze performance across various departments, identify pain points, and support overall operational improvements.

The *Denials Management* training handbook is a clear, concise guide to the denials management process. Best practices and tips will help hospitals turn denials into successful appeals.