Every day, someone at a health system or hospital asks me a variation on this question: *How can I better manage denials?*

There's tremendous pressure to reduce denials. According to CMS, 20% of all claims are denied, 60% of lost or denied claims will never be resubmitted, and 18% of claims will never be collected.\(^1\) Reworking each claim costs around $25.\(^2\)

The problem is worsening as the complexity of claims processing intensifies. Our population is aging rapidly, and care needs are increasing. Medicare enrollment is rising. Comorbidities and chronic conditions are more prevalent. And population health management is also taking hold. Health systems are transitioning more patients across multiple settings and specialists, requiring multiple claims.

No wonder CFOs, CNOs, and CMOs are working to better understand what’s driving denials at their hospitals. Many are devoting significant resources and leadership time into developing denials and appeals management programs. They want solutions that will improve performance and ensure they’re reimbursed promptly, efficiently, and for every dollar they’re legitimately owed.

Myriad issues drive denials, but there’s one area that denial management programs can overlook: issues related to medical necessity. According to McKesson research, while medical necessity only accounts for about 5% of denials nationally, those numbers and the revenue they represent add up and can be significant for any health system.

Moreover, medical necessity is foundational for a broader set of process opportunities that can reduce denials and help improve care quality. As such, the care management system must be examined to identify gaps that cause denials. Once done, processes that reduce denials must be put in place along with programs to support and enhance the appeals process for denials that still occur.

When you’re asked, “How can I better manage denials?” respond with a focus on these ten steps that identify common gaps that can cause medical necessity denials.

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Make a Case for Case Management Leadership

A hospital needs strong case management leadership with a clear vision, focus, and goals. Case management isn’t just a department. It’s an organizational philosophy. It requires an enterprise-wide approach to reduce variation and provide a forum to use best practices.

Are nurses, physicians, and ancillary departments vested in length-of-stay and transition management? Are they aligned around priorities and strategies? Is there a case management plan with documented workflows that integrates utilization and case management functions? Is there transparency between case management and the CFO? In particular, does leadership help the CFO understand what case management is, what case managers do, how their work helps close gaps, and how the CFO can help from a data perspective?

Case management is often seen as the case manager’s problem and isn’t owned by anyone else in the organization. In fact, every stakeholder has a significant impact, and needs to understand their role.

Beef Up Your ED Case Management Program

Every hospital needs a robust ED case management program. That means ensuring admissions are appropriate at the time the decision to admit a patient is made. Attention must be directed toward the nurse case manager and the role of social workers.

Ensure that ED physicians understand key concepts, such as the Two-Midnight Rule, case management’s role (see tip #1), the role that evidence-based content (such as InterQual) has in admissions, the importance of documentation, the correct level-of-care assignment, and the existence of an onsite ED Case Management Model that functions 24/7.

Spend time with ED physicians discussing what an ideal case management model looks like, how they should be working with case management more effectively, and how to ensure entry points are covered not only in the ED, but for direct admissions and transfers.

Ensure Observation Management Works

The review of observation patients should be a priority. When a patient arrives at the ED, they go through triage and are admitted for observation or as an inpatient. Observation requires a rapid course of treatment. But many hospitals don’t do much testing after 5 p.m. or on weekends.

When observation management isn’t effective, patients who would have been discharged after tests are conducted are instead kept in short-stay units, despite the fact that the evidence shows it’s not necessary.

To close gaps and reduce denials, it’s important to triage effectively and make an appropriate decision on whether a patient should be admitted for observation or on an inpatient basis. Observation must drive a rapid course of testing, diagnosis, and treatment, because treatment gaps or delays can lead to denials.

To fix this, dive into the analysis of admission data. Once the types of cases that get admitted to observation are understood, the organization can ensure testing is available for typical cases, even on nights and weekends. And the first areas of focus should be those with high volume, where denials are high due to treatment delays.

Take Level-of-Care Management to a Higher Level

There are many cases in which decision support criteria (such as InterQual Criteria) supports the decision that admission is medically necessary, yet those claims are still denied because care is not being rendered at the appropriate level.

This is often a sign that cases aren’t being elevated to the physician advisor for further discussion. For example, a need for telemetry doesn’t necessarily require admission to a higher-level unit. Any patient can be monitored and yet not require an intermediate level of care. Documentation has to be specific to validate the level of care being requested.

Have Consistent Processes and Frequent Reviews

Most case management models have room for improvement to develop consistent practices and more frequent medical reviews. When helping organizations address denials, spend time looking to determine whether the case management model operates as intended.

Look at whether all entry points—ED, direct, transfers, elective admissions, etc.—are covered around the clock. It’s crucial to make decisions and validate medical necessity for all admissions prior to the patient being admitted. Encourage proactive engagement of the care manager in the rounding process and focus on findings, interventions, and plans that demonstrate medical necessity.

Problems arise when ED reviewers, floor reviewers, and social services staff responsible for discharge planning don’t share an understanding of the rules and processes, or aren’t following established guidelines effectively. In other words, there are often gaps between the care management model’s theory and practice.
Next, look at the timing and frequency of medical necessity reviews. Many hospitals ensure the ED makes an initial review to determine whether a patient is to be treated as an inpatient or an outpatient—yet it’s often days later when a case manager reviews the case with a medical review, using decision support criteria, to determine whether the patient still requires a particular level of care, and ensures a discharge plan is in place.

The ideal timing is to hold reviews daily or every other day, especially for those facilities reimbursed primarily by DRG. Otherwise, patients who could have been discharged or transferred remain hospitalized, patients who aren’t responding as expected aren’t managed appropriately, or new conditions and treatment needs are added without updating the case management or discharge planning documentation.

This can lead to problems in organizations where there’s a lack of community resources, such as skilled nursing facilities, rehab facilities, or home care support agencies. If discharge planning takes place at the last minute, those resources might not be available immediately and discharge will be delayed.

Also, use decision support criteria to help drive appropriate length of stay. The criteria should provide an outline of expected course of care and response by episode day, and provide proactive care management guidance to help address the patient who is not responding as expected, in order to keep that patient on track. It should also incorporate benchmark length-of-stay data in the review process, to help establish an estimated length-of-stay with the care team.

Process gaps around the timing of the initial and continued stay reviews are an important element in managing transitions. Revisit the organization’s review timing to be more aggressive with both length-of-stay and discharge planning for readmission management.

6 Improve the Clinical Documentation Improvement Program

Many hospitals have clinical documentation improvement programs. From a clinician’s perspective, those programs often lack documentation required for the initial and subsequent decision points. By working with physicians and nurses, organizations can identify problem areas and establish documentation processes that avoid going down paths that lead to denials.

Ensure the medical review demonstrates a holistic understanding of the patient, with clearly articulated medical and discharge plans. Documentation must support treatment and level-of-care decisions. Physicians have a critical role to play in this area. They must understand how cases are prioritized and how reviews are submitted to payers.

Technology has given us a “cut and paste” mentality where current status and plans are simply copied from the history and physical examination reports. This impedes the ability to clearly determine the current state of a patient and next steps, and can be a red flag for payers. Instead, avoid cut and paste, and provide specific, succinct case documentation to help denials.

7 Make the Physician Advisor a True Member of the Care Management Team

Many hospitals employ dedicated physician advisors that spend time rounding on the unit and have frank conversations related to denials that can assist the care management team. Hospitals that enlist this support can have fewer denials, because they can intervene proactively to ensure documentation is robust and processes more effective.

That said, sometimes these physician advisors aren’t full-time employees, but rather, practicing physicians who perform this kind of work on a part-time basis. Such physician advisors might not see themselves as part of the care management team or have sufficient dedication to care management processes and goals.

Conversely, when full-time physician advisors are on the team, they can help train residents on their utilization management roles, and contribute to building a cadre of physicians who understand how to use best practices to reduce denials.

8 Train Staff on the Use and Role of Decision Support Criteria

For accurate medical necessity and appropriate care guidance, ensure the organization’s staff uses decision support criteria consistently and effectively. Also ensure they’re aware of the criteria’s various tools and best practices—including condition-specific review processes, use of episode days, discharge screens, and so on. Provide annual refresher training on the criteria, tools, and the continued stay review process. Organizations should also reinforce the need for adequate medical record documentation to support the criteria selected.

The organization also needs an effective auditing program. Some decision support criteria, such as InterQual, provide tools for evaluating staff consistency (e.g., InterQual Interrater Reliability). In addition, pull cases quarterly (at a minimum) to identify variation across the staff. Where
variations are found, build action plans or educational programs to reduce them. Lastly, build an onsite “Certified Instructor” program to create onsite expertise in the use of decision support criteria and supporting tools. Such programs are optimized when the team is using all the tools correctly, and audits are being performed to identify improvement areas.

9 Engage the Staff with Data-Driven Insights

Data is a crucial part of any case management program. It’s extremely important to share it at the staff service-line level to expand understanding of denial issues and close gaps that impede success.

Very few people in a hospital actually know what’s actually going on in terms of denials. While leadership might have an understanding of the resources wasted and revenue lost, and the case manager might have a strategy to improve performance, the staff rarely if ever see a report on denials. They don’t know length-of-stay or denial rates and they’re not being asked for input on how they can help improve processes.

Ensure operational reports from finance and revenue cycle are being circulated and reviewed. Data should be the driver of a denials management program. Teams need access to service level reports to build action plans for improvement. If you have the data, and teams are developing action plans and looking for improvement opportunities, they will find ways to reduce length-of-stay and cost, and help improve quality.

10 Use Specific and Objective Criteria Regardless of What a Payer is Using

No matter which vendor’s guidelines or decision support criteria a payer is using, an organization can use InterQual to support the medical necessity of care provided. InterQual provides specific and objective evidence-based guidance, so there’s no gray area in determining whether a patient meets the criteria for necessary care.

Guide staff in a consistent approach to gather the clinical information used as part of the InterQual review. Evidence-based criteria can help ensure appropriate care and documentation of decisions, and that can help increase appeals win rates dramatically.

Denials are an increasingly serious problem at most hospitals and health systems. Closing the gaps that drive up denials and cost hospitals revenue requires an enterprise-wide approach. Leadership from across the organization must be involved. The CFO, CMO, and CNO are key. But physician leaders must also be enlisted to drive change in physician practices. Case management is ultimately accountable for appropriate utilization. They are entitled to a seat at the table. This type of holistic approach will affect the organization at every level.

The good news is that noticeable improvements can come early and easily. Measurable progress in the first few months helps affirm the importance of the work, and gives it focus and momentum. Consistent processes, good tools, transparent data, and rigorous documentation helps, but it’s just as important to have ongoing conversations with clinicians—and everyone else who supports case management—to enlist them in the search for better approaches.

The positive impact to the hospital’s bottom line can be significant while also helping ensure patients receive the most appropriate care.

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