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Complete Healthcare Compliance Manual
Revenue Cycle: Denials Management

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What Is Denials Management?

To properly analyze the compliance risks of denials management requires stepping back and analyzing the factors that led to the denial. First, claim denials are a refusal of an insurer to pay for a patient's healthcare services at a healthcare provider. These denials can be generally classified into several types, each with a different root cause and compliance risk. Here are some of the most common types of claim denials.

Technical denials encompass those where information on the claim renders the claim unpayable. These technical factors include incomplete claim completion, submission of a claim to the wrong payer, submitting past the timely filing deadline, claims for services that have already been billed, and services not authorized.

Coding denials involve improper application of coding rules. This would include the use of invalid or nonspecific HCPCS or ICD-10 codes, improper use of modifiers, not following coding rules by unbundling services, use of codes that are not supported by the documentation, bypassing edits, and improper coding of services such as infusions or injections. Many coding denials make reference to citations such as Coding Clinics, the official guide to coding information published quarterly by the American Hospital Association. It is important to check those citations to ensure they are being interpreted correctly by the auditor and that subsequent guidance in Coding Clinics has not superseded the cited source.

Clinical validation audits, where denials state that a reported diagnosis was not clinically present, require careful analysis to determine if the diagnosis definition used by the auditor remains valid. Several conditions, such as malnutrition, have definitions that have evolved over time, and a denial based on an outdated definition should be appealed.[2] For other diagnoses, as with sepsis, the criteria for defining sepsis have evolved as the science has advanced, often leading to coding confusion and denials.[3]

Diagnosis Related Grouping (DRG) denials occur when the auditor determines that the codes entered on the claim were not valid. The audit may determine that the primary diagnosis was not correctly assigned or that a secondary diagnosis was not supported. As noted above, the audit may find a diagnosis is not clinically valid and remove it from the claim, resulting in assignment to a different DRG that is usually lower weighted. They may also determine that although the diagnosis was present, it does not meet the standard for inclusion as a secondary diagnosis as determined by the Uniform Hospital Discharge Data Set (UHDDS).[4] The UHDDS states that for reporting purposes, "the definition of 'other diagnoses' is additional conditions that affect patient care in terms of requiring clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring."[5]

Medical necessity denials constitute the most complex denial category. Medical necessity denials generally fall within one of two broad categories: medical necessity for the service itself and medical necessity for the level of care of the service. Medical necessity for the service itself calls into question whether the patient met the payer's guidelines to receive the service. These medical necessity guidelines may vary by payer. While some plans have

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an internal team that independently evaluates services to set medical necessity guidelines, others rely on the prevailing medical standard of care. This coverage can even vary within a payer. For plans that provide both commercial plans and government-sponsored plans, such as Medicare Advantage, the coverage for their commercial plans can follow internal guidelines, but the coverage for Medicare Advantage must match what is available to a fee-for-service Medicare patient.[6]

If the payer does not have a published policy for medical necessity coverage for a service, the determination of coverage often defers to the professionally recognized standard of healthcare. While defining the standard of care is difficult, the Centers for Medicare & Medicaid Services (CMS) refers to predetermined elements of healthcare developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a healthcare service may be compared.[7] Innovation in medical practice changes rapidly and adoption of new technologies and practices varies greatly not only geographically between regions of the country, but also within organizations amongst medical staff at a single facility. As new procedures and practices are adopted, it is incumbent on the compliance team to ensure that there is a scientific basis for adopting the practice and that the service will be covered by payers.

CMS and the Medicare Administrative Contractors (MACs) publish National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) in the Medicare Coverage Database.[8] Proposed NCDs and LCDs are published with a comment period prior to being finalized. NCDs are binding on all providers and auditors, but LCDs are not binding on appeals at the Administrative Law Judge and higher levels, although deference must be given to the policies.[9] NCDs and LCDs outline covered indications and, in many circumstances, noncovered indications. In 2015, the Department of Justice (DOJ) settled a false claims case with nearly 500 hospitals over implantation of defibrillators.[10] An analysis of that case noted that while the NCD for defibrillator placement clearly specifies when a device is covered, it does not indicate when a device is not covered, suggesting that the hospitals that settled had the opportunity to appeal each case.[11] Careful analysis of the coverage policy is necessary to determine if a denial is appropriate or should be appealed.

As noted, if an NCD is not available, a MAC may choose to develop an LCD. With multiple MACs across the country, that leads to potential confusion, especially for health systems and regional or national providers that provide services in multiple MAC jurisdictions that may then face differing medical necessity standards for the same service depending upon their location. The Office of the Inspector General (OIG) reported in 2014 that this significant variation in LCDs creates disparities in access to care for beneficiaries and is contrary to the growing practice of evidence-based medicine that eschews local variation. The OIG recommended at that time that CMS work to standardize LCDs across jurisdictions.[12]

Medical necessity denials for the level of care rest on the decision to admit the patient as an inpatient or treat the patient in the hospital as outpatient. As with medical necessity for the service, status determinations vary greatly between and within payers. It is important to note that status and medical care are not directly related. A hospitalized patient who is an outpatient should receive the same care as a hospitalized patient with the same condition who is admitted as inpatient. The difference is almost completely one of payment to the provider for the services provided. In general, inpatient admissions pay at a higher rate than the rate for the same care provided as outpatient, although this is not absolute.

Two major nonfinancial differences should be considered. For a traditional Medicare patient, if skilled rehabilitation care is needed after the hospital stay at a skilled nursing facility, the patient must be an inpatient for three or more days, not counting the day of discharge.[13] For any patient who is eligible for Medicare

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benefits, immediate discharge appeal rights are only available if the patient is admitted as inpatient.[14]

The status determinations for traditional Medicare beneficiaries are determined by the Two-Midnight Rule, adopted October 1, 2013.[15] This rule also applies to admissions of Medicare Advantage patients who are admitted to facilities that are not contracted with their Medicare Advantage plan. The basis of the Two-Midnight Rule is that inpatient admission is appropriate when patients are expected to have a hospital stay that crosses two midnights; the need for a surgery on the Medicare Inpatient-only list (published each year as addendum E to the Outpatient Prospective Payment System Final Rule); or a patient with a one-midnight expectation who meets one of the exceptions established by CMS.

For contracted providers providing care to a Medicare Advantage enrollee, CMS has stated that as long as the patient receives the necessary care, the determination of status and payment are a contractual issue between the provider and payer.[16] For nongovernmental payers, it is once again a contractual issue. Many payers use commercial criteria tools to aid in determining the appropriate patient status. While these tools, and internally developed guidelines, can aid in determining patient status, they are not definitive. They simply act as guides that can be overridden by a physician if clinically appropriate.

Claim denials must also be separated by payer. Denials of services provided to those insured by transitional government payers, such as Medicare and Medicaid, involve federal and state laws and regulations. Denials from commercial payers, such as employer-based plans, must be viewed on the contractual basis. If the provider is contracted with the payer, the terms of the contract apply. If the provider is noncontracted, then state laws may be applicable. Plans that are government-sponsored but provided under contract by another entity, such as Medicare Advantage or Managed Medicaid, are handled differently depending on whether the provider is contracted with the payer. Contracted providers would be bound to the provisions of the contract and noncontracted providers would use the federal or state regulations as guidance.

The proper management of denials is also crucial. While reviewing denials individually and responding appropriately is the main objective, every denial is an opportunity to collect data and improve processes. And the more granularity of data that can be collected, the more information an organization will have to prevent further denials. Each denial should be categorized by type, payer, service line, provider, coder, biller, day of the week, time of day, and so on. Accumulating this information will allow you to ascertain patterns to address in denial prevention. For example, denial for an inpatient admission that was determined to be more appropriate as outpatient with observation should be analyzed for payer; admission source (emergency department, direct admission, conversion from outpatient, surgery); admitting physician who made the admission decision; utilization review nurse who reviewed the case; physician advisor who made the second-level determination; diagnosis; day of the week; and time of day.

Who will prepare the appeal must also be determined. In the case of coding appeals, it would seem common sense to have the coding staff handle the appeal, but many coding denials are properly coded and include a clinical basis for the denial. Such would be the case in what are called "clinical validation denials," where a diagnosis is documented by a provider and coded properly onto the claim, but the payer disputes that the diagnosis actually exists. In this case, the denial must be reviewed collaboratively between the coding and clinical staff and the appeal formulated.

Denial and appeal tracking is important to ensure not only that deadlines are not missed, but also to monitor auditor behavior. CMS maintains a data warehouse that tracks the activity of all audit contractors to ensure that two auditors do not review the same case. In recent years, commercial payers have contracted with outside audit agencies to audit claims they have already paid. In some cases, this audit may be of a claim that was already audited by the payer themselves and found to be compliant. The contract should be reviewed to determine if a

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claim can be audited twice.

Every denial is also an opportunity to ensure that everyone is acting compliantly. While isolated denials rarely indicate intentional disregard of rules, patterns of denial types may develop, warranting a more in-depth review to ensure there is no compliance risk. While actions of individuals may not be malicious or intentionally fraudulent, the purposeful deviation from the rules should never be permitted.

The denial rate may also be subject to discussion with concerns that higher denial rates may suggest that noncompliant activities are occurring. This is not correct. A high denial rate warrants analysis, but it may be due to overaggressive denial practices by payers. Likewise, a very low denial rate is not necessarily a measure of excellent compliance, as lack of denials may suggest overly conservative practices.

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