Optum

The secret to untangling medical necessity denials

Over the past few years, commercial payers have changed their denial strategy. More denials are now issued for clinical reasons, such as medical necessity, which are often associated with a higher dollar value. These denials are more challenging for hospitals to manage since they require a clinical perspective.

When analyzing their denial challenge, many providers begin by focusing on individual metrics like the overall denial rate or the denial overturn rate. However, focusing only on these two metrics doesn't give a complete – or, in some cases, accurate – picture of that organization's denial challenge.

These common denial metrics don't account for two key influences on denials: silent denials and peer-to-peer appeals. Silent denials do not show up on denial reporting, and hospitals often do not track them. Though often heavily underutilized, success at the peer-to-peer level avoids denials and isn't reflected by denial and overturn rates.

Overlooked focus areas:

Peer-to-peer appeals

Silent denials

Silent denials

Defeated before even beginning?

Silent denials occur when case managers withhold a case from physician advisor review based on their subjective opinion about whether a payer is likely to deny. By denying these cases a physician advisor review, they allow some cases to remain outpatient for which an inpatient status would be more appropriate. This kind of reimbursement reduction doesn't appear on any reports because these cases look like appropriately paid outpatient cases instead of cases that should have been inpatient.

Silent denials have many causes. They can occur because of failures in the utilization review process despite even the best of intentions. Case managers review hundreds of cases for the same payers and learn payer habits as a result. This knowledge can improve the utilization review process, but it can also condition case managers to anticipate payer decisions. Almost all utilization review processes involve case managers applying a criteria set (InterQual® or Milliman) in a first-level review. If they believe a payer won't approve a case as inpatient when it fails first-level criteria, case managers may simply leave it as outpatient, even though a physician advisor might have recommended inpatient.

Sometimes, "gray cases" that aren't clearly inpatient or outpatient happen when a physician advisor isn't available and case managers accept the results of first-level criteria instead of waiting for a physician advisor review. Though they are simply trying to operate efficiently amid heavy workloads, case managers inadvertently miss the opportunity for appropriate inpatient reimbursement.

Some silent denials occur because treating physicians don't follow a physician advisor's recommendation or fail to recognize the importance of patient status. Attending physicians are sometimes reluctant to change a gray case to inpatient, regardless of how strong of an argument can be made. If they do, it could lead to a confrontation with payer medical directors at the peer-to-peer stage, which they are ill-equipped to handle, and diverts time from patient care. In some cases, treating physicians may resent case managers interfering with their work.

Utilization review analytics and AI can help indicate silent denial problems and opportunities to correct them.

Identifying and fixing the silent denial problem

Digging deeper into your utilization review analytics can reveal combinations of metrics that indicate silent denial problems. Organizations with a silent denial problem will often see higher observation rates, mortality rates and average cost of care. They may also experience an artificially higher case mix index when compared to peer organizations.

Upon first glance, a low denial rate and a high appeal success rate might be encouraging, but when combined with the above metrics, they could indicate problems. A low medical necessity denial rate with a high observation rate suggests that an organization may be experiencing silent denials. If insurers aren't issuing denials, providers probably aren't assigning inpatient status appropriately. Likewise, a high medical necessity appeal success rate could indicate that only cases with a strong argument supporting inpatient status — those cases that are easiest to appeal — are reaching the payer in the first place.

Fixing a silent denial problem requires a complete utilization review process. It has to account for every possibility and leverage physician advisors to assess any case that is not clearly outpatient. Providers cannot allow shortcuts. Your process must also clearly record the reasons justifying an inpatient status determination to support the peer-to-peer and retrospective denial stage in case an insurer questions your determinations.

More importantly, you must apply your utilization review process consistently. Technology can help govern the process. Cutting-edge artificial intelligence (AI) technology can help by automating initial case review and sorting to help determine which cases require a physician advisor review. Likewise, AI can present physician advisors with condition-relevant, evidence-based medical research so they can build their determinations from evidence, not subjective opinion. When you accomplish this, you know your utilization review team has resolved your silent denial challenge.

Peer-to-peer reviews

First, best chance to prevent denials

Virtually all commercial payers allow a hospital physician (or physician advisor) to discuss a case with an insurer physician medical director after an early denial concurrent to the patient inpatient admission request. This discussion, usually a phone call, is a peer-to-peer review. Many hospitals don't fully utilize this best opportunity to prevent denials.

Most payers rely heavily on first-level criteria to support denials. But each patient can have subtle risks, history and prior presentations that this criteria do not take into account. Insurers recognize this by offering the peer-to-peer review process. If the first-level review criteria and payer's denial process were infallible, peer-to-peer calls would be unnecessary.

Peer-to-peer reviews are the most efficient means of preventing retrospective denials because they take only a few minutes and don't involve time-consuming administrative tasks like preparing appeal letters. They also offer the best chance of overturn. Physicians, speaking the same clinical language, can quickly get to the heart of a case, highlighting relevant risk and severity factors. A physician representing the hospital can respond to a payer medical director's objections immediately with pertinent facts.

Many hospitals struggle with peer-to-peer reviews when using attending physicians to argue the case with payer medical directors. While insurers have deep knowledge of policy terms and payer standards, attendings usually do not. This creates an inherent imbalance.

Often, attendings don't want to participate in peer-to-peer reviews. Some believe these reviews call their judgment into question. Or payer medical directors may schedule these calls at inconvenient times for the attending's schedule. Even if they can attend, attending physicians must review case details

Peer-to-peer reviews can be complicated when the right personnel aren't engaged in the process or properly trained.

to prepare, diverting more time from patient care. And many hospitals lack procedures to reliably brief attendings with key information prior to the call, such as relevant payer policy and contract terms.

Furthermore, attendings often aren't trained to speak with insurers. They are unlikely to know what a particular medical director is looking for and what arguments have succeeded in the past. Medical directors may reject an inpatient status, but offer to approve an outpatient status instead. Attendings may view this as a victory, when it is actually a defeat. Additionally, this peer-to-peer work can further increase burnout for attending physicians.

Assessing and improving your peer-to-peer review process

Reviewing your peer-to-peer overturn rates and overall denial rates on a per-payer basis is the first step to evaluating the health of your peer-to-peer process. Feedback from physician advisors can provide further clarity. Assess how well your organization prepares physicians for engaging in peer-to-peer reviews. Do you document evidence-based medical support for each case? How do you share payer-specific habits and trend data with physicians?

The peer-to-peer review process can greatly benefit an organization. A true "peer-to-peer" review should occur between a medical director and a physician advisor. Both share the same knowledge of insurer policies and procedures. When physician advisors conduct peer-to-peer reviews, they will learn the tendencies, habits and standards of specific medical directors for each payer. This familiarity allows them to apply lessons from prior reviews to future ones.

If attending physicians must conduct the peer-to-peer review, it's vital for a physician advisor to brief the attending beforehand on contract considerations, trends about a particular medical director or payer, and vital case details that strengthen the inpatient argument. This brief may take only a small amount of time, but will improve peer-to-peer success rates and ensure that the payer has all relevant clinical information to make an accurate decision.

In either case, verify both that the review actually occurred and that the attending clarifies the documentation to reflect the results. These reviews can only support medical necessity if the documentation gets updated.

With these adjustments, your hospital can effectively leverage peer-to-peer reviews to prevent medical necessity denials and defend reimbursement.

More than a metric

A hospital's denial and overturn rates on their own aren't sufficient to reflect the health of your revenue integrity and utilization review process. They do not account for silent denials, which often disguise themselves as appropriate payment. And many hospitals don't fully leverage the peer-to-peer review process, even though it can both strengthen utilization review and reduce the flow of denials. Both are critical tools to help a hospital achieve the reimbursement it deserves and assign the right patient status upfront. An effective utilization review process must account for and track both to achieve all appropriate reimbursement.

Learn how Optum can help your facility address the true causes of its denial challenge.

optum.com/contactus

Optum

11000 Optum Circle, Eden Prairie, MN 55344 | optum.com