

**2023 Mid America Summer Institute** Aug. 7-9 • Minneapolis

# Igniting the Spark

**FOR HEALTHCARE TRANSFORMATION**

**HFMA Region 8**

GREATER HEARTLAND • IOWA • MINNESOTA • NEBRASKA  
NORTH DAKOTA • SOUTH DAKOTA • SUNFLOWER

# Preventing Clinical Denials When Subjective Decision-Making is the Cause

# Meet Today's Presenters



**Stacy Gearhart, JD, LLM**  
Operations Executive,  
Enterprise Transformation Office



**Laurie Beck, RN, BSN, CCM**  
Sr. Vice President,  
Clinical Operations



## Agenda

- Medical Necessity Denial Prevention
- Subjective vs. Objective Decision-making
- Process Improvement Opportunities

## SESSION OBJECTIVES

- Learn effective and consistent documentation to prevent and overturn clinical denials.
- Understand how to utilize Revenue Cycle/UM processes to prevent denials.
- Identify areas of opportunity and process improvement to address and prevent clinical denials.
- Obtain pointers and suggestions for drafting persuasive appeals on the provider's behalf to overturn the denials and hold payers accountable.



# Medical Necessity Denial Prevention Tactics



**Root Cause  
Analysis**



**Appeal  
Resolution**



**Payer  
Escalation**



**Team  
Education**

## CARCs: Medical Necessity

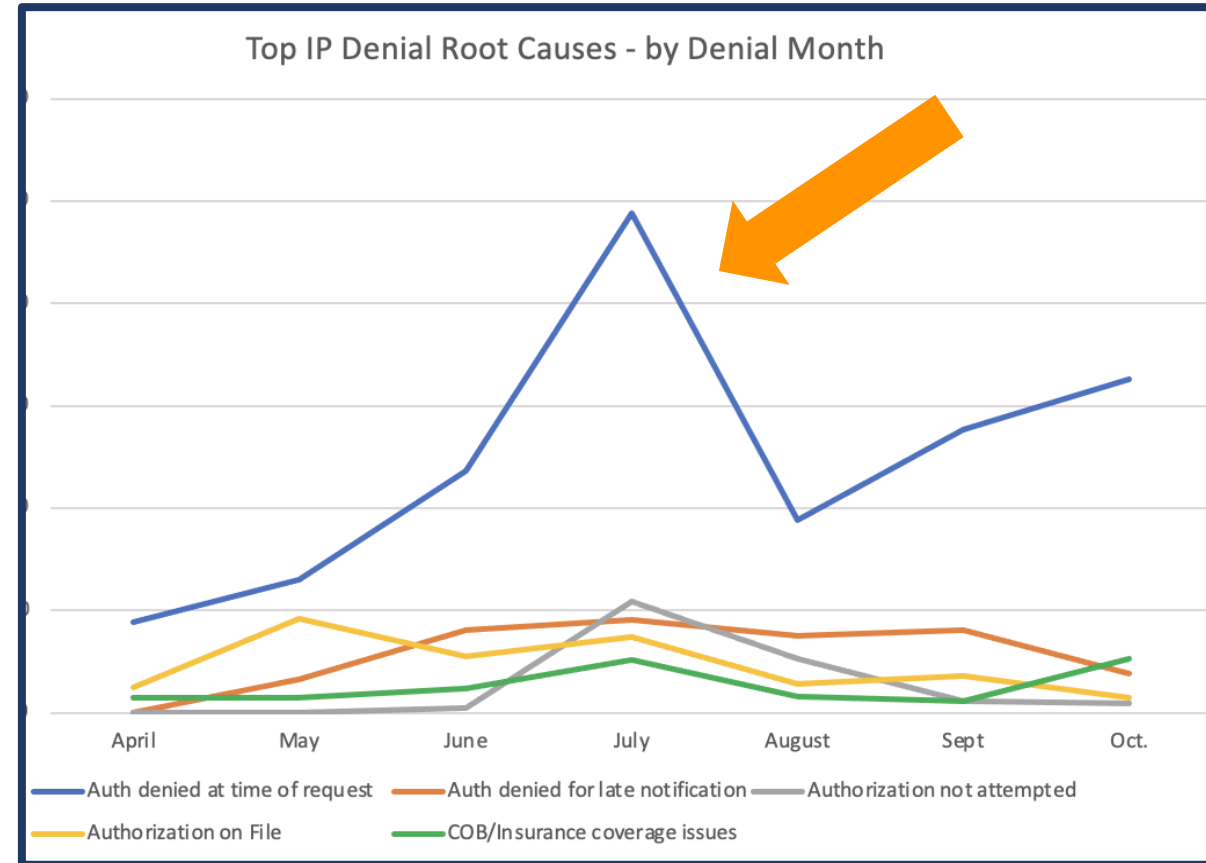
50	These are non-covered services because this is not <b>deemed</b> a 'medical necessity' by the payer
55	Procedure/treatment/drug is <b>deemed</b> experimental/ investigational by payer
56	Procedure/treatment has not been <b>deemed</b> 'proven to be effective' by the payer
58	Treatment was <b>deemed</b> by the payer to have been rendered in an inappropriate or invalid place of service
150	Payer <b>deems</b> the information submitted does not support this level of service

# The Challenge:

## Analyzing Medical Necessity Denials

To provide deeper insight into the medical necessity decision making process to identify denial prevention action items for:

- Physician Advisor
- Utilization Management/ Case Management
- Payers

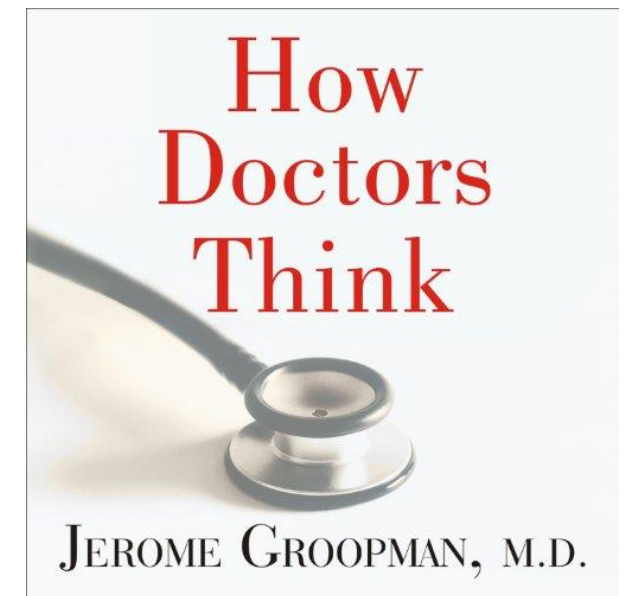


# Understanding Physician Judgment

“The ability to know when algorithms work for patients and when to choose different treatments, which might conflict with algorithms, becomes clearer the more patients one treats.”

“Anchoring error” – the tendency to seize on an initial symptom or finding and allowing this to cloud medical judgment.”

“Attribution error” – tendency to fit people into stereotypes based on one’s past experience or what one has heard – this prevents the physician from viewing the patient’s clinical picture de novo.”





# What is Subjective Decision-Making?



## OBJECTIVE

- ✔ Information or analysis is fact-based, measurable and observable.
- ✔ **Clinical criteria / guidelines**



## SUBJECTIVE

- ✔ Information or analysis is based on personal opinions, interpretations, points of view, emotions and judgment.
- ✔ **Physician judgment**

- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality
- ✓ Communication / Process Issue



The patient can be treated at a lesser level of care.



Health Plan



Inpatient authorization denied at time of request

## ✓ Access to Documentation

- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality
- ✓ Communication / Process Issue

## Electronic Medical Records (EMR)

Payer access at time of inpatient authorization request/concurrent reviews

- ▶ Sufficient information "turned on" for payer to review?
- ▶ Timing of documentation and payer access
- ▶ Confirm payer accessed EMR prior to decision-making
- ▶ Change in staff at payer?

- ✓ Access to Documentation
- ✓ **Timing of Inpatient Order**
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality
- ✓ Communication / Process Issue

## Inpatient Order



Are orders written within 24 hours of discharge?



Does the admission status in your system match the physician order?



Conversions from OBS to IP



- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ **Physician Rationale**
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality
- ✓ Communication / Process Issue

## Physician Rationale

- ▶ Was physician rationale for inpatient admit clearly documented?
- ▶ Documented in the MR or UM section of the EMR?
- ▶ Copy & Paste of physician progress notes – area of opportunity

- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ **Peer-to-Peer Review**
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality
- ✓ Communication / Process Issue

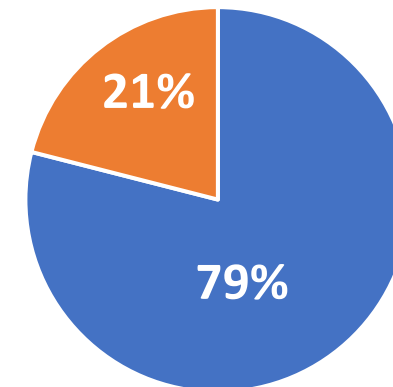
## Peer-to-Peer Review



Was P2P Completed? If not, what is the reason?





What to include in the P2P discussions



■ No ■ Yes

- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ **Clinical Guidelines Utilized**
- ✓ Documentation Quality
- ✓ Communication / Process Issue

## **Clinical Guidelines Utilized**

-  InterQual
-  Milliman Care Guidelines (MCG)
- Payer vs. Hospital guidelines used.
- Is the criteria used correct?
  - By the hospital UM team?
  - By the payer?
- Is the physician reviewer qualified to conduct the review?
- Patients admitted with multiple conditions .

- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ **Documentation Quality**
- ✓ Communication / Process Issue



If it's not documented,  
it didn't happen.

**Medical Necessity Documentation:**

- Severity of Illness
- Intensity of Service
- Risk Stratification
- Comorbidities
- Physician Judgement

**Verbiage – choice of words**

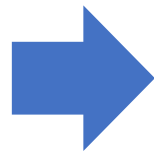
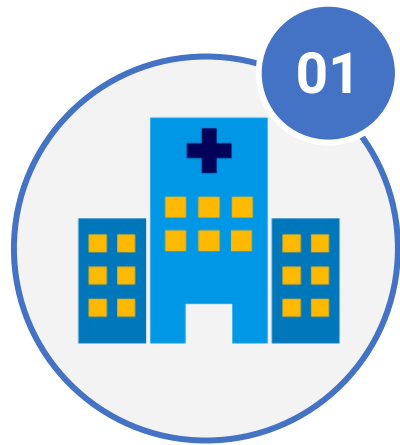


- ✓ Access to Documentation
- ✓ Timing of Inpatient Order
- ✓ Physician Rationale
- ✓ Peer-to-Peer Review
- ✓ Clinical Guidelines Utilized
- ✓ Documentation Quality

✓ **Communication / Process Issue**

## Communication/Process Issue

- ▶ Was UM notified when there was a change in payer?
- ▶ Did payer provide a determination timely?
- ▶ Accuracy of admission status based on physician order?
  - Physician agreed with observation level of care, but claim was billed inpatient
- ▶ Secondary physician review



### Hospital Opportunities

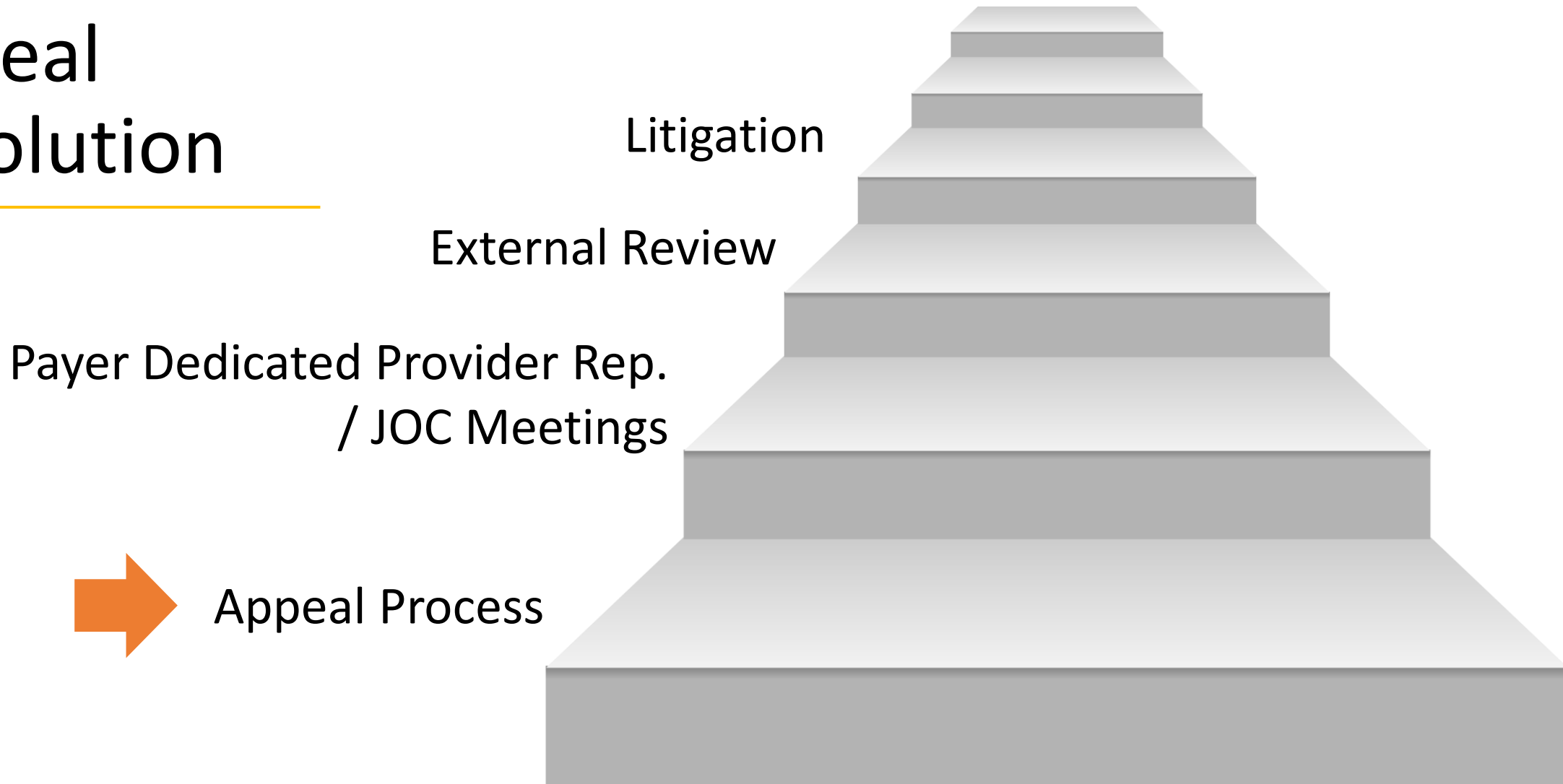
- No P2P conducted
- Physician rationale not clear
- Process/communication issue

### Payer Opportunities

- EMR not accessed
- Wrong criteria utilized
- P2P issue

# Appeal Resolution

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# Denial Escalation

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Payer Dedicated Provider Rep.  
/ JOC Meetings

Appeal Process

External Review

Litigation





# Sample Contract Language: JOC Meetings

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The JOC will meet quarterly, and will discuss, ... matters pertinent to the business relationship between the parties:

Quality, UM, Discharge Planning, and unresolved claims/denials issues

Either party may bring any other issue, including clinical review and/or clinical denial issues, to the JOC for resolution

Among other things, the JOC will address issues pertaining to ... unresolved denials, ...

The JOC will meet quarterly and will discuss matters pertinent to the business relationship between the parties.

# Team Education: JOC Meetings

## Information Sharing + Process Improvement Actions



### IDENTIFY

Identify accounts in which IP order written within 24 hours of discharge to further review



### CAPTURE

Capture accounts in which UM review was not completed



### EDUCATE

Conduct UM nurse education & additional training on criteria selection



### DOCUMENT

Provide physician education on documentation opportunities

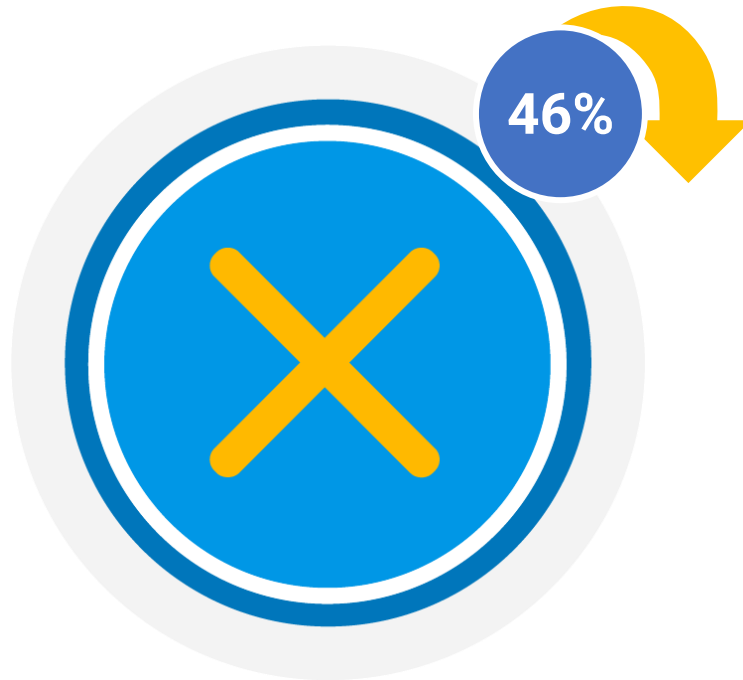


### FEEDBACK

Share feedback with payer when incorrect criteria was used to deny the claim

# Results:

## Objective Level-of-Care Decision Making



**46% ≈**

reduction  
in level of care denials  
over the past  
11 months



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# Questions & Answers



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# Thank you

**Stacy Gearhart, JD, LLM**

Operations Executive,  
Enterprise Transformation Office  
[stacy.gearhart@aspirion.com](mailto:stacy.gearhart@aspirion.com)

**Laurie Beck, RN, BSN, CCM**

SVP, Clinical Operations  
[laurie.beck@aspirion.com](mailto:laurie.beck@aspirion.com)