Report on
MEDICARE COMPLIANCE
Volume 22, Number 15 • April 29, 2013

Denials Mount in Private-Pay Audits, but Medicare Business Consumes Hospitals

Swamped with Medicare audits, some hospitals are short-changing claim denials by private payers, compliance experts say. Self-denials are also a problem, with hospitals not bothering to bill payers when they are convinced the claim isn't eligible for payment, which may or may not be the case.

Most hospitals are consumed by Medicare fee-for-service audits — fulfilling documentation requests from recovery audit contractors, Medicare administrative contractors and the HHS Office of Inspector General and appealing claim denials, according to Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa., who spoke at the Health Care Compliance Association's annual Compliance Institute at National Harbor, Md., on April 22.

"Because of that diversion of resources, the focus and attention on the commercial side has fallen off dramatically," he said. Reducing commercial payers' claim denials for medical necessity isn't just a matter of expanding Medicare defense audit procedures. While Medicare compliance depends heavily on the quality and accuracy of documentation that's examined by auditors nine months to two years later (except in the case of prepayment reviews), commercial payers assess the medical necessity of a service or admission right off the bat, before or during a patient's treatment. To survive commercial audits, "it's more important to have resources available immediately," Wuebker said.

Hospitals also have to be on guard for arbitrary audit policies. One private payer implemented a policy that requires notes to be documented, reviewed and signed in the medical record on the date that services were performed, said Stephen Gillis, director of billing compliance for Massachusetts General Hospital and Massachusetts General Hospital Physicians Organization in Boston. "That's totally unreasonable," he said. In contrast, Medicare requires hospitals to defer to state law or get physician signatures and authentication "promptly," which gives them some leeway *(RMC 5/21/12, p. 1)*. Gillis complained to the auditors, but they wouldn't budge. "Eventually they agreed to give a written clarification, but if we had not pushed back, they would continue to deny claims" when physicians didn't sign notes on the date of service.

Another private payer adopted a policy saying that evaluation and management (E&M) claims would be denied if physicians wrote in the documentation that they spent the "majority of the time" with patients counseling and coordinating care instead of "greater than 50% of the visit." The definition of "majority" is greater than 50%, which is what the payer wanted, so the denials were inexplicable. "We pushed back on the audit team, but they did not give in," he says. Mass General's legal counsel and contracting department complained and eventually the private payer backed down. "The point is, if other physician groups and hospitals are not evaluating audit results and verifying the appropriateness of the outcome of audits, [payers] are just taking money back for no good reason," he said.

Another complication with private payers is that hospitals may go into self-fulfilling prophecy mode. Case managers, billers or coders decide a case isn't appropriate for whatever reason — either they anticipate it will be denied or decide it doesn't meet their understanding of payer guidelines — and they "self-deny" the claim, Wuebker said. That means discounting the claim before submitting it to the payer or just skipping it altogether, even when the payment is justified, he said. "By aggressively denying cases over time, commercial payers have trained hospitals to self-deny cases that meet medical necessity criteria," he contends. This typically manifests itself when cases fail the first level of admission screening (e.g., InterQual) even though they may qualify for admission after a second-level review by a physician, or with observation patients who may qualify for inpatient care, Wuebker said. Sometimes hospitals, which are often paid *per diems* by private payers, pre-emptively carve out a couple of days at the end of the stay. Or maybe a case manager decides a patient's stay in the ICU should be downgraded to regular acute care.

Diagnose Self-Denials Through Symptoms

There's no way to quantify self-denials, but compliance officers may be able to diagnose them through the symptoms, he said. One symptom of self-denials is hospitals contending they have "a great relationship with the payer" because they win 90% of the cases they appeal. "It is a fairly rare phenomenon for a facility to win 90% of

the time," Wuebker said. It probably means the hospitals are not appealing as often as they should.

Another symptom of self-denials is high rates of observation billing. Hospitals should investigate whether theirs have increased. "It could also mean you have contract terms that are pushing it up," Wuebker said. When payers expedite payment for observation, reduce review of observation services and ease documentation requirements (e.g., not requiring a formal history and physical), that may push hospitals in the direction of observation use.

Here are Wuebker's tips for reducing self-denials in particular and commercial denials in general:

◆ ***Make sure the front-line staff (case managers, physician advisers) understands the source of denials.*** It makes sense to concentrate resources on areas where denials translate into lost dollars, Wuebker said. With private payers, sometimes there's no difference between the inpatient and observation payment or the beneficiary liability, so move on.

◆ ***Have a reference sheet for key players — nurses, physicians, case managers — that shows the differences among payers*** in documentation, admission time and contract terms. "Some of these differences can be referenced at a glance to make the process run more smoothly," he said.

◆ ***During concurrent reviews, have a hospital physician call the private payer's medical director to discuss the case.*** He recommends physician advisers — whether employed or contracted — because they understand the coverage and reimbursement nuances. Usually they don't treat patients. Beware of the recent trend of private payers adding provisions in contracts that don't allow peer-to-peer contacts with the payer medical director except for the attending physician at the hospital, Wuebker said. "That limits your appeal capability if you can't talk to a physician adviser."

◆ ***Appeal more cases if they have merit.*** Private payers are less likely to deny legitimate cases if they know you will fight back.

◆ ***Increase the transfer of information to cut down on denials.*** The No. 1 reason that claims are denied or payment is reduced is a lack of information, Wuebker said. The emergency room physician, attending physician or physician adviser should relay more clinical or continuing-stay information to the medical director at the private payer. The chart may not tell the whole story and if a utilization manager does a limited review of the medical records and sends it to the payer, the claim may be denied. Even attending physicians may not be attuned to what payers want to hear before approving admissions or continued stays, Wuebker said, because they are focused on patient care and not on hospital reimbursement.

Contact Wuebker at rwuebker@ehrdocs.com. ✧