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REVENUE CYCLE RESOURCES

Session Check In!

Denials: Beating Payors At Their Own Game

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CAH Conference2025

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Check In for this Session

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Current Denial Landscape

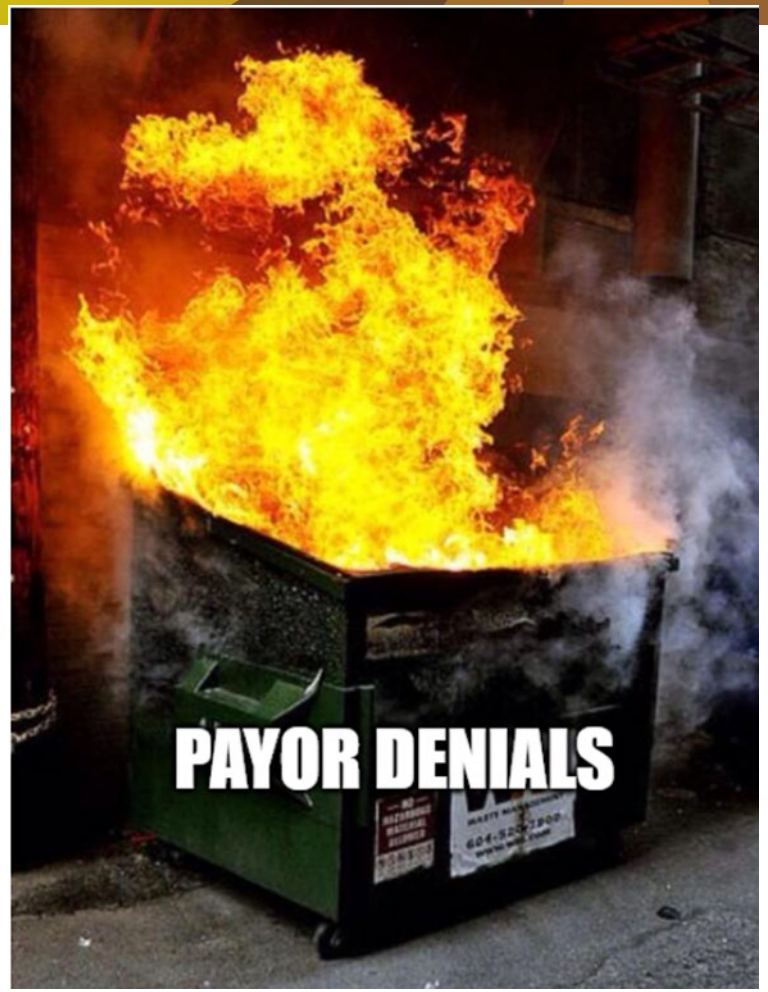
Denial Statistics

Hospitals Spend $19.7 Billion Annually Fighting Denials

- Average cost of $43.84 per claim

17% of In-Network Claims Initially Denied

- Denials rates range from 2% to 49% depending on payor
- One health system recently reported their UHC denial rate was 56%



Resource: KFF: Marketplace Plans in 2021 2% to 49% depending on payor, Premier National Survey

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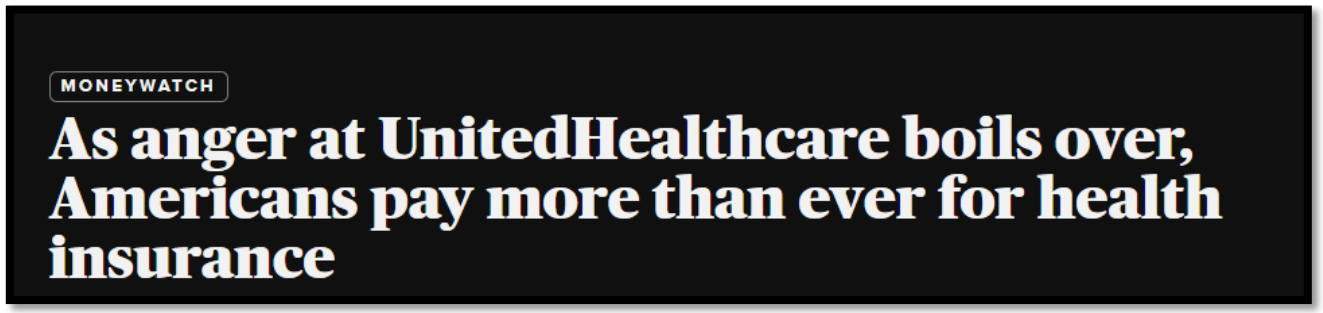
Denials In The News


CNN Health Life, But Better Fitness Food Sleep Mindfulness Relationships Watch

‘Not medically necessary’: Inside the company helping America’s biggest health insurers deny coverage for care


UnitedHealthcare Has Faced Scrutiny Over Denying Claims

The company has been accused of using algorithms to deny treatments and refusing coverage of nursing care to stroke patients.


MONEYWATCH

As anger at UnitedHealthcare boils over, Americans pay more than ever for health insurance


Doctor says health insurance companies play games to deny legitimate claims

20 percent of claims are denied nationwide


News

Cigna uses algorithm that auto-denied 300,000 claims, alleged in lawsuit

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Focus of Scrutiny

Payor AI Utilization

- UHC, Humana, and Cigna are facing class-action lawsuits alleging reliance upon algorithms to deny care
  - UHC AI program, *nH Predict*, superseded physician judgement, resulting in a 90% error rate, meaning 9 of 10 appealed denials were ultimately reversed
  - Cigna algorithm, *PXDX*, denied more than **300,000** claims in a two-month period, which amounts to about **1.2 seconds** for each physician-reviewed claim

Sources: Cigna Sued Over Algorithm Allegedly Used to Deny Claims, Class Action Lawsuit Against United Health's AI Claim Denials Advances, 'Not medically necessary': Inside the company helping America's biggest health insurers deny coverage for care

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Focus of Scrutiny

Pay to Play!

Third-Party Companies Incentivized to Deny Claims

- Evicore
  - Promises a 3 to 1 return on investment- for every $1 spent, the payor pays out $3 less
  - Boasts a 15% increase in denials
  - “Turning the Dial”- Algorithm reviews a request and gives it a score. If EviCore wants more denials, it turns the dial. “That’s the game we play”

- Cotiviti, Conduent, Optum, Carelon
  - “AI-driven payment integrity solutions”
  - Scare tactics: **“**More than half (51%) of emergency department (ED) visits are coded inaccurately.”

Sources: Cigna Sued Over Algorithm Allegedly Used to Deny Claims, Class Action Lawsuit Against United Health’s AI Claim Denials Advances, ‘Not medically necessary’: Inside the company helping America’s biggest health insurers deny coverage for care

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Political Intervention-Federal

- **CMS Interoperability and Prior Authorization Final Rule**
  - Implementation of *Application Performing Interfaces* (APIs) to streamline the exchange of information
  - Prior authorization process improvements
  - Impacted Payors: MA, Medicaid, and Marketplace Plans
  - Timeframe: January 2027, some provisions in 2026

- **2024 Medicare Advantage Final Rule (CMS-4201-F)**
  - NCD/LCD alignment
  - Two Midnight Rule adherence
  - Medical necessity determinations made by a physician with appropriate expertise
  - Prior authorized services cannot be later reviewed for level of care
  - Site of service restrictions

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Political Intervention-State

Nebraska LB 77, *Ensuring Transparency in Prior Authorization Act:*

- Adverse determinations to be made by a physician with appropriate expertise
- Prohibits use of AI as the sole basis for denying healthcare services
- Prevents compensation of review entities based on denial volumes
- Annual reporting of prior authorization statistics
- Prior authorizations valid for one year
- Prior authorizations for chronic conditions valid for length of treatment
- Exemption of prior authorization for certain healthcare services, such as emergency services, cancer care consistent with certain guidelines, and preventive services

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What It Seems Like…

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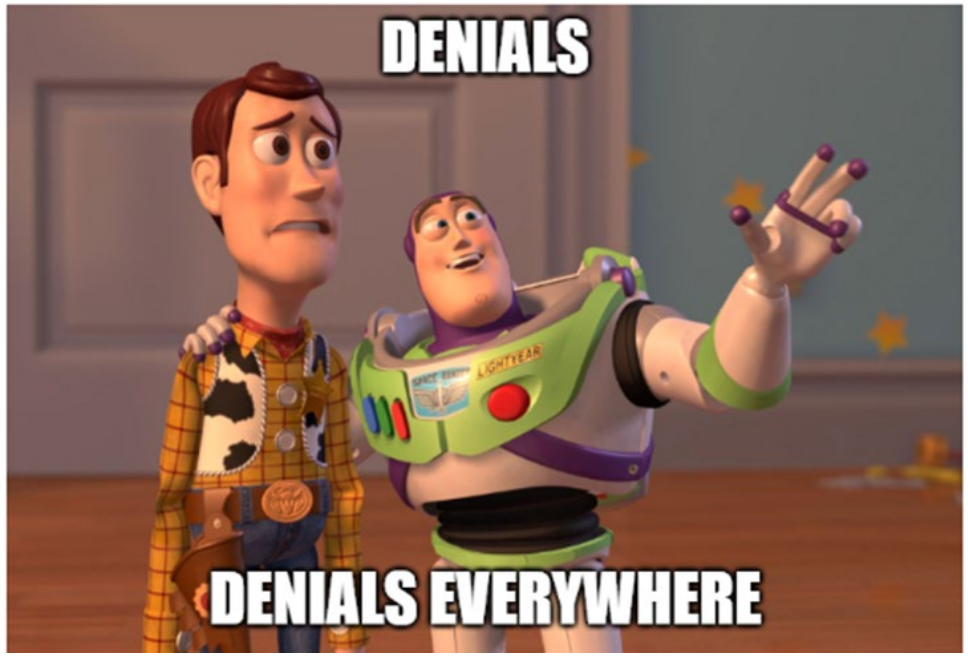
Let’s Play!

Payor Move-Deny More!

- **Denial Trends:**
  - Level of Care
  - Prior Authorization
  - Medically Necessity/Experimental
  - Bundled Items
  - NDC
  - Non-Descriptive Denials- CO-16
  - Coordination of Benefits

Includes Hidden Denials!

  - Adjustment in Full-CO-45 and CO-97
  - Contract Load Incorrect



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Our Move- Denial Identification

Initial Denials

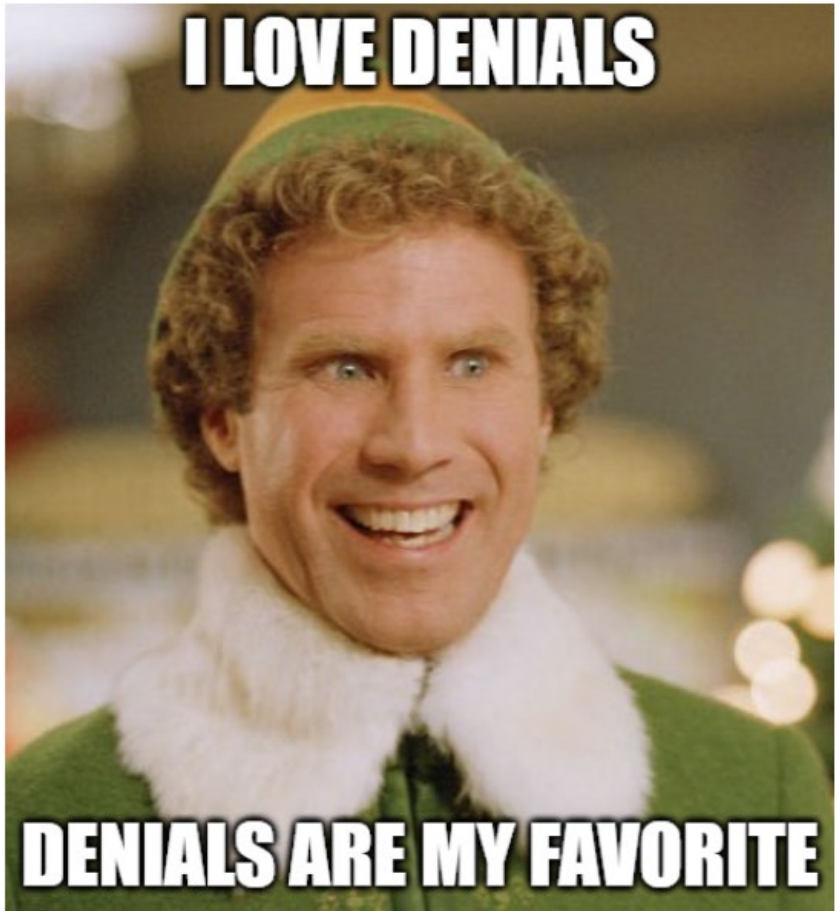
- Denial Reports to Identify Trends
- Biller Identification-Verify With Reporting

Final Denials

- Detailed Adjustment Categories
- Trend Out Each Month

Hidden Denials

- Reimbursement Audits



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Our Move-Denial Prevention

- **Act Quickly!**
  - Once trend is identified utilize reports to verify
  - Update processes and procedures
- **Facility-Wide Involvement**
  - Revenue Cycle Steering Committee
  - Clinical Education
- **Payor Scorecards (Vitality)**
  - Denial Validation and Measurements
- **Predictive Analytics-AI**
  - Data analytics to identify and understand patterns in denial trends
  - Identification of high-risk claims, prior to submission, based on payor denials

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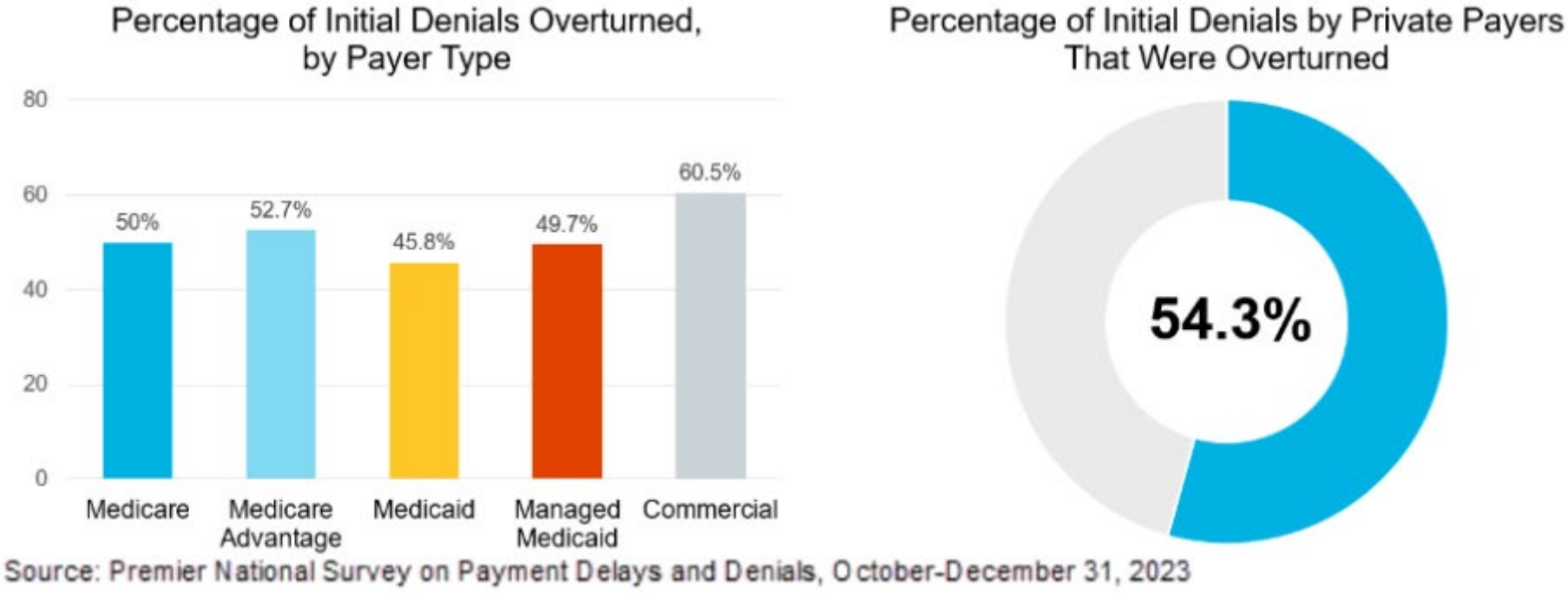
Our Move-Fight The Fight



Source: Premier National Survey

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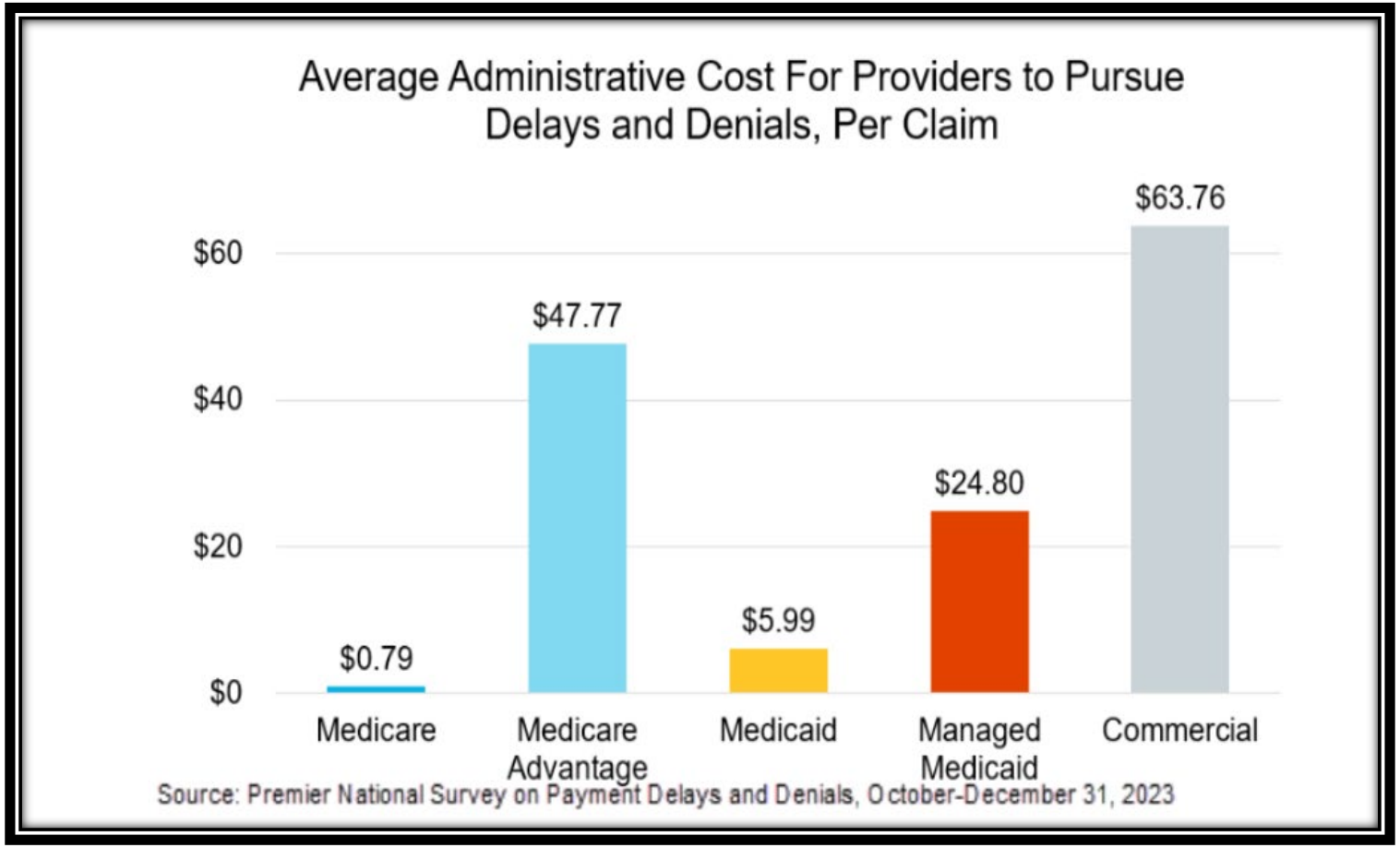
Take Into Consideration

Consider a Denial Threshold, BUT Monitor Trends

- Create Specific Adjustment Aliases
- Monthly Reporting and Analysis



Source: Premier National Survey

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Tactical Moves!

Contract Utilization

Payor Move

- More Restrictive Language & Enforcement of Provisions

Our Move

- Contract Education
  - Frontline Staff Access and Education
  - Payor Contract Matrix Development & Utilization
- Know When to Fight
  - Timely Filing- Initial Claims Submission vs. Corrected Claim
  - Absent Contract Language & No Reimbursement Policy
- Know When Not to Fight
  - UHC 96 hour Language
  - Medica Revenue Code 760
  - Wellcare/Ambetter- Facility Fees (510 & 762 Revenue Code)

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Contract Utilization

- **Our Move**
  - Contract Negotiation- Specific Language
    - Method II & CRNA Passthrough Denials- Amendments to Allow
    - Level of Care Denials- Language to Allow Rebilling of Observation, Regardless if Order is Inpatient
    - Facility Fee Denials- Language Specifying Allowable
    - Per Diem Underpayments- Removal of “Lessor Than Language”
  - Contract Load Validation
    - Reimbursement Audits are Key!
    - Must Be Timely- 12 Month Lookback Period

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Medical Policy Increase

Payor Move

- Decrease in Prior Authorizations BUT Increase in Medical Policies

Our Move

- Increase Pre-Service Work
  - Financial Clearance
  - Review Medical Policies ➡ Incorporate Clinical Review ➡Tip Sheets
- Labs
  - Review payor policies for commonly denied labs
  - Implement an Internal Procedure
    - Based on payor policies that represent the facility's payor mix
    - Neutral policy that takes an "average" of the payor policies
    - Easy for clinical staff to follow
  - Monitor All Final Denials & Tweak Policy As Necessary Based on Volume/Dollar

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Level of Care

- **Payor Move- Level of Care Denials**
  - Inpatient- Leave You Hanging…IP Denied!
  - ER/Office Visits- Downcode E/M-No Denial-Decreased Payment
- **Our Move**
  - Inpatient
    - TRICK MOVE- Know when to fight and when to maneuver
      - Will Reimbursement Change?
    - “Rebill as Observation” Written Allowance
  - ER/Office Visits
    - ER-Separately bill procedures
    - Timely monitoring through reporting

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Pre & Post Payment Reviews

- **Payor Move**
  - Pre and Post-Payment Reviews
- **Our Move**
  - ROI Processes and Education
    - MARs-Tricky Area!
    - Outside Records
    - Secondary coder or clinical review for records on high dollar claims
  - Bundling Supplies
    - Reduces risk of recoupment upon post payment reviews

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Regulation Utilization

Payor Move

- Dance in the Shadows of Regulations

Our Move

Hold Payors Accountable!

- 2024 Medicare Advantage Final Rule (CMS-4201-F)
  - Two Midnight Rule Adherence
  - NDC/LCD Alignment
  - Determinations Made by a Physician with Appropriate Expertise
  - Site of Service Restriction
  - Unable to Later Deny Stay that was Prior Authorized

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Regulation Utilization

- **CMS Regulations & Guidance**
  - No Suprises Act
  - Marketplace Plans
  - Affordable Care Act
- **Nebraska Revised Statute 48-125.02**
  - Requires Workers Compensation Carriers to Pay Within 30 Days
    - Failure to Pay Timely Results in Requirement to Reimburse 100% of Billed Charges
- **Nebraska Healthcare Prompt Payment Act**
  - Health Insurers must pay clean claims within 30 days
    - Failure to Pay Timely Results in 12% interest rate

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Effective Appeals

Payor Move

- Automatic Denial of Appeal

Our Move

Effective Appeals!

- Written by Expert in that Area
- Concise
- References Specific Points in Record
- Provides Other Relevant Information
  - Payor Medical & Reimbursement Policies
  - CMS Publications
- Utilize AI as a Starting Point

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Appeal

AI Debridement Appeal

I am writing to formally request reconsideration of a denied claim for wound care debridement services rendered to **[Patient Name]**, Member ID **[ID Number]**, on **[Date of Service]**. The denial was issued on the grounds of **medical necessity**, but upon review of the clinical documentation and applicable coverage guidelines, it is evident that the service meets **all criteria outlined in WPS Local Coverage Determination (LCD) L37228: "Wound Care"**.

Key Points Supporting Coverage:

1. **Compliance with LCD L37228**
   The debridement performed was medically necessary and supported by clinical findings that align with the indications listed in WPS LCD L37228. Specifically, the patient presented with **[brief description of the wound, e.g., stage 3 pressure ulcer with devitalized tissue, presence of infection, drainage, etc.]**, which clearly meets the criteria for debridement under this LCD.

Documentation includes:

- Wound measurements
- Presence of necrotic/devitalized tissue
- Clinical justification for debridement
- Evidence of ongoing treatment plan

2. **Requirement for MA Plans to Follow Medicare Coverage Policies – CMS 4201-F**
   As outlined in **CMS Final Rule 4201-F**, effective January 1, 2024, Medicare Advantage (MA) organizations are required to adhere to the same coverage criteria as Traditional Medicare, including applicable **Local Coverage Determinations (LCDs)** and **National Coverage Determinations (NCDs)**. WPS LCD L37228 is the governing policy for wound care services in this jurisdiction and must be applied to all Medicare Advantage beneficiaries.

Therefore, under CMS 4201-F, MA plans **must cover** services that meet the criteria in this LCD. Denial based on "medical necessity" contradicts both CMS regulations and the clinical evidence submitted.

Escalation Avenues

Payor Move- Final Denial!

Our Move- It's Not Over Yet!

Escalation Avenues:

- Medicare Advantage-Review by Part C Independent Review Entity (IRE) (Non-Contracted)
- Medicare Advantage- CMS Regional Office- CMS ROkcmORA ROkcmORA@cms.hhs.gov
- Medicaid – Department of Health and Human Services
- Fully Insured Plans- Nebraska Department of Insurance
- Policies Purchased in Another State - Map to States & Jurisdictions
- Federal Employee Health Benefits Program –Healthcare & Insurance, Office of Personnel Management
- Workers' Compensation – Nebraska Workers' Compensation Court
- Self-funded Benefit Plans – Employee Benefits Security Administration, US Department of Labor
- Tricare: Tricare File a Complaint

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