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How silent denials erode hospital margins virtually undetected

Hospitals have worked hard over the past few years to refine operations and counter commercial denials. However, commercial payers have also adjusted, issuing more denials for clinical reasons than ever before. These denials, including medical necessity denials, are often associated with higher dollar values and are more challenging, since overturning them requires a clinical perspective.

When analyzing their denial challenge, many providers review the overall denial rate or denial overturn rate. But these metrics don't account for clinicians' conservatism regarding medical necessity decisions. They overlook a type of denial that occurs before the actual claim submission and affects revenue integrity – silent denials.

Defeated before even beginning?

Silent denials emerge from clinicians' conditioned behavior in the utilization review (UR) process and experience with denials. Case managers have many responsibilities, some of which directly affect quality measures and key hospital priorities, such as those focused on readmission. Understandably, they seek ways to optimize their operations.

Sometimes, case managers will withhold a case from physician advisor review based on their subjective opinion about whether a payer is likely to deny. When case managers review many cases for a specific payer, they learn that payer's habits. This knowledge may condition case managers to anticipate payer decisions. If they believe a payer won't accept a given inpatient case based on past behavior, case managers may leave it as outpatient. Such behavior is understandable – but dangerous. "Every case is different, though they may look similar," explains James Lloyd, an Optum physician advisor.* "The nuances of a case can have huge effects on patient status, and these are easy to overlook, even for physicians."

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* "James Lloyd" is a pseudonym of a physician advisor with a client in the Midwest.

In other instances, they will simply accept the results of first-level criteria when a physician advisor isn't available to review further. Though case managers are only trying to operate efficiently, they inadvertently miss out on inpatient reimbursement on that case. Denial reports view these claims as appropriately paid outpatient cases when they actually represent a reimbursement reduction.

Physicians can also cause silent denials. Effective UR requires the cooperation of treating physicians since only they can amend clinical documentation to justify an outpatient or inpatient order. But many physicians have little interest in the administrative functions related to hospital reimbursement. "As an attending, I didn't care about UR," says Lloyd. "It's not that I didn't want the hospital to be paid; I just didn't have the time." Some silent denials occur because treating physicians don't follow a physician advisor's recommendation or fail to recognize the importance of patient status. "At my hospital, 1–2% care about UR, 20–30% are completely uninterested, and the rest don't view UR as a priority when they're trying to keep people alive," Lloyd adds.

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Even when they are engaged with UR, attending physicians are sometimes reluctant to change a case to inpatient despite the appropriateness. Doing so could lead to a confrontation with payer medical directors at the peer-to-peer stage in the case of a concurrent denial. Few organizations provide training to help guide treating physicians through these peer-to-peer discussions, and the prospect of enduring this ordeal can make some physicians uncomfortable.

"The concurrent review process is frustrating," explains Lloyd. "Payers would call when I'm eating lunch and ask these detailed questions I'd need the case to answer. Sometimes, they'd start by asking for my NPI number. I'd give up. Nobody wants to deal with that." Even if they do feel comfortable, negotiating with payer medical directors diverts time from patient care. Unsurprisingly, some physicians will leave a case as outpatient to avoid the hassle and distraction.

Effectively, each of these causes represents a failure of UR that reduces reimbursement just like a denial but without ever alerting hospitals about the problem.

Identifying and fixing the silent denial problem

Digging deeper into your UR analytics can reveal combinations of metrics that suggest a problem with silent denials. Organizations may notice higher observation rates, risk of mortality rates and average cost of care. They may also experience an artificially higher case mix index (CMI) when compared to their peer organizations. "Gray-area" cases tend to be of a lower acuity than clear-cut inpatient cases. When cases that should be inpatient remain as outpatient, it inflates acuity for CMI and severity-of-illness calculations.

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A low denial rate and a high appeal success rate may seem encouraging, but when combined with the above metrics, they could signify problems. A low medical necessity denial rate with a high observation rate might suggest

that insurers are only seeing clear-cut inpatient cases and that providers are misidentifying the less-complex inpatient cases as outpatient. A high appeal success rate could indicate that only strong inpatient cases – the easiest to appeal – are reaching payers in the first place.

Fixing a silent denial problem requires hospitals to put each case through the same process and review them against the same standard, without exception. Often, providers may focus their utilization review on individual conditions or specific payers (for instance, Medicare patients, or those for a particularly challenging payer). Limiting UR in this fashion can allow hospitals who face resource constraints to focus on the greatest opportunities. However, by allowing cases to slip through unreviewed, hospitals are essentially accepting inaccurate payments and harming their revenue integrity. Providers cannot allow shortcuts.

However, manually reviewing every case requires more resources than many hospitals can afford. Fortunately, technology can streamline the process and solve this challenge. Artificial intelligence (AI) can automate initial case review and sorting to help determine which cases require a physician advisor review. AI requires seconds to do what would take hours under traditional UR paradigms, so case managers can devote their time to actions that provide greater value.

Likewise, AI can contribute to physician advisor efficiency. Natural language processing can scour medical records for relevant medical facts and pair them with supporting medical research and the results of prior case reviews, all before physician advisors open a case. This kind of technology allows physician advisors to spend their time reviewing relevant information rather than searching voluminous medical records for the important details. They can quickly construct their determinations on facts and research, not subjective opinion, which will help to reduce denials and protect a hospital's revenue more efficiently.

Achieving this value depends upon hospitals asking the right questions at the outset of the process, however. Not all AI approaches provide equal value. Many health systems have found that, for AI to contribute meaningfully to utilization review, they prefer to start with a foundation built from clinical intelligence. Current best practice involves drawing in sources of knowledge and data – such as medical research, prior case reviews, regulations and best practices – beyond the limited value of first-level review criteria sets.

Recently, health systems have also started to seek new levels of flexibility and accessibility from AI. One revenue cycle executive noted that even the most comprehensive repository of guidance wouldn't provide much value to his physician advisors if it required them to perform lengthy searches each time they want to consult it. Instead of creating additional to workflows, AI can now bridge the gap between raw research and the specifics of an individual case to serve up this data for physician advisors. Expectations are changing such that any technological tool or solution should clearly and concretely accelerate and improve the UR process.

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Finally, for all the sophisticated approaches available, don't overlook the basics. Payers will still question your medical necessity determinations, so your UR process must clearly record the reasons justifying inpatient status to support your peer-to-peer and retrospective appeals.

Digging beneath the surface

Silent denials look remarkably similar to appropriately paid outpatient cases. Reviewing denial and overturn rates on their own isn't sufficient to understand the health of your revenue integrity and UR process. Diagnosing and correcting a silent denial problem requires digging into other quality metrics, including CMI, observation rate and mortality rate. Don't be afraid to take advantage of AI to accelerate and enhance the skilled work of your case managers and physician advisors.

In these challenging times, hospitals must take advantage of every tool that supports their operations. Those hospitals who undertake the effort of uncovering and correcting a silent denial problem will improve revenue integrity and medical necessity compliance.

About the author:

Kurt Hopfensperger, MD, JD, is regional vice president for provider relations and education for Optum Physician Advisor Solutions. He is a diplomate of the National Board of Medical Examiners and a member of the Health Law Section of the American Bar Association.

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