

Insights Report



DENIALS ARE INCREASING — HOW STRONG PHYSICIAN LEADERS ARE MAKING A DIFFERENCE

Physician advisors share top challenges and new opportunities in denials management at the ACDIS Physician Advisor Exchange

Discussion

Denials Are Increasing — How Strong Physician Leaders Are Making a Difference

Physician advisors share top challenges and new opportunities in denials management at the ACDIS Physician Advisor Exchange

While providers feel some relief as COVID-19 cases wind down, they aren't getting a break regarding denials. Denials have come back with a vengeance due to payers pushing for greater post-pandemic cost containment. As facilities marshal resources to address the denial hot spots, physician advisors are proving to be powerful allies in helping develop a strategic framework and best practices to prevent denials.

At the August 2022 ACDIS Physician Advisor Exchange, physician advisors explored new denial patterns, emerging challenges, and opportunities for improvement during three discussion panels on Denials Management and Quality, led by Rebecca Hendren, ACDIS director of programming. Physician advisors identified six top areas of concern:

- **Higher-than-usual denial volumes and denial batching**
- **Confusing, arbitrary payer rules and criteria**
- **Egregious auditor behavior**
- **Shortage of qualified appeals writers**
- **Health plan megamergers that wield more power**
- **Lack of political will to change payer behavior**

The panel also weighed in on physician advisors' evolving roles, looking at how they allocate time for various denials management efforts, including attending Administrative Law Judge (ALJ) hearings and addressing documentation, contracting, and peer-to-peer responsibilities. Below is a summary of these discussions.

PHYSICIAN ADVISORS: KEY FOCUS AREAS

Physician advisors have many responsibilities, including UM/UR review, peer-to-peer meetings with payer medical directors, CDI oversight, and participation in ALJ hearings. Medical necessity reviews, denial appeals, and payer contracting comprise a significant portion of their responsibilities, with some panelists indicating that their organizations employ several FTE physician advisors.

Physician advisors spend considerable time reviewing and supporting appeals writing, especially for high-impact areas such as clinical validation and medical necessity or high-dollar denials. However, they acknowledge the frustration of having to pick and choose which cases to work on due to the

high volume of denials they are experiencing. When delegating time for denials, "we are doing what seems to be the most impactful," says Purvi K. Shah, MD, medical director of population health at NorthShore University Health System in Evanston, Illinois, noting that the organization currently has two FTE physician advisors for just UM peer-to-peer meetings; that number will soon expand to five FTEs, she adds.

Most panelists delegate a portion of responsibilities related to first and second-level denials and the appeal letter writing process to other team members, including an internal nurse or an outside vendor. "I have 30 sepsis denials that have been sitting in the queue, so we're going to use an outside vendor to help," says Aaron "AJ" Hegg, MD, physician advisor of UM/CDI and critical care physician at Essentia Health in Duluth, Minnesota. He notes that he is also looking to implement a more streamlined process using appeals templates that other PAs can easily use at volume. "I author the templates for the first level of DRG denials, but don't do the letters," adds Howard Rodenberg, MD, MPH, CCDS, physician advisor of CDI at Baptist Health in Jacksonville, Florida. "Once something comes back to a second or third level, I personally write the letter."

THE PARTICIPANTS

Muhammad Al Mounayer

Physician Advisor
Atrium Health

Kory Anderson

Medical Director of Physician Advisor
Services & CDI
Intermountain Healthcare

David Balt

Physician Advisor
Avera Health

Alvin Gore

Physician Advisor; Director of Utilization
Management
St. Joseph Health System

Aaron (AJ) Hegg

Medical Director of Sepsis, East Region;
System Physician Advisor—Clinical
Documentation Integrity
Essentia Health

Malek Adawi

CDI Physician Advisor-Director
Community Health Systems

Vaughn Matacale

Director, Clinical Documentation Advisor
Program
Vidant Health

John Pettine

Vice President, LVHN Clinical Documentation
Integrity Services
Lehigh Valley Health Network

Christina Rama

Chief of Hospital Medicine/Chief Physician
Advisor
Cone Health

Howard Rodenberg

Physician Advisor, Clinical Documentation
Integrity
Baptist Health Jacksonville

Jessie Roske

Internal Medicine Hospitalist; Physician
Section Director, Improvement, within
Performance Excellence and including
Clinical Documentation Integrity; Utilization
Review Physician Advisor
St. Cloud Hospital-CentraCare

ALJs are also a critical area of responsibility for panelists. For instance, Alvin Gore, MD, medical director of UM and CDI at Providence in Sonoma County, California, says he participates in ALJs, which in the past were primarily related to medical necessity denials involving Medicare patients. “However, as RAC activity has slowed down, CDI and coding denials are becoming more prevalent,” he says.

GROWING OBSTACLES

It’s no surprise that physician advisors say denials are their top challenge. “The volumes in 2022 have been a lot more than prior years,” says Deepa Velayadikot, MD, CHCQM-PHYADV, medical director of care coordination at Cooper University Hospital in Camden, New Jersey. She says it has been difficult to keep up with appeals due to the volume and payer requests for quicker turnaround times. “One of my biggest challenges right now is just bandwidth because we are getting hit from everywhere.”

The panelists are also frustrated over confusing and changing payer criteria and rules, including frequent changes to provider manuals behind the scenes. “There are many different games being played and [payers] have many different rules by which you need to play, which is very challenging,” says Kory Anderson, MD, CHCQM-PHYADV, FACP, medical director, physician

advisor services, CDI and quality at Intermountain Healthcare in Ogden, Utah. “It’s impossible for the frontline physicians to know how to do it and almost impossible for the physician advisors to know.” He continues that every payer operates with a different set of rules. For example, with commercial Medicare Advantage, “you don’t know what’s in the contract, and they don’t know what’s in it. You’re trying to put out a five-alarm building fire, one bucket of water at a time. You’re not fixing the overall problem of the system.”

Jessie Roske, MD, physician section director of improvement at CentraCare, St. Cloud, Minnesota, says the first stage of a denial “is often based upon application of seemingly clinically irrelevant, arbitrary criteria” by someone who has never seen the patient and can supersede the impression of the provider who saw the patient. Superseding is a fundamental challenge, and they will pick and choose the criteria that work in their favor.” Additionally, Roske and other panelists agree that auditors are a significant problem. “Denials are often run by their auditors instead of by payers themselves. So, you are dealing with a third party who isn’t necessarily accountable and clearly has a conflict of interest for what they are trying to gain by getting the denial through,” she says.

Roske also notes that payers are increasingly sending large batches

“There are many different games being played and [payers] have many different rules by which you need to play, which is very challenging,”

KORY ANDERSON, MEDICAL DIRECTOR OF PHYSICIAN ADVISOR SERVICES & CDI, INTERMOUNTAIN HEALTHCARE

Amy Sanderson

Physician Advisor, CDI Program
Boston Children's Hospital

Jack Sublett, II

Systemwide Physician Advisor
Baptist Health (Arkansas)

Deepa Velayadikot

Medical Director of Care Coordination;
Medical Director, Hospital Medicine
Cooper University Hospital

Purvi Shah

Medical Director, Population Health—
Complexity Capture and Post-Acute Care
NorthShore University Health System

Cohen Angelique

Director, Clinical Transformation
Ascension Saint Thomas

Jonnalagadda Nageshwar

Physician Advisor
Baystate Health

Arkansas, also says batching has been problematic. “They’re hitting us every step of the way and inundating us with volume because they assume we don’t have the administrative capability to keep up with the large volume of denials. They’re downgrading our DRGs; they’re trying to take away sepsis or whatever the diagnosis in question is.” Now, even patients with acute strokes, with a previously independent level of function are getting denied for inpatient rehab, he points out. “10 years ago, that was unheard of. I’m all for cost-efficient healthcare, but why are you denying that patient the right to get back some functionality?” At issue is also the fact that payers increasingly are wielding more power, he adds. “It’s really tough for a lot of health systems to fight back.”

Shah says, “We had fairly good relationships with many of our payers pre-COVID, but since the pandemic, there was a realization of needing to contain costs on all levels.” It also feels like payers will deny the claim no matter what is in the appeal, she adds. “We put in all this effort using experts and data resources to write the appeals, and we get the same decision back—clearly, it shows that the decision was already made.” Other panelists also expressed frustration with the lack of qualified staff who can write the different types of appeals, especially clinical validation appeals. “A clinical validation appeal

has to be good, otherwise don’t bother because it will just fall flat,” says Gore.

FREQUENT FLYERS: A REVOLVING DOOR OF DIAGNOSIS DENIALS

Physician advisors say that payers continue to deny the same diagnoses, including the following:

- Sepsis
- Respiratory failure
- Severe malnutrition
- Encephalopathy
- Acute kidney injury
- Stroke
- Hyponatremia
- Acidosis

Stroke is very common, says Roske. “They will argue over stroke if you get a patient who can’t have an MRI, even though they still have symptoms beyond 24 hours, or the stroke center physician has said it’s a stroke.” Others say they are seeing more instances of payers dropping the principal diagnosis in favor of the secondary diagnosis, which is a lower-paying DRG. Overall, they agree that when they push back and appeal, payers will send a copy of the same denial letter. Even more frustrating is that it can require two to three appeals before they are approved for a peer-to-peer meeting with a plan medical director. For instance, clinical validation DRG downgrades are less apt to lead to a peer-to-peer. “This is because it is a downgrade rather than a straight-up denial, which is a failure of contracting,” says Roske.

of denials. “We have had 300 split-bill professional fee denials come at once. On another occasion, there were 50 sepsis clinical validation DRG downgrade denials at once. Our backlog got so large we ended up having to cut off 46 cases below \$2000 because we just didn’t have time to assess them because of the time involved,” she says, adding, “after all, evaluating a \$200 appeal is the same time investment as a \$200,000 appeal.”

Jack Sublett II, MD, FAAFP, CHCQM-PHYADV, CCDS, physician advisor at Baptist Health in Little Rock,

“We put in all this effort using experts and data resources to write the appeals, and we get the same decision back—clearly, it shows that the decision was already made.”

PURVI SHAH, MEDICAL DIRECTOR, POPULATION HEALTH—COMPLEXITY CAPTURE AND POST-ACUTE CARE, NORTHSORE UNIVERSITY HEALTH SYSTEM

Physician advisors agree that having systemwide definitions for clinical criteria are helpful in fighting denials, but most are at various stages of starting this process or are still considering it. “We have a living library,” says Sublett. “It’s helpful to have something in black and white that level sets the entire system.” Anderson agrees, adding that having a sepsis definition in the organization’s policy library has led to positive outcomes from ALJ hearings. “We had two [cases] go to the ALJ, and having a sepsis definition and a care process model for how the physicians go about these cases was very helpful in the judge making a determination; we won both of those cases.”

SUCCESS STRATEGIES FOR PREVENTING AND APPEALING DENIALS

Like their colleagues across the industry, the physician advisor panel notes that they deploy a variety of strategies and tactics (and even some that are unconventional) to prevent and appeal denials in an era in which denial and appeal decisions appear to be more arbitrary and at the whim of a single person rather than based on clearly defined payer rules and criteria. They agree that peer-to-peer reviews are critical and can lead to successful outcomes when handled tactically. Getting to know the payer medical directors in your region is an essential first step. Developing a respectful relationship over time can pave the way for payers to see the legitimacy of your appeals.

Still, it also takes sheer perseverance to get in front of the right person who will objectively look at the appeal, says Gore. “I had

“I don’t know our denial diagnosis patterns, denial frequency, or the overturning rate. So, my frustration grows deeper. How am I supposed to address it and prevent denials if I don’t have access to granular data?”

VAUGHN MATACALE, DIRECTOR, CLINICAL DOCUMENTATION ADVISOR PROGRAM, VIDANT HEALTH

a medical director from one of the bigger payers who was denying 98% of my peer-to-peers without even giving me a chance to argue, and I had to complain my way up to their [regional] medical director to get a different person to talk to.” Malek Adawi, MD, CCDS, CDIP, CCS, CDI-physician advisor at Community Health System in Franklin, Tennessee, says his organization is equally persistent. Although it takes much effort to appeal a denial, it’s important to follow through. “As a CDI director/PA, I get involved in clinical validation denials more than coding denials,” he says. “It’s important to keep fighting when applicable to get to the third appeal level and share what you are going through with your medical staff.”

Rodenberg adds, “I learned at one of my first ACDIS lectures on denials from Trey La Charité that you have to fight everything and make yourself a hard target. If you don’t keep fighting, they will assume you are a soft target, and they will come after you even more.”

Others point out that having a consistent theme during peer-to-peer discussions, such as focusing on auditor behavior, can turn cases in a positive direction. “Every case I bring is an egregious denial; I have had 100% overturns for everything I brought to them,” says Roske. On the other hand, Velayadikot says she waits until she is justifiably upset

before writing an appeal letter. “If I’m in a very good mood, I won’t write the appeal because you have to be a passionate patient advocate to write them. Those are the ones that get overturned.”

Data is another area that facilities will need to address more strategically in the future if they want to leapfrog progress to prevent and appeal denials. Payers often use powerful data analytics to drive every word in a contract, which gives them a significant advantage over providers. Lack of accurate, timely data is an issue when trying to prevent and overturn denials, says Vaughn Matacale, MD, CCDS, medical director, clinical documentation advisor group at ECU Health in Greenville, North Carolina. “I don’t know our denial diagnosis patterns, denial frequency, or the overturning rate. So, my frustration grows deeper. How am I supposed to address it and prevent denials if I don’t have access to granular data?”

To this point, John Pettine, MD, FACP, CPHQ, CCDS, vice president of CDI services at Lehigh Valley Health Network in Allentown, Pennsylvania, says his organization recently hired a data analytics expert to develop an analytics solution that provides payer insights. “The goal was to stop spinning our wheels and actually go into contracting discussions with

“We need professional organizations to help us figure out where we can take this in a broader sense because we cannot collaborate due to FTC rules,”

JESSIE ROSKE, INTERNAL MEDICINE HOSPITALIST; PHYSICIAN SECTION DIRECTOR, IMPROVEMENT, WITHIN PERFORMANCE EXCELLENCE AND INCLUDING CLINICAL DOCUMENTATION INTEGRITY; UTILIZATION REVIEW PHYSICIAN ADVISOR, ST. CLOUD HOSPITAL-CENTRACARE

data to hopefully change the payer denial pattern,” says Pettine. “We have a very strong, aggressive CFO, who supports this, and we were able to hire key people and build a database that tracks everything we want to know about every denial by payer.”

Keeping frontline physicians in the loop about denial rates is also key. “In part, it reinforces good behavior,” says Shah. “When you go back and say they are doing a great job, you build your local champions.” On the other hand, when a case gets denied, it presents a learning opportunity for the physician to review the reason for the denial, she

adds. “One of my areas of focus is educating physicians,” says Adawi. “For example, with sepsis being the number one [denial] this quarter, I might need to pay more attention and send more clinical validation queries.”

The panelists concurred that it all goes back to having a solid contract from the start, the right data when appealing, and a strong appeals writer. “Contracts are so important because if you don’t have that external appeal, then [the denial] just goes into their system,” says Velayadikot.

ADVOCATING FOR A BETTER FUTURE

Throughout the panel discussions, the same themes bubbled to the surface, including the need for additional payer reform, real-time metrics and information on denial trends, and more advocacy. “Having data has been a game changer for us,” says Pettine. “We all need to get to this level of detail at our organizations.” The panel also agrees that the perceived lack of political/legislative will in addressing provider concerns over payer contracts, auditor behavior, and confusing criteria is a growing issue that must be addressed. “We need professional organizations to help us figure out where we can take this in a broader sense because we cannot collaborate due to FTC rules,” says Roske. “Advocacy is important, otherwise behavior won’t change,” adds Gore.



REVENUE CYCLE WORKFORCE SOLUTIONS *REIMAGINED.*

TWO BRANDS, ONE *GOAL*.

Meleeco and GHR RevCycle have joined forces to improve Revenue Cycle key performance indicators impacting:

- ✓ Physician Advisors
- ✓ Denials Prevention
- ✓ Case Management
- ✓ Coding
- ✓ Clinical Documentation
- ✓ Utilization Management



DISCOVER

how our subject matter expertise and data driven approach to continual process improvement can help you achieve your clinical and financial goals.

CLICK HERE TO LEARN MORE



ghrrevcycle.com/solutions



(813) 513-3790



info@ghrrevcycle.com