aspirion

# PREVENTING CLINICAL DENIALS WHEN SUBJECTIVE DECISION-MAKING IS THE CAUSE

*White paper*

# SUBJECTIVE DECISION-MAKING

**Subjective decision-making is at the heart of clinical denials.**

Getting a handle on denials can be difficult for any healthcare organization, but clinical denials specifically pose special challenges.

With administrative (or technical) denials, communication and training are often straightforward—for example, if a claim is denied because benefits were not verified, team members can get refresher training on verifying benefits.

Clinical denials are more difficult to manage as deeper root cause analysis and collaboration between hospitals, physicians, and payers are needed.

After all, the clinical judgment behind those denials is subjective, and how do you find a root cause when it comes to subjective decision-making?

**The good news is that through deep analysis of medical necessity decision-making processes, healthcare organizations can gain insights to prevent denials from happening, and overturn them when they do.**

**Of all denial types, medical necessity is the denial you want. When the denial is based on medical necessity, the payer 'invites' you to change their mind," said Stacy Gearhart, co-president of clinical denials for Aspirion. "Review the explanation of benefits for a medical necessity denial and you will see that the claim adjustment reason codes utilized by the payer specifically use the word 'deemed' in denial reasons. 'Deem' is opinion. There is room for interpretation.**

## Figure 1: Example medical necessity CARCs

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

*Source: Aspirion*

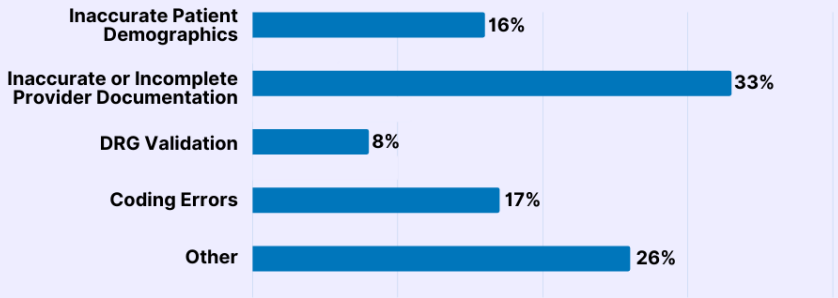
Since clinical denials are often based on differences of opinion, it is important for medical teams to clearly communicate the basis of their decision-making through clinical documentation. This is a common area of opportunity for many healthcare organizations.

**“Back when physicians had to handwrite what they were thinking, it worked. Today, with electronic records there's a lot of copying and pasting,” said Laurie Beck, senior vice president of clinical operations for Aspirion. “We find that educating medical staff on the impact of insufficient clinical rationale documentation and specific word use can have on claim denials to be extremely beneficial.”**

Given that the root cause of clinical denials involves subjective decision-making, it’s not surprising there’s continued opportunity for improvement. But even though subjective decision-making is a central part of clinical denials, there are objective components that are key to understanding root causes and getting denials overturned that also need to be addressed.

## Figure 2: What is your facility’s top cause of denials?

**This 2021 survey shows that issues with provider documentation are a leading cause of denials. Furthermore, in the “other” category, write-in responses pointed to denials related to authorizations/pre-authorizations and payer criteria for medical necessity.**




*Source: National Association of Healthcare Revenue Integrity, 2021 Council Survey Part 2*

# SOLUTION

## Identify categories of objective data in subjective decision-making.

Understanding that clinical decision-making involves subjective and objective dimensions, the Aspirion team has extensively analyzed clinical denials during the appeal process.

Their analysis revealed seven main categories of objective data in the subjective decision-making process. The following insights on the seven categories highlight where healthcare organizations have opportunities to reduce clinical denials.

### 1. Access to documentation

Today, most payers have direct access to a hospital's electronic record system, but payers may still deny an inpatient admission request, stating documentation does not support the inpatient level care. It could be that the payer did not have access to all information in the electronic medical record.

***Root cause analysis questions***

- Do you know if the payer looked at necessary information in the electronic medical record?
- Does your organization have too much or too little information accessible to the payer?
- Has the payer had a change in staff so that new training is needed?

## 2. Timing of inpatient order

Level of care denials may occur if an inpatient order is written the same day or within 24 hours of discharge. In some cases, the inpatient order is written based on utilization management (UM) or physician advisor review, but then the attending physician comes after the order was placed and discharged the patient.

### *Root cause analysis questions*

- Do you have a process for reviewing inpatient orders written within 24 hours of discharge for the correct status?
- Do emergency room (ER) case managers or utilization management nurses verify that the order and admission status match before submitting a claim?

## 3. Physician rationale

Denials may be due to the physician's rationale for the change of patient status not being documented everywhere it needs to be.

### *Root cause analysis questions*

- Does the physician's rationale match what is documented in the medical record?
- Is the rationale noted in the UM section of the record as well as the physician progress notes?
- Is copying and pasting progress notes an issue? A phrase like "admitted for observation" may be copied even after a patient is converted to inpatient.

## 4. Peer-to-peer review

Peer-to-peer reviews are a great option to get an initial denial for inpatient authorization overturned before the claim is billed.

### *Root cause analysis questions*

- Do UM staff know which payers allow a peer-to-peer option and the required time frame for completion?
- Is there a process to ensure peer-to-peer reviews are completed when available?

## 5. Clinical guidelines utilized

The two commonly used clinical guidelines are InterQual and Milliman Care Guidelines. Irrespective of which guideline is being used, documentation by the physician in the medical record must be objective and detailed.

### *Root cause analysis questions*

- Are the criteria used correct?
- Does the medical record support the criteria chosen?
- Did the payer utilize the correct criteria when making their decision?

## 6. Documentation quality

When it comes to documentation, a physician's word choice can have a big impact on a payer's decision to deny for level of care.

For example, if the physician notes a patient is being admitted for tests to "rule out" a particular condition, the payer is going to assume observation status is appropriate.

### *Root cause analysis questions*

- Does the medical staff know how certain words and phrases can lead to denials?

## 7. Communication/process issue

There may be breakdowns in communication and processes that lead to avoidable denials. Admission status reviews, inpatient length of stay authorizations by payers, and access to clinical information by payers are a few areas where breakdowns can occur.

### *Root cause analysis questions*

- Are admission reviews being done?
- If the payer authorizes a specific number of inpatient days, are clinicals being made available for concurrent review to get additional days approved?

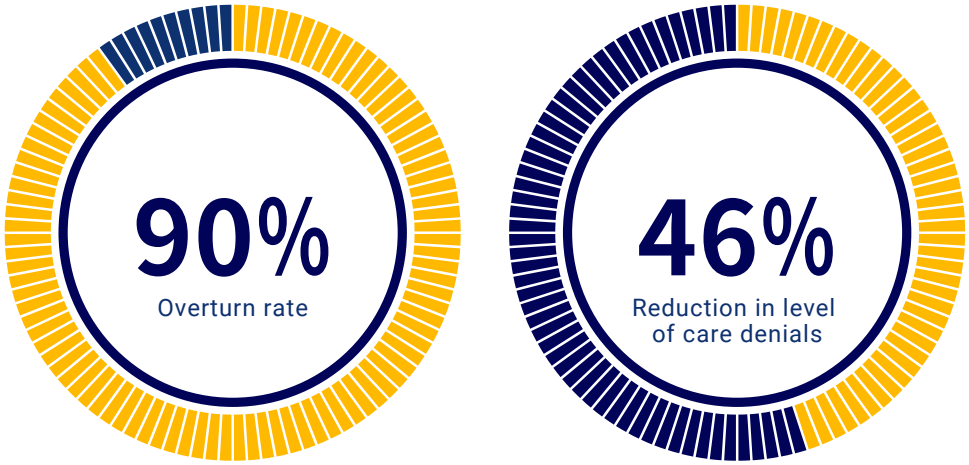
# RESULTS

## Reduce denials, increase overturn rate.

Healthcare organizations that implement improvements based on analysis of the seven components described above can achieve notable results. In terms of benchmarking, another metric organizations ought to track is the overturn rate of appeals.

When root causes are identified and suboptimal processes are corrected, hospital and health system medical teams understand the critical nature of not only ordering medically necessary care, but also ensuring the care is documented appropriately.

## Figure 3: Example results from clinical denial root cause analysis




*Source: Aspirion*

Although subjective decision-making is central to clinical denials, there are objective elements that organizations can home in on to identify improvement opportunities, leading to fewer denials and more overturns on appeal.

By implementing proactive denial management techniques, healthcare organizations can successfully navigate medical necessity denials.

# ABOUT ASPIRION

At Aspirion, we're exclusively focused on complex reimbursements. Staffed by a team of over 100 attorneys, 30+ clinicians, and hundreds of specialists with a far-reaching understanding of medical and technical denials and powered by its proprietary business intelligence platform, Aspirion is uniquely qualified to achieve success on your behalf. And that success comes in the form of more overturned claims, more revenue, and a healthier bottom line.

To learn how Aspirion can help your organization successfully tackle claims denials, reach out to us at info@aspirion.com or visit us at aspirion.com.

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