CASE STUDY

Advicare Digs Deep Into Clinical Claim Denials, Reveals Improper Payer Review

Advicare Ensures Appropriate Specialty Review And Reclaims Revenue

Denied clinical claims are on the rise, sparking discussions of front-end denial prevention. But what about a hospital's appeals process and follow-up strategy? Advicare's recent experience with one client illustrates the importance of careful review and proactive measures to reclaim lost revenue.

How It Began

Advicare's client, a multi-hospital health system in the Midwest, filed appeals for several claims, which ranged in condition from acute respiratory failure to sepsis. Its team filed detailed appeals that included:

- The clinical condition of the patient
- Treatments provided
- Specific rationale supporting medical necessity

The payer upheld its previous denials, citing medical necessity for Inpatient Level of Care. **The client immediately engaged Advicare's team of clinical and legal experts. After an exhaustive review of the claims, Advicare vehemently disagreed with the decision and refused to take "no" for an answer.**

Did you know?

The national denial rate for claims denied upon initial submission jumped 23% since 2016.

Expedited, Escalated Review

Advicare's team of clinical and legal experts knew something was wrong, and after scrutinizing **the payer's process, uncovered an alarming discrepancy – the payer's physician reviewer did not have the requisite experience and background necessary to review the claims in question accurately**. The state statute, and the contract between the health system and the payer, required utilization reviews to be performed by physician reviewers of the same specialty as the physician managing the medical condition or disease. Additional criteria includes having experience treating patients with the medical condition for which the health care service was being requested. In these cases, the payer's physician reviewer specialized in long-term care and did not possess the requisite acute care hospital experience.

With that knowledge, Advicare escalated these claims to the Provider Representative for further review even though all levels of appeal had previously been exhausted.

A Demonstration Of Tenacity

Understanding the complexity of clinical denials and the high risk they pose to net revenue, Advicare ensured the denied claims were discussed during payer escalation workgroups and monthly meetings. Advicare continued to maintain that a physician with acute care hospital experience – and a related specialty background – needed to complete the reviews for these particular accounts.

Advicare's efforts paid off when the payer's provider representative finally agreed to schedule a meeting with its Medical Director to review account-level details. Initially, the Medical Director defended their decision to uphold the denials, maintaining the physician reviewers were qualified to render a decision on the medical necessity of the services provided. However, upon further review, the Medical Director found that the reviews were actually being completed by physicians of a contracted third-party of the payer. Those physicians were not qualified to perform the reviews in question.

The Medical Director then had the accounts reviewed by his internal physician reviewers, who had the necessary credentials. They agreed that the medical necessity for inpatient level of care had been met. He had the denials overturned, and the claims paid. **The total charges of all the claims were greater than $115,000 and were paid as expected per contractual rates.**

Key Takeaways

- Even though a physician may review an appeal for a payer, this does not mean the physician is qualified to do so for the specialty in question.
- Even after appeals are exhausted, there are escalation options to get denials overturned and paid.
- Highly skilled, multi-specialty nurses – like those who work at Advicare – demonstrate the importance of having a keen understanding of Utilization Review, medical necessity criteria, and important claims guidelines.

Process Change For Long-Term Success

Additional changes followed. The payer's Medical Director evaluated the use of a third-party vendor and determined that all appeals would be reviewed internally – and by physicians of related specialties. In addition, the Medical Director determined that he needed to be more accessible to ensure the success of a justified claim.

These changes would not be possible without the collaboration of Advicare, the client, and the payer. **Advicare's Payer Relations team stepped in and got results**. Not only did this collaboration result in the recovery of revenue, but it also resulted in new, more effective processes that will impact future claims.

For more information about what Advicare can do for you, contact Bob Colón, Senior Vice President of Business Development at Advicare, at (484) 787-7151 or bcolon@myadvicare.com.

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