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Strategies for ICD-10 Appeal Success

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Appeal Solutions

ICD-10 Impact

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- New Implementation Date: Oct 1, 2015
- Denials expected to increase 100 – 200% during the initial phase of implementation due to lower productivity, data entry errors, new payer regulations, crosswalk interpretation challenges. Source: ICD-10 Transformation: Five Critical Risk-Mitigation Strategies www.HIMSS.org

ICD-10 Appeal Success Strategy

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- Avoid ICD-10 Storm Fatigue
- Denial Avoidance
  - Precertification improvements
- ICD-10 Denial Appeal Success:
  - Identifying denials
  - Winning Level I appeals
  - Level II appeal success

ICD-10 Irony

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ICD-10 is part of the HIPAA and PPACA administrative simplification requirements:

- Enable tailored care management
- Lower rates of denial in the long term
- Administrative simplification due to technology adoption

ICD-10 Patient Access Staff Training

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- AHIMA role-based training recommendation for non coders (awareness) should be expanded to include:
  - Precert request tracking resources
  - Access to payer updates
  - Escalation of ICD-10 delays/issues
  - Precert Appeal Letters: no payer response/poor payer response

Precertification- No Payer Response

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- Sample Precertification Appeal wording:
  - "Our office requested precertification related to the above patient. However, no response was received from your company. It is our position that your failure to promptly respond to this request is a breach of industry-recognized care management standards."

Payer Compliance Enforcement

How to enforce quality case management:

- Know state licensing agency
- Utilization Review Accreditation Commission (URAC.org) has an online complaint form for filing complaints against URAC-accredited organizations.
- URAC includes compliance officer in member contact information

Payer Timely Decision Enforcement

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- Case management laws and standards typically require:
  - Written appeals policies and procedures that explicitly state the time frames for both initial decision and appeal decisions
  - If in doubt, ask for a copy of the written policy to determine if the payer is compliant

Patient Access Engagement

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- Staff engagement depends on communicating impact to financial targets and patient care. Patient access can monitor:
  - Delayed precertification = delayed care
  - Denied precertification = change in care plan
  - Use payer performance stats in managed care negotiation

Appeal Process Utilization - Medicare

- Few appeal are filed. 2012 OIG study of Level I appeals found than 2.6 percent are appealed.
- Overturn rates vary considerable across levels.
  - 2012 Level I overturn statistics: Level 1 25% (Part A) – 50% (Part B) overturned.
  - 2015 (QIC) overturn to-date stats: Level 2 19% overturned.

Appeals Cost Benefit Analysis

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- Time intensive
- Outcome uncertain
- Financial benefit questionable
- Intangible benefits during ICD-10:
  - Another Means of Dialogue
  - Obtain unpublished payer criteria
  - Route to external review

Tips to Improve Claim Denial Assessment

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- Review the financial threshold for appeals
- Adjust the threshold during ICD-10 if your technology enables an automated process
  - ICD-10 will likely involve more coding appeals opposed to clinical (bundling/downcoding/mismatch)
  - Technology improvement may facilitate identification and batch appeal generation

Tips to Improve Claim Denial Assessment

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- Examine denials by payer:
  - Medicaid has the highest denial rate
  - "Medicaid payers continue to be the most difficult to do business with. This is a potential issue for some providers as many additional Medicaid patients are expected to enter the system in 2014." Source: AthenaHealth PayerView 2013

Tips to Improve Claim Denial Assessment

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- Monitor top procedures for “revenue neutrality”:
  - Review your managed care contracts for revenue neutrality wording
  - Appeal Benefit Variances
  - Some contracts define “financial impact” as one percent above or below previous levels - Source: www.blueandco.com

Level I Appeals

- Make sure your Level I Appeal makes a disclosure demand such as a request for the coding guideline used to assess the claim.
- Cite your coding authority.
- Request peer review:
  - Clinical – peer-to-peer
  - Coding – review by a certified coder

Goal: Quality Appeal Review

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- Coding appeals frequently result in form letter responses by non-certified reviewers. Coding appeals may require a Level II appeal for a quality review:
  - Level II appeals are more likely to be reviewed manually
  - Level II appeals are more likely to be reviewed more carefully due to the potential escalation to external review

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Sample ICD-10 Coding Appeal Wording

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- "If your company utilized published ICD-10 coding guidelines, please provide the publisher, product name and version of any guideline used so that we may assess the accuracy of the information. Further, non-standard, payer-specific ICD-10 coding edits should be explained in detail and supported by applicable information from the controlling policy or plan documents."

Level II Appeals

- Are appeals filed and forgotten?
- Most states have a deadline for answering an appeal. Tracking payer response times results in:
  - More complete appeal documentation
  - Confirmation of receipt and status of appeal
  - Poor response data can be used to negotiate contract terms and penalties

Level II Appeals

- Level II appeals should respond to gaps in evidence
- Level II appeals should point out how the patient's condition varies from the subjects of the underlying scientific evidence.
- Level II appeals should request information on the external/independent review availability

PPACA External Review

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- ACA outlined broader criteria for external reviews: med necessity, setting level of care/effectiveness
- 4 month deadline and > $25 filing fee
- Expedited access for emergency situations or if internal review non-ACA compliant
- Plans must pay cost (est. $605/review per Interim Final Regulation)

AHIP External Review Study

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- Association of Health Insurance Plan (AHIP) 2006 study on external appeals:
  - 37% overturn rate/4% partial overturn
  - 59% denial upheld by reviewer
  - “This high number of overturns can be attributed to the use of plan clinicians at the internal level that are not qualified to review the subject matter of the appeal” NAIRO position paper

Next Steps: Continuing Education Units

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- Webinar recording and handouts
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Questions And Answers

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