Case Study

Clinical Appeal for No Authorization for Acute Rehabilitation

Managed Resources partners with healthcare systems, hospitals and payers across the United States in achieving accurate and appropriate charging, documentation and payment. The following is a client case study demonstrating the value our clinical appeals team was able to deliver to our client.

Challenges

This was a denial for 6 days of acute rehab denied for no authorization. The patient initially presented to our client for right leg weakness and for an infection with Methicillin Resistant Staph Aureus (MRSA) at the site of a prior dorsal column stimulator that had been placed to treat back pain.

The patient was then transferred to the Acute Rehabilitation Unit for right leg weakness for an expected stay of 13 days. Later, the patient had symptoms of a bowel obstruction and was transferred back to the medical unit for a laparoscopic repair of an internal hernia and lysis of adhesions.

During the same month, she was transferred back to the Acute Rehabilitation Unit to complete the rest of her rehabilitation as planned.

Our Solution

The denial was assigned to our specialist RN and appealed using the following:

Authorization: Community Health Group authorized inpatient Acute Rehabilitation level of care for this patient prior to her admission to the unit for an expected 13-day length of stay.

Notification: After the patient was transferred back to the Acute Rehabilitation Unit, a face sheet was faxed to Community Health Group to notify them of her return to the unit.

Medi-Cal Manual of Criteria: Medi-Cal outlines the criteria for acute rehabilitation level of care in the Medi-Cal Manual of Criteria Chapter 5.5.

Medical Necessity: We demonstrated why the services were medically necessary and appropriate to treat her right leg weakness until she was stable for a safe discharge to her home.

California Statutes: California Health and Safety Codes and the Knox-Keene Act.

Results

The total charges on this account was $36,606 with an expected reimbursement of $10, 200. This was completely overturned for the acute rehabilitation charges. We were able to identify that the hospital facility sent in a late notification to the insurance company of the patient's return to the Acute Rehabilitation Unit.

Although this was the case, we successfully overturned this denial based on the prior authorization, statutory obligation by the payer, and medical necessity for Acute Rehabilitation as described in the Manual of Criteria for Medi-Cal which is Medicaid in California. This was an educational opportunity on the importance of timely notification to the payer.

We recovered $10,200 of denied revenue.

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Case Study

Clinical Appeal for Downgraded Level of Care

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Challenges

Our client, a specialty children's hospital in California had an 8-year-old cancer patient that had been receiving chemo and PRBC's on an outpatient basis. He was admitted to the Hem/Onc unit at our client's 324-bed hospital due to an elevated temperature of 102°F following a blood transfusion.

His condition required continued hospitalization for 8 days. These dates of service were downgraded from DOU to M/S level of care by Aetna. The client is considered a tertiary level of care facility with specialty services.

Our Solution

The denial was assigned to our specialist RN and appealed using:

The Client's Hem/Onc unit protocol:
We demonstrated that the services rendered were specialty care services that could not have been provided at a lower level of care.

Aetna Specialty Health Care Management Team policy statement: We established that their member qualified for specialty care services for his serious and chronic condition, i.e., Stage IV Extra-Renal Rhabdoid Teratoid Sarcoma.

Current evidenced based medical literature:
We provided information on Malignant Rhabdoid Tumor as the most aggressive and lethal malignancies in pediatric oncology.

Non-compliance by Aetna to statutory obligations per Knox-Keene agreement: Aetna had previously authorized this admission but had since rescinded their authorization. This is not acceptable per their Knox-Keene agreement with our client.

Results

This denial was processed by our team within 2-weeks, and then overturned for $14k.

We recovered $14,262 of denied revenue.

In addition, we were able to demonstrate that the Payer did not adjudicate the claim correctly in accordance with the payer's policy guidelines for this specific level of care.

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Case Study

Clinical Appeal for NICU III to IV Level of Care

Managed Resources partners with healthcare systems, hospitals and payers across the United States in achieving accurate and appropriate charging, documentation and payment. The following is a client case study demonstrating the value our clinical appeals team was able to deliver to our client.

Challenges

This denial was for 132 days of NICU III and IV level of care for a newborn female at 24 weeks' gestation with a birth weight of 586 grams.

This newborn baby had multiple complex medical conditions including respiratory failure requiring intubation, and an extensive hospital stay. In addition, several life-saving procedures, including tracheostomy, were provided in order to maintain this newborn's stability.

The baby's condition required multiple specialists and services including Pulmonary, GI, Cardiology, Otolaryngology, Ophthalmology, and Pediatric Surgery. HealthCare Partners acting for Anthem Blue Cross downgraded these services to NICU II level of care.

HealthCare Partners downgraded these dates of service with no specific explanation.

Our Solution

The denial was assigned to our specialist RN and appealed using:

Payer Specific Policy Guidelines
We appealed this extensive length of stay at the NICU III and IV level of care utilizing Blue Cross' Medical Policy guidelines for NICU services.

We were able to demonstrate that this critically ill infant required and received a high intensity of services only available at the NICU III and IV level of care.

We carefully compared the medical records against the Payer's specific policy guidelines for this level of care. We were able to validate that their member met the policy guidelines for a higher level of care than what was authorized and paid for.

These services were in accordance with the policy guidelines established by Blue Cross.

Results

This denial was processed by our team within 2-weeks, and then overturned for $1.12M.

We recovered $1,120,000 of denied revenue.

In addition, we were able to demonstrate that the Payer did not adjudicate the claim correctly in accordance with their own policy guidelines for this specific level of care.

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Case Study

Clinical Appeal for No Medical Necessity with an Extensive Length of Stay

Managed Resources partners with healthcare systems, hospitals and payers across the United States in achieving accurate and appropriate charging, documentation and payment. The following is a client case study demonstrating the value our clinical appeals team was able to deliver to our client.

Challenges

Our client had a patient in the hospital for 84 days with new onset weakness and inability to walk. The payer denied 56 of the 84 days for no medical necessity.

Payer had utilized and cited specific InterQual criteria in their denial. Upon review of the remaining denied dates of service, it was determined that some of the dates reflected pending placement efforts to a Skilled Nursing Facility and other dates reflected the patient's intermittent periods of decompensation.

Another complication to this denial is that the patient's insurance coverage changed to a managed Medicaid plan during their hospitalization.

Our Solution

The denial was assigned to our specialist RN and appealed using the following:

Inappropriate use of InterQual Criteria by the payer

Medical Necessity/InterQual Criteria at Acute Level of Care: we provided an alternate InterQual which appropriately applied to this patient's medical status

Medical Necessity at Administrative Rate & Policy which specifies the rate for Medicaid/Medi-Cal patients with pending placement issues to contracted facilities

The payer's Case Management guidelines were cited to highlight the payer's responsibility regarding transfer of their patient

Results

This was an extensive appeal with multiple factors complicating the potential outcome. As a result of our efforts, we were able to overturn the total balance due of $98,000.00. In addition, we were able to point out to the client that even though the payer may cite specific criteria, we are very aggressive in confirming the criteria that was utilized. Furthermore, this appeal was unique in that the patient's condition was intermittently acute or pending placement. Fortunately, the entire balance was paid at the expected reimbursement and not at the Medi-Cal Administrative rate.

We recovered $98,000 of denied revenue.

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Case Study

Clinical Appeal for Outpatient Noridian Denial of J9355 – Excessive Units

Managed Resources partners with healthcare systems, hospitals and payers across the United States in achieving accurate and appropriate charging, documentation and payment. The following is a client case study demonstrating the value our clinical appeals team was able to deliver to our client.

Challenges

Noridian denied the Outpatient services with HCPCS code J9355 for administration of Herceptin (Trastuzumab injection) as "excessive units".

This injection is used for the treatment of breast cancer. There are multiple accounts for this patient as it is an ongoing Outpatient service.

Per the National Cancer Comprehensive Network, the recommendation is repeat administration every 21 days. Trastuzumab (Heceptin) is supplied in a 440 mg vial, however, the patient only required 435mg.

Our Solution

Managed Resources appealed this Outpatient service utilizing Medicare's MLN Matters #4229 which specifically addresses this matter:

"At times, **a facility provides less than the amount provided in a single use vial** and there is waste, i.e., **some drugs may be available only in packaged amounts that exceed the needs of an individual patient.** Once the drug is reconstituted in the hospital's pharmacy, it may have a **limited shelf life**.

Since an individual patient may receive less than the fully reconstituted amount, CMS encourages hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, **if the hospital must discard the remainder of a vial** after administering part of it to a Medicare patient, the **provider may bill for the amount of drug discarded plus with the amount administered**…"

Results

As a result of our appeal, the denied balance due of $3,844 was overturned. This affected not only the appealed encounter but was successful in overturning this patient's other encounters for the same Outpatient service.

We recovered $3,844 of denied revenue for one encounter. $11,532 for a total of 3 encounters.

In addition, the client was able to use the denial as an educational tool to assist in the prevention of future Payer denials.

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