

Service Denial Standardization

Changes, Challenges, Tips & Tools For Improving Compliance

Presented by the
Service Denial Standardization Team- Main

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Objectives



- Locate & Identify Team Updates
- Correctly Select & Apply Appropriate Templates
- Integrate Regulatory and Accrediting Changes
- Implement Best Practices

Overview Commercial

- Turn Around Timeliness (TAT)
 - Delay/Pend Process
- Language Assistance Program (LAP)
 - Required Notice of Translation (NEW)
- Denial Reason and UR Criteria
 - Medical Necessity versus Benefit
 - Lack of additional information

Commercial TAT Standards

- Last update 8/30/07
- Additions
 - Standing Specialist Referrals (slide 7)
- Corrections
 - Post Service Pend/Delay Timeframes for Expert Reviewer (slide 13)



Commercial TAT Standards

- Urgent
 - Decision, Initial Notification, Written Notification = **72 hours**
 - Pend/Delay = **24 hours**
- Additional Information only
 - Received = **48 hours** from receipt
 - Not Received = **48 hours** from expiration
- Downgrade to Non-Urgent?

You Be The Auditor

- Is this timely?
 - Received: 11/6/08, Thurs. 2:50 PM
 - Pend letter: 11/7/08, Friday, 4:00 PM
 - No Info Received by _____?
 - Decision: 11/10/08, Monday, 3:17 PM



Commercial TAT Standards

- Concurrent – Rarely used by groups
 - Inpatient or Ambulatory
 - Decision, Notifications = **24 hours**
- May not pend for information or expert review
- Acceptable to downgrade
 - < 24 hours prior to end = **Urgent**
 - Extension of non-urgent service = **Non-Urgent**

You Be The Auditor



- Physical Therapy, 2 visits per week
- 12 visits approved 9/4/08
- Request for 12 + received 10/13/08
- First auth expires 10/16/08
- Pend?
- Decision due _____
- Why?
- If received on 10/17/08?

Commercial TAT Standards

- Standing Referral to Specialist/Group*
 - Decision must be timely, no more than 3 days
 - Initial and written notification per classification (urgent, concurrent, non-urgent)
 - Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.

*Addition for 2007

Commercial TAT Standards

- Non-Urgent
 - Decision = **5 business days**
 - Initial = **24 hours from decision**
 - Written = **2 business days from decision**
- Pend/Delay
 - Additional Information or Expert Reviewer
 - Notification as soon as determined necessary
 - Notification must be sent within 5 business days

Commercial TAT Standards

- Non-Urgent Pend/Delay
- Additional Information Received
 - Must allow **45 days** to submit information
 - Decision = **5 business days from receipt**
 - **Same Initial and Written timeframes apply**
- Additional Information Not Received
 - Must allow full **45 days** to submit information
 - Decision = **5 business days from expiration**
 - **Same Initial and Written timeframes apply**

Commercial TAT Standards

- Non-Urgent Pend/Delay
- Expert Reviewer
 - **15 days** for consultation
 - Decision = **5 business days, <= 15 from pend**
 - **Same Initial and Written timeframes apply**

You Be The Auditor

- Request received 9/08/08
- Only diagnosis, service codes
- Need clinical notes for MRI
- Delay/Extension sent 9/15/08
- When does pend expire?
 - $9/15 + 45 \text{ days} = ??$
- No info received
- Decision on 10/29/08
 - Timely?



Commercial TAT Standards

- Post-Service
 - Decision, Written Notification = **30 days**
 - Initial Notification for approvals only = 30 days
- Pend/Delay Notification
 - Additional Information or Expert Reviewer
 - As soon as determined necessary
 - Must be sent within **30 days**

Commercial TAT Standards

- Post-Service Pend/Delay
- Additional Information = 45 days
- Additional Information Received
 - Decision = 15 calendar days from receipt
 - Written notification = 15 calendar days from receipt
- Additional Information Not Received
 - Need to give the full 45 days
 - Decision = 15 calendar days from expiration
 - Written notification = 15 calendar days from expiration

Commercial TAT Standards

- Post Service Pend/Delay
- Expert Reviewer Needed* = 15 days
 - Decision = Within 15 days of the pend/delay notice
 - Initial notification of approvals = 15 days of notice
 - Written notification = Within 15 days of delay notice

*Change for 2007

Commercial LAP Notice

LAP (Language Assistance Program)

- Required Notice of Translation
 - PDF Notices
 - CSDN and Delay Word templates Health Plan Specific
 - Notice is embedded as JPG to avoid corruption
 - Must add to SNF-EXH, NONCTOS, and RTT
- Please visit the “Approved ICE Documents” for other ICE C&L Main team LAP tools

Commercial Denial Reasons/ UR Criteria



Main changes since 2006:

DMHC

- Denial reason must be either medical necessity (MN) or benefit coverage/exclusion
- Must be clear and concise

NCQA

- UR Criteria Source and Name must be cited in the denial letter

Commercial Denial Reasons/ UR Criteria

Denial Reason Essentials Requires
CLEAR DELINATION BETWEEN:

- Medical Necessity
 - Refer to clinical information
 - Do not refer to benefit coverage
- Benefit Coverage
 - Refer to the EOC limitation or exclusion
 - Do not refer to clinical information or medical necessity

Medical Necessity Versus Benefit Coverage

EXAMPLE

Routine foot care such as: removal or reduction of corns and calluses, clipping of toe nails, treatment of flat feet or fallen arches, and chronic foot strain are not covered under your Health Plan benefit. Your health plan covers only medically indicated foot care for specific medical conditions. Please refer to your evidence of coverage/brochure for additional information regarding foot care coverage.

- What are the problems in this example?

Medical Necessity Only

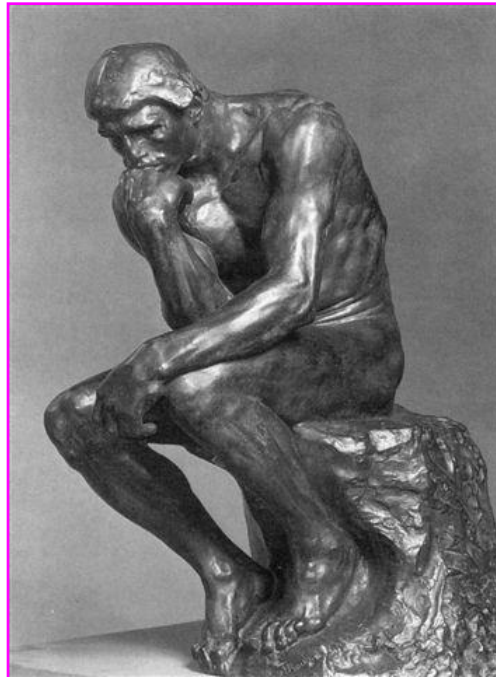
Specifically, XYZ Health Plan guidelines for routine foot care, including the removal or reduction of corns and calluses, clipping of toe nails, treatment of flat feet or fallen arches, and chronic foot strain, state that care is provided only if diabetes or impaired circulatory conditions exist. According to the chart notes, you do not have diabetes or impaired circulation in your feet, therefore this service has been denied. Please contact your PCP for further assistance with your healthcare needs.

UR Criteria

- Missing Name & Source of UR Criteria
 - Cite name & source within denial reason
 - “*XYZ Plan* guidelines for *routine foot care...*”
- Missing specific UR Criteria
 - Cite specific conditions eligible for foot care
 - “...are for diabetic foot disorders or other disorders that affect circulation to the feet.”

Commercial Denial Reasons/ UR Criteria

See Handout



Commercial Denial Reasons/ UR Criteria

UR Criteria Essentials

- Medical Necessity
 - Name and source of criteria, guidelines or policy

Milliman guidelines for **MRI of the knee**

Source

Name

Source

Name

XYZ Provider Group's criteria for **post-service review**

Source

Name

Source

Name

Pending CSDN Changes

See Handout



Commercial Review

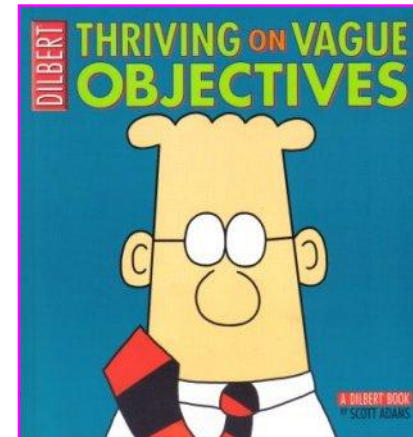
1. Crafting Denial Language
2. Elements of the Language Assistance Program
3. Turn Around Time Applications

Medicare



Objectives

- Locate & Identify Team Updates
- Select & Apply Correct Model Notice (Template)
- Effectuate Best Practice
- Clarify Processes



Overview Medicare

- ICE MA Folder Changes/Updates
 - 2007-Present
- Challenges
 - Direct Request
- Tools
 - Model Notices & Templates
- Tips
 - Best Practice
- Future

Changes & Updates in the MA Folder



- DENC
- DND
- IMM
- Matrix
- NDMC
- NOMNC
- TAT Standards

Detailed Explanation of Non Coverage (DENC)

- **What Changed:** Replaced the previous CMS version
- **Purpose:** Provide to an enrollee receiving SNF, HH, or CORF services upon notice from the QIO that the enrollee has appealed the termination of services in these settings.
- **TAT:** Must issue to both the QIO and member no later than close of business of the day the QIO notifies the HP/Delegate of the appeal.
- **Model Notice (Template)**

Detailed Notice of Discharge (DND)

- **What Changed:** New CMS model notice
- **Purpose:** Provide to an enrollee receiving acute hospital services upon notice from the QIO that the enrollee has appealed the termination of services
- **TAT:** Must issue to both the QIO and member as soon as possible but no later than noon of the day after notification by the QIO
- **Model Notice (Template)**

Important Message From Medicare (IMM)

- **What Changed:** Replaced the previous CMS version
- **Purpose:** Provides the enrollee with hospital inpatient rights and discharge determination appeal rights
- **TAT:** Within 2 calendar days of admission or not more than 2 calendar days prior to discharge or in an unexpected discharge must be given with adequate time for the enrollee to consider their appeal rights
- **Model Notice (Template)**

MA Preservice Denial Reason Matrix

- **What Changed:** Replaced the previous version
- **Purpose:** Provides sample generic denial reason language for general reoccurring situations, which facilitates compliance with regulatory requirements
- **TAT:** Non Applicable
- **Template:** Recommended for usage by CMS Region IX, but not required

Notice of Denial of Medical Coverage (NDMC)

- **What Changed:** Replaced the previous CMS version
- **Purpose:** Complete and issue this notice when denying an enrollee's request for medical service
- **TAT:** Dependent upon level of urgency
- **Model Notice (Template)**

Notice of Medicare Non Coverage (NOMNC)

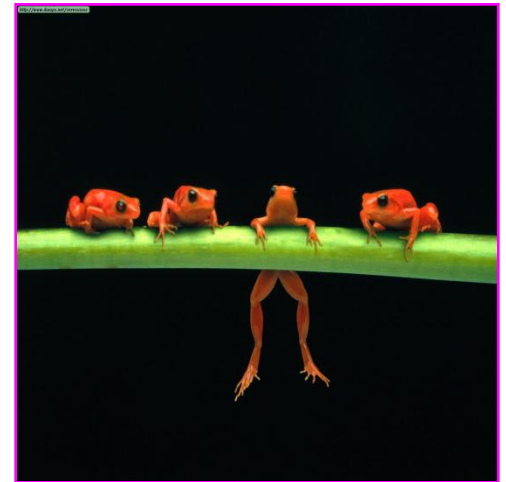
- **What Changed:** Replaced the previous CMS version
- **Purpose:** Complete and issue this notice of appeal rights to enrollees receiving SNF, HH, or CORF services before the termination of those services
- **TAT:** No later than 2 calendar days or 2 visits prior to the proposed termination of services. If expected LOS is 2 days or less, give notice on admission
- **Model Notice (Template)**

Medicare Turn Around Time Standards (TAT)

- **What Changed:** Updated the previous version (deleted NODMAR, added IMM and DND)
- **Purpose:** Combines regulatory timeframes for decision determination & notification in an easily readable grid thus facilitating compliance with regulatory requirements
- **TAT:** Non Applicable
- **Template:** Recommended for usage but not required

Challenges

- Criteria
- Extensions & Organizational Determinations
- Retro Service Requests
- Template Usage
 - Model Notices
 - Refusal to Transfer



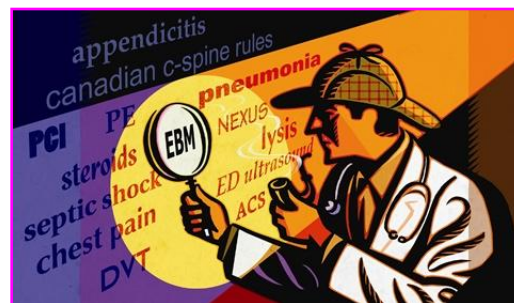
What's In A Name?

MMCM Chapter 13

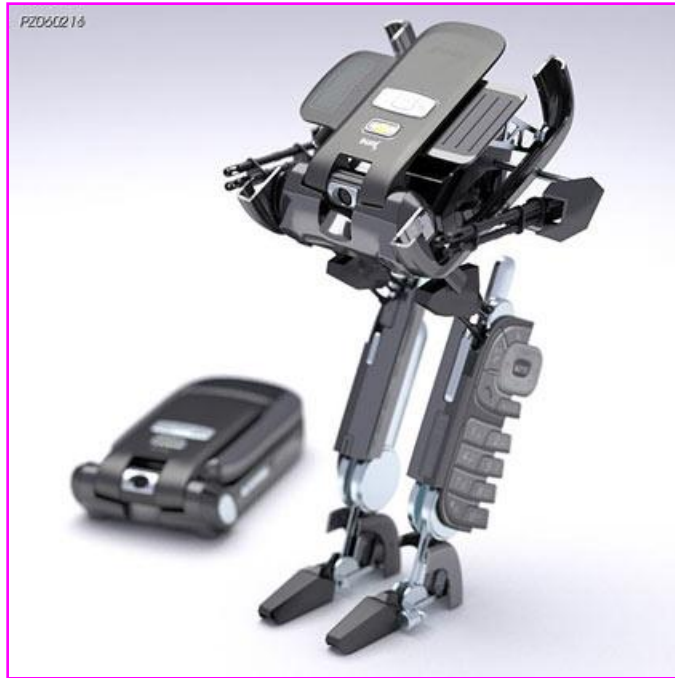
- Specific to Enrollee
- Language is Easy to Understand

NCQA, UM 7.C.2 (2008)

- A reference to the UM criteria, benefit provision, clinical practice guideline or protocol



Can We Change This?



- “...may not rewrite, re-interpret, or insert non-OMB approved language into the body of the notice except where indicated.”

Exceptions are

- Model Notice specific
- May require RO prior approval



What? No Extension Allowed !

There is no CMS model extension notice, however there is a ICE template.

CMS only recognizes extensions if:

1. The enrollee requests one, or
2. The organization justifies a need for additional information and documents how the delay will be in the interest of the enrollee

Retro, Retro, Retro

- CMS does not recognize retro UM service requests
- Review & develop the request through the claims process



Model Mania or How I Learned to Love Templates

| WHAT | WHY |
|----------------------|--|
| Carve Out | For referring enrollee and/or physician to another entity or source for requested services that the group does not have responsibility for providing or authorizing) |
| DENC | Provide to an enrollee receiving SNF, HH, or CORF services upon notice from the QIO that the enrollee has appealed the termination of services in these settings |
| DND | Provide to an enrollee receiving acute hospital services upon notice from the QIO that the enrollee has appealed the termination of services |
| Exp Criteria Not Met | Notifies the enrollee that expedited criteria was not met and allows the enrollee their appeal rights |
| Extension | An enrollee/provider requests or the HP/PPG justifies a need that is in the best interest of the patient |
| IMM | Provides the enrollee with hospital inpatient rights and discharge determination appeal rights |
| NDMC | Issue this notice when denying an enrollee's request for medical service |
| NOMNC | Complete and issue this notice of appeal rights to enrollees receiving SNF, HH, or CORF services before the termination of those services |

Tips-Best Practice

- Denial language must be concise and understandable to the layperson
- Be sure criteria reference is to Medicare criteria/guidelines
- Post the Turnaround Time Matrix in everyone's cubicle and re-educate often
- Partner with your SNF's and HH agencies for timely delivery and signatures

Future Service Denial Standardization-Main Projects

- Possible AB1324 Implications
- Ongoing LAP Assistance
- Constant Vigilance for Best Practice

Questions & Comments

