

HealthLeaders

INFORMATION TO LEAD

FINANCE



Taking on Denials

Some hospitals are managing potential clinical denials before they happen, reducing unnecessary inpatient days. **BY PHILIP BETBEZE**

IT WAS TIME TO PUT HIS THEORY TO the test. Robert Corrato, M.D., was trying to prove that he could save his hospital client thousands of dollars by helping patients receive optimum, but cost-effective, care. A prime opportunity presented itself. A 99-year-old patient had been diagnosed with a bone infection by her admitting physician, and was going to require 30 days of intravenous antibiotic treatment.

But from the hospital's point of view, there was a problem. Such treatment does not require an inpatient stay, so keeping the patient there would have her occupying a bed that could be used by a paying patient. The woman's family wouldn't hear of placing her in a nursing home for the duration of the treatment, a scenario that Medicare would have covered. And Medicare would not pay for home treatment. No potential outcome seemed likely to please the referring physician, the hospital and the patient. Exactly this sort of situation mirrors hundreds of other diagnoses that seemingly present no-win situations for large hospitals on a regular basis.

In the elderly woman's case, Corrato accessed a special cash reserve that he convinced the chief financial officer to set up for just such situations. He used that reserve to pay for home care for the patient, creating a positive outcome for the patient's family and her doctor. But

most importantly for the hospital, he opened up a scarce bed for use by a patient who really needed it, and for which the hospital would be reimbursed.

The American Hospital Association, which in February gave a rare endorsement to Corrato's company, Executive Health Resources of Drexel Hill, Pa., says the concept works because EHR's physician consultants are experts on their hospital clients' insurer contracts and because the consultants review patient treatment decisions constantly, bridging the gap between the referring physicians' clinical decisions and the impact those decisions have on potential clinical denials. The process has saved hospital clients millions because the physician-to-physician dialog often helps time-strapped referring doctors to provide more efficient care. For the hospital, this means insurance companies won't later say that certain treatments were unnecessary and thus unreimbursable.

"The gold-standard is real-time intervention," says Thomas McCarter, M.D., chief medical officer at Main Line Health System of West Chester, Pa., which operates three acute-care hospitals. Using EHR physicians as consultants to admitting doctors, the system



has recovered \$1.3 million in a little more than two years by appealing clinical denials after care has been delivered. The hospital, he says, also has saved at least as much on fewer denials and length-of-stay reductions, which are much more difficult to quantify.

Payment denials by insurers and Medicare have become so much a part of the hospital payment tangle that many CFOs accept that a certain portion—in many hospitals between 20 to 30 percent—of total patient days will be unreimbursed. Hospital executives say that many of those days are lost due to denials by insurers looking to hold down costs through utilization management protocols that use statistical data to second-guess care decisions. The AHA estimates that the average hospital loses \$3.3 million each year on such denials. Hospitals can appeal, but by the time the denial notification reaches the business office, the patient is long gone and the hospital is stuck trying to prove that the physician-approved care was warranted.



Economic incentives for referring physicians and hospitals don't always mesh, which is one reason hospitals traditionally use case managers to try to avoid dispensing treatment that insurers might later deem unnecessary. Insurers sometimes deny payment as a result of such after-the-fact reviews. Case managers, often nurses by occupation, try to encourage admitting physicians to move patients more efficiently along to discharge, but communication can sometimes be a problem.

Admitting physicians "use our hospital because it's convenient," says Mark J. Baumel, M.D., chief medical officer at Mercy Health System, a five-hospital, Philadelphia-area system that has saved \$4.8 million in a little more than two years by appealing denials using EHR protocols. "The fact that the hospital is reimbursed appropriately or fully is not particularly germane to them."

Also, referring physicians often rightly have higher priorities than making sure that the hospital's length-of-stay goals are met and that the hospital is properly reimbursed.

"I might have eight to 12 patients in the hospital plus one or two that might be in emergency care, and I can't be on top of filling out all that paperwork [required for discharge]," says Steven Cohen, M.D., a hematology and oncology specialist who refers patients to

Bryn Mawr Hospital, another Pennsylvania EHR client.

Depending on the contract, EHR's physicians operate on site and work regular hours, continually reviewing patient charts and consulting with referring physicians on care decisions that might be ripe for a denial. Most

the late 1990s, helped develop clinical utilization management protocols for insurers that he's now fighting against for his hospital clients. "This brings some balance to the marketplace," he says, adding that he had a change of heart regarding his career when he realized payors had created a utilization

"I SAW THAT HOSPITALS WERE LOSING MILLIONS BECAUSE THEY JUST COULDN'T MANAGE THE HOOPS AND HURDLES THAT CONTRACTUALLY HAD BEEN PLACED IN FRONT OF THEM."

such decisions are reviewed in real time using proprietary software—similar to that used by managed care companies—that can identify questionable decisions before they're made, arming the hospital with critical information it can use on appeal. The software also can help identify coding errors.

The fact that physicians are leading the denial management process is one key piece of the puzzle, says McCarter of Main Line. The other is the sophisticated database. EHR's database allows the hospital to track every case and every patient interaction as well as tendencies on potential denials for payors, regions and insurer medical directors.

"Payors have this data and had the advantage in the past," says Corrato, who as an independent consultant in

management infrastructure that he found often was used to "inappropriately" deny reimbursement to hospitals.

"I saw that hospitals were losing millions of dollars because they just couldn't manage the hoops and hurdles that contractually had been placed in front of them," he says.

Baumel was skeptical that EHR's system would work, at first.

"I wasn't terribly optimistic," he says of his initial meeting with Corrato and another EHR associate. "I had the glare and folded arms. Two hours later I was grabbing them as they tried to leave."

Philip Betzeze is finance editor with HealthLeaders. He can be reached at philip.betzeze@healthleaders.com.



For information contact us at:
877-EHR-DOCS
or visit www.ehrdocs.com