

Be the Voice



Navigating Systems of Coverage

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Navigating Systems of Coverage Denials Resolution

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How It All Began

A Ten-Year Effort at Resolving Denials Effectively

2010 - Present

- California Knox Keen Act
- AB 235
- St. Joseph's Behavioral Health Center - Developing/
Learning Mindset to Effectively Resolve Denials.



Understanding Psychiatric Emergencies

Psychiatric Emergency Defined:

A mental disorder manifested by acute symptoms that render the patient:

- 1) An immediate danger to himself, herself, or others;
- 2) Immediately unable to provide for, or utilize food, shelter, or clothing (Health and Safety Code 11317.1(k)).
- 3) Psychiatric emergencies may present independently or concurrent with a physical emergency medication condition.



An All too Common Discussion

Patient & Family Perspective...

- *“We need help....”*
- *“Can you fix our son/daughter or friend...”*
- *“They need more time in the hospital...”*
- *They are not ready for discharge...”*
- *“Its your job to fix them!”*
- *“You were supposed to get that authorization.”*



Denials - An All too Common Pattern

The Insurance Denials

- *“Authorization can best be served at a lower level other than Inpatient/Outpatient facility.”*
- *“Medical Necessity is no longer justified.”*
- *“The patient is no longer suicidal, appears stable, is eating, and has a plan for a place to live.”*
- *“It appears the voices have resolved, the patient is medically stable, and family support is active.”*



Denials - An All too Common Pattern (cont.)

With Denials came Frustration...

Family Perspective	Facility	Outcome
Patients/Families trust in the Treatment became “distrust” in the uncertain direction of their Treatment.	Facility navigated Denials by way of lengthy Appeals process and correspondence to and from Insurance Companies.	3-6 months delays in responding to Appeals and waiting for outcome.
Recovery was about cost and long-term means to pay for treatment.		Outcome - Loss in Revenue and or delayed payment. Excess Administrative time and cost incurred in developing an Appeal.



Patient Care & Uncertain Trust

- Patient's denied coverage in part, or fully developed an uncertain trust in their Provider-Patient resolution.
- Families became frustrated with the system of care.

Outcome
Patients often pushed for premature discharge.
Hospitalization was reoccurring due to rapid decompensation and insufficient discharge planning.



Frequent Experiences with Insurance Plans

- Treatment length was being dictated by plans.
- Lengths of stay were affected.
- Interpretation of medical necessity was inconsistent and not aligned with provider practices.
- Unclear policy language and multiple medical guidelines conflicted with what was provided in denials given.
- Plans themselves were slow to adopt language and procedure of AB235 and Knox Keen Act.



Frequent Experiences with Insurance Plans (cont.)

- Despite legal holds (5150's, 5250's, 5270's), plans denied continued inpatient stay citing “*stabilization and medical necessity is no longer needed.*”

Application of the Knox - Keen Act was Real!

- Patients were denied appropriate access to proper care with insufficient Outpatient Provider lists, and often given program referrals for AA/NA versus authorization to requested outpatient provider.



Educating All Involved

With Knox Keen Act/AB235 - Authorization was no longer required for hospitalization. SJBHC continued to call and provide notification only.

CA Health & Safety Code 1317.4(b) prohibits health plans from requiring a provider to obtain authorization prior to the provision of “emergency services and care” needed to “stabilize” an enrollee’s medical condition.



Educating Staff

- SJBHC utilized interquel criteria for hospital admissions.
- Utilization Review staff obtained plan updates and notified physicians and case managers of pertinent changes leading to continued stays and or continued care.
- A roadmap from initial to concurrent reviews was developed with reviews by CM's and Physician's.



Road Map # 1- Education

EDUCATING the Patient/Family:

1. Identifying the patient's insurance benefits and coverage.
2. Presenting the patient/family with their coverage benefit.
3. Providing education on: In-network benefit from Out-of-Network benefit, Co-Pays, Deductibles, and Out-of-Pocket expenses.



Road Map # 1 – Education (cont.)

Educating the Patient/Family:

4. Providing the patient/family with an outline of BHC's Continuum of Care:

Inpatient → Outpatient Services → Individual Therapy → Ancillary Supports

5. Explaining the benefits of an Evidence Based Therapy versus traditional community-based models.



Road Map # 2 - Internal Resolutions

- Reconciliation/Review of admissions and Insurer Notifications and Outpatient Authorizations daily.
- SJBHC established standards in medical documentation and timely submission of clinical to end of day.
- Staff education and training became ongoing.
- Identifying upfront “services not covered.”
- Review of Appropriateness of Care.
- All clinical staff were responsible for their part.



Road Map # 3 - Discharge Planning

- Discharge Planning was prioritized and ran consecutive to treatment.

Effective Discharge Planning

- | | |
|--|--|
| 1. Identified Post-Discharge Provider within 24-hours of admission. | 4. Review of benefits were discussed with family and patient to ensure expectations were clear and consistent. |
| 2. Psychosocial Needs were factored and resolution to avoid fallouts preventing discharge. | 5. Barriers to discharge were identified and resolved <u>together</u> . |
| 3. Family Updates/ Education were concurrent and consistent throughout the hospital stay. | 6. Discharge planning was effectively executed on the day of discharge. |



Road Map # 4 - Patient Driven

Paradigm Shift:

- Patient & Treatment Team discussed post-discharge options related to their health benefits.
- Patient was ultimately in charge of determining their next step for referral.



Road Map # 5 - Denial Strategy

Identifying Voluntary Patients from Involuntary

Voluntary Status	Involuntary Status
<ul style="list-style-type: none">• Required authorization prior to starting an Inpatient Stay or Outpatient Stay.	<ul style="list-style-type: none">• “Notification” given to plans indicating patient was inpatient.
<ul style="list-style-type: none">• CM’s and treatment team staff were responsible for review of the medical record to ensure medical necessity was consistent.	<ul style="list-style-type: none">• Authorization for inpatient stay was not required.
<ul style="list-style-type: none">• Denials issued were reviewed by Physician/CM for Immediate Appeal.	<ul style="list-style-type: none">• Providers focused on Treatment.
<i>Denials were reviewed with patient’s and options discussed for immediate Resolution with DMHC, DOI, and Livanta were initiated.</i>	



Road Map # 6 - “Real Time” Denials Issued

Quick Resolution

Notification of Physician
& Treatment Team

Review of the Denial/ Chart

Physician & CM reviews
Treatment Plan.

Request for Peer to
Peer for resolution and
continued stay.

Submission for 3rd Party Review

Utilization Review opens
Resolution Process with
3rd Party Review
Organization.

Clinical is uploaded and
submitted.

Response time- average
48-72 hours response
time.



Road Map # 7 - “Real Time” Denials Issued

	HMO Commercial Plans	ERISA Plans/ DOI	Medicare Advantage Plans
Resource	California Department of Managed Care	Department of Insurance	Livanta (Northern California Region)
Web Address:	https://www.dmhc.ca.gov	http://www.insurance.ca.gov	https://www.livantaqio.com/en
Submission:	Portal Submission	Portal Submission	Fax Submission
Real-Time:	SJBHC Utilization Staff pursued advocacy and outcomes of 3 rd party appeals.		



Appeals Strategy

On-Site Denial Management	Off-Site Denial Management
In-House Reviewers became <u>empowered</u> with a sense of helping patients and families beyond the hospital walls.	Poor Tracking and follow-through of denials/appeals.
Denials were no longer, “just a denial.” This was personal!	Appeals rarely went beyond 2 nd level, or third-party appeals.
UR/CM’s had a clear understanding of the patients needs rather than seeing a chart as a stack of paper.	Claims were partially paid.
Response time was within 24-48 hours versus traditional 3-6 months appeals.	Unpaid balances were written off to bad debt.



Effective Advocacy

Appealing to Insurances:

1. Our commitment to helping patients was beyond the Denial. It was reaching out to plans and identifying policies and practices inconsistent with state and federal standards.
2. SJBHC held firm in regard to AB 235 legislation.
3. Appeals are costly! Immediate resolution became the favorable option for BHC's resolution of Denials.



“Real-Time” Denial Prevention Strategy

Evolving

- Admission Screening to Initial Review.
- Treatment Team focused on beginning treatment consistent with practice.

Informational

- UR staff updated Physicians & Treatment Team with current trends and plan updates.
- Staff were encouraged to open dialogues with Reviewers regarding treatment delivery and models used.

Effective

- Emphasis was understanding Federal/ State Legislation with Insurance Plans and Updates.
- Where gaps and or “lapses” took place our UR team worked to actively Appeal.
- Advocacy was Education and Action.



Medicare Advantage Appeals Strategy

Applied Understanding & Advocacy

Plan language and benefits were often frustrating to patients/families.

Medical terminology and guidelines varied.

Notification became “Certification” and “Real-Time” appeals strategies remained consistent with BHC’s resolution of denials.



NO's became "Learning strategies"

Denials were no longer JUST DENIALS.

Denials gave us:

- insight to strategy
- patterns used to delay payment
- active treatment



References & Resources

California Health & Safety Code 1317.1(a)(1)

1317.1(a)(2)(a)

1317.1(k)

1371.4(b)

Health & Safety Code 1345 (B)

Health & Safety Code 1367(i)



Thank You

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Questions?

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www.menti.com and enter code 95 34 60