Children's Hospitals and Clinics of Minnesota

Memo

Date: June 17, 2015

To: Clinicians

From: Sheldon Berkowitz, MD, physician advisor

Subject: Insurance denial patterns

Over the last 10 months that I have been in my new role as Physician Advisor, one of my responsibilities has been to deal with insurance company denials for care that was provided at Children's. These may be denials for all the care or procedure provided (e.g. if a Prior Authorization was not received) or more often, the denial will be for the in-patient services we provided with an "offer" to pay for observation status instead. In general, observation status pays Children's at a lower reimbursement rate than does in-patient status and also, potentially leads to higher patient/family financial responsibilities (unless they are on Medical Assistance/MA). For all these reasons, it is not only essential we get the status (i.e. inpatient or observation) correct on admission but also contest what we consider to be inappropriate insurance company denials. Here are some of the patterns I've seen – both leading to denials and also to getting them overturned – that may be helpful to you in your documentation. As an FYI –of the cases I have tried to get the denials overturned and we have heard back – 21 of 29 cases have been overturned.

1. Overnight stays where the patient goes home the day after admission are frequently denied by insurers. **Thus, it is very important in your ED or admission H&P notes to be clear why the pt is being admitted with inpt status. If you state they are being admitted for "observation" – it's hard to make a case for inpt so please, don't state that unless you placing the pt in observation status.**
2. Pts admitted with suicidal ideation – while some insurers push back on these being inpt while waiting for an inpt psych bed – most are ultimately overturned. **Please include language in your documentation to the effect that pt. is at risk of harming themselves and requires 1:1 supervision.** This usually gets the denial overturned.
3. For pts staying longer than expected – e.g. pt with AGE, **please document why they are needing to stay.** This could include that a pt is not yet taking po fluids and requires IVF.
4. If you anticipate a pt being discharged that day and they don't go due to changes in their condition after you initially rounded and did your daily progress note – **please add an addendum or do a new note indicating what changed requiring the pt to stay longer (e.g. started requiring O2 again).**
5. If a pt is transferred to us from an outside hospital and part of the reason for the admission here is based on what occurred elsewhere, **please include in your documentation the pertinent details/labs/xray results and/or vitals (e.g. O2 Sat of 80%) from the other hospital to help justify why the pt was admitted here.**
6. Keep in mind that if a pt is admitted to inpt status, but doesn't receive any care that could not have been provided on an outpt or observation basis (e.g. pt with asthma admitted on q 4hr nebs, oral meds, no O2 and taking po fluids) – it will probably be denied and offered as observation instead.

7. **Documentation is the key** – if a pt. is admitted for unresponsiveness, but the admit H&P states, "awake, alert, communicative, quite engaging" or for respiratory distress and the admit H&P states, "easy work of breathing" – then the inpt status may be denied.
8. If a Prior Authorization for a procedure or care is required by the insurer, and we didn't have it **in writing** prior to providing the care/procedure – we will probably be denied. We are working on developing systems to help make sure this doesn't occur.

I hope this is helpful to you. If you have any questions – please feel free to let me know.
Thanks,
Sheldon

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