Denial Impact:
Inpatient vs Outpatient Level of Care

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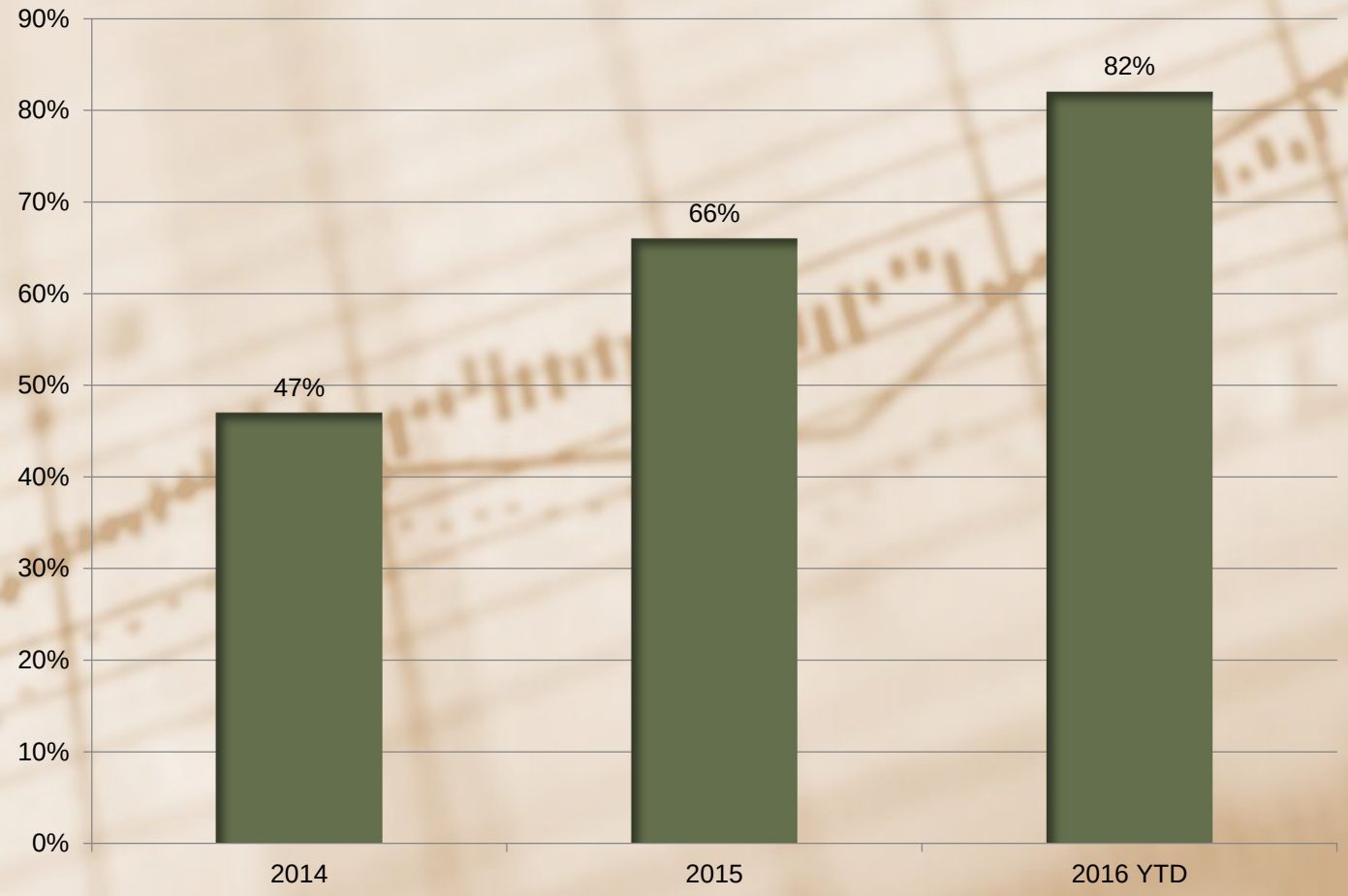
Major Reasons for Denial

- No Authorization or Notification
  - Notification of the I-Plan occurred past the contractual timeframe
  - Authorization was not initiated by the treating physician prior to admission – elective cases
  - Authorization for level of care is not approved by I-Plan
  - Claim was billed with a different procedure code than had been authorized
- Timely Filing
  - Claim was billed past the contractual timeframe
- Medical Necessity
  - Services not medically necessary
  - Level of care: inpatient versus outpatient

Level of Care: Admission Status Determination

- What do you mean by admission status?
  - Inpatient – services can only be safely provided in an acute care setting
    - Medicare's 2 Midnight Rule
  - Outpatient – services can be provided as an outpatient
  - Outpatient Observation – an unstable or "rule out" condition in which the patient is being evaluated for inpatient vs. outpatient care
- How is this determination made?
  - Always by a physician at the time services are provided, and supported by medical record documentation
  - Level of care guidelines for the non-medical reviewer – used by case managers to assist physicians with level of care determination
    - McKesson's InterQual Guidelines
    - Milliman Care Guidelines (MCG)
    - Hybrids and Payor specific guidelines
- How does the I-Plan factor into this?
  - Utilization Review
  - I-Plan medical director level of care determination – approval or denial
- What if there is discrepancy in the level of care determination?
  - Peer to peer review of care is allowed
    - Contractual timelines
    - Can be difficult to operationalize

Inpatient Denials:
Inpatient versus Outpatient Level of Care



Inpatient LOC Denials by Length of Stay