TITAN HEALTH

CASE STUDY

Titan auditors recover $2.3 million of lost revenue for multiple health systems by challenging auth-related denials.

Zero Balance Audit & Recovery

220 Accounts
# of Affected Patients

$2.3 Million
Recovered Revenue

Challenge

Several health system clients were experiencing a surge in authorization-related denials and turned to Titan Health for revenue recovery assistance. Denied services included chemotherapy/oncology, PT/OT/ST, outpatient surgery, inpatient admissions, high-cost drugs, and high-cost diagnostic testing.

Solution

Titan auditors investigated the root cause of numerous authorization-related denials and found that payors were denying claims for the following reasons:

- Authorization not obtained
- Authorization obtained for incorrect provider/NPI
- Authorized dates of service do not match billed dates of service
- Services found to be "not medically necessary"
- Authorization obtained for CPT code(s) other than those billed
- Provider advised by payor in error that authorization was not required

The auditors successfully appealed the authorization denials and then recommended the following steps to overturn each type of authorization denial moving forward.

Authorization not obtained: First, determine *why* an authorization wasn't obtained.

- Did the services occur on an emergent/urgent basis and there wasn't time to obtain authorization?
- Were the services rendered after hours such that authorization requirements could not be confirmed with the payor?
- Was there an administrative error from either the referring physician's office or the hospital?

When the hospital is truly at fault, asking for compromise and cooperation from the contracted payor is always worth a try. Be prepared to explain why authorization was not obtained and attach medical records to support medical necessity.

Authorization obtained for incorrect provider/NPI: Submit a reconsideration request with an explanation of why the services needed to be rendered at an affiliated facility (bed availability, broken diagnostic imaging equipment, etc.) Remind the payor that they have already approved the services as medically necessary, as evidenced by the issuance of the original authorization.

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"Authorization-related denials don't have to be a dead-end. There is often a workaround to them, but you must research the account and prove due diligence any way you can. Any evidence that you attempted to comply with the payor's requirement is key in getting these denials overturned."

Nicole Helfrich
Client Delivery Manager
Titan Health

Authorized dates of service do not match billed dates of service: Submit a request for reconsideration with an explanation of why resource availability caused the services to be rendered either before or after the authorized service date and ask the payor to update the date range of their authorization. Remind them that they have already approved the services as medically necessary, as evidenced by the issuance of the original authorization.

Services found to be "not medically necessary": Locate the payor's coverage policies and any other industry-standard software they use to determine medical necessity, such as Milliman Care Guidelines (MCG) and/or InterQual. Have a nurse auditor and/or a physician conduct a clinical review of the coverage policies, guidelines, and medical records. Do the services meet the criteria for medical necessity?

- **Yes:** Submit a request for reconsideration with clinical citations and all supporting documentation. Remember that supporting documentation may be documentation from prior patient visits.
- **No:** Review the diagnosis coding. Was a key diagnosis code that would otherwise prove medical necessity mis-coded, down-coded, or omitted in error? If yes, submit a corrected claim.

Authorization obtained for CPT code(s) other than those billed: Titan has been very successful in overturning this type of denial. In this scenario, we argue that a provider can't know with certainty exactly how a planned procedure will unfold in the operating room. The plan can and often does change during the procedure. Remind the payor that the provider's office complied with plan requirements by obtaining prior authorization, and that by issuing the authorization, the payor has already acknowledged the medical necessity of the services.

Provider advised by payor in error that authorization was not required: Submit a request for reconsideration stating the date you called, the phone number you dialed, the name of representative you spoke with, a summary of what was discussed along with the call reference number. State that your facility complied with payor requirements by requesting an authorization, and that you were misinformed by the payor's staff. Attach medical records to your request to support medical necessity. If the denial is not overturned, continue the appeal process by asking the payor to pull and review the call log (from their recorded calls) for the date/time/representative that advised you incorrectly.

Results

Titan auditors recovered $2.3 million of lost revenue on approximately 220 patient accounts, an average of more than $10,000 per account worked.

Titan Health's consultative approach toward revenue recovery provides customized solutions rooted in urgency and innovation, powered by a blend of technology and deep auditor experience.

For more information, visit
Titan-Health.com

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