

These tips can save you time and frustration when dealing with health plans.

**M**ost physicians would define utilization management as purely a hassle. Its official definition, according to the Utilization Review Accreditation Commission, is the evaluation of the medical necessity, appropriateness and efficient use of health care services, procedures and facilities under the provisions of the patient's health benefits plan. Health plans consider utilization management important for quality assurance and cost control, which explains why they usually focus their efforts on inpatient admissions, orthopedic procedures, potential cosmetic procedures, alternative and complementary medical services, and expensive imaging studies.

Utilization management can complicate physicians' lives by requiring them to submit precertification paperwork, deal with the fallout of denied services and participate in time-consuming appeals. While these processes aren't going away, the right approach can make them less painful.

# Precertification, Denials and Appeals: Reducing the Hassles

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## Precertification

A health plan's precertification (or prior authorization) process usually begins with a nurse employed by the health plan completing an initial review of the patient's clinical information, which is submitted by the practice, to make sure the requested service meets established guidelines. If it does, the nurse authorizes the request and the health plan will cover the service. If the service does not meet the guidelines, the nurse refers the case to the health plan's physician reviewer (usually the medical director or a physician consultant), who decides whether to approve or deny the request based on the information provided to the health plan. The physician reviewer may also "pend" the request and ask the physician for additional information before making a final decision.

The precertification process is one of the reasons physicians and patients are so dissatisfied with HMOs, which

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use this strategy more often than other managed care organizations in an effort to contain costs. The trade-off is that HMO premiums are usually lower than those of other managed care organizations that offer fewer restrictions (e.g., PPOs and POS plans). Although many health plans are finding less punitive ways to cut costs, such as using care coordination, some form of utilization management will always be used because it encourages both patients and physicians to make cost-effective decisions and abide by the plan's rules.

## Precertification tips:

- Become familiar with evidence-based clinical guidelines, particularly for common conditions. Some excellent sources are <http://www.guideline.gov>, [http://www.icsi.org/knowledge/browse\\_bydate.asp?catID=29](http://www.icsi.org/knowledge/browse_bydate.asp?catID=29) and <http://www.ahrq.gov/clinic/uspstfix.htm>.
- Ask your health plans what guidelines they use. They may even be able to provide you with a copy of the guidelines if the licensing agreement allows it. Medicare makes its coverage guidelines available on its Web site. See "Searching the Medicare coverage database" on the opposite page for more information.
- Submit legible documentation clearly stating the reason for the requested service. Health plans make their coverage decisions based on the documentation you provide, so it's in the best interests of both you and your patient to provide complete information up front. If the documentation required by one of your health plans seems excessive, you should certainly register that complaint, but

don't withhold the information. It will only complicate matters down the road.

- Follow up with the health plan if it hasn't responded in a timely manner. Most large health plans are required to follow standards set by the National Committee for Quality Assurance which stipulate that precertification decisions must be made within 15 calendar days of receipt of the request, if the request is not urgent. It's reasonable to hold health plans to that standard.

## Denial of services

According to a 2005 Web survey of health plans, the most common reasons health plans deny services are as follows:<sup>1</sup>

- 1) The services are not medically appropriate (47 percent).
- 2) The health plan lacks information to approve coverage of the service (23 percent).
- 3) The service is a non-covered benefit (17 percent).

When informing physicians of a denial of services, health plans are required to state the exact reason for the denial and provide an opportunity for the physician to discuss the denial with the reviewer. This applies only to denials due to a lack of medical necessity, not to denials due to benefits being excluded in the patient's contract (cosmetic procedures, for example). Medicare defines *medically necessary* services or supplies as those that are proper and needed for the diagnosis or treatment of the patient's medical condition, meet the standards of good medical practice in the local area and are not mainly for convenience.

Health plans are required to inform their members of services that are excluded and, therefore, not covered; however, not all members read this information until they receive a denial letter from their health plan. Physicians also usually learn about the excluded

Health plans use precertification, denials and appeals to encourage patients and physicians to make cost-effective decisions and abide by the plan's rules.

To ease the precertification process, familiarize yourself with the clinical guidelines that your health plans use and submit clear documentation.

Denials can sometimes be avoided with proper diagnosis coding and documentation of medical necessity.

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## SEARCHING THE MEDICARE COVERAGE DATABASE

To find out the circumstances under which Medicare will cover a specific service, you can search a database of Medicare's National Coverage Determinations at [http://www.cms.hhs.gov/mcd/index\\_list.asp?list\\_type=ncd](http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd). For example, under "Glycated Hemoglobin/Glycated Protein," Medicare states that A1C measurement "may be medically necessary every three months to determine whether a patient's metabolic control has been on average within the target range. More frequent assessments, every one to two months, may be appropriate in the patient whose diabetes regimen has been altered to improve control or in whom evidence is present that intercurrent events may have altered a previously satisfactory level of control (for example, post-major surgery or as a result of glucocorticoid therapy)." The page also links you to a list of covered codes, including diagnosis codes that can be used to support the medical necessity of this service.

Coverage information is also available in the *Medicare National Coverage Determinations Coding Policy Manual and Change Report*, which can be downloaded at <http://www.cms.hhs.gov/CoverageGenInfo/downloads/manual2.pdf#10>.

benefits when they receive the denial letter after the services have been provided.

### Denial tips:

- Don't underestimate the value of proper coding. Accurate coding decreases your denial rates. For example, submitting a claim for an A1C to Medicare without a diagnosis code such as 250.02 (diabetes mellitus, type II or unspecified type, without complications, uncontrolled) to support medical necessity would probably result in a denial. (To find out what codes Medicare will cover for a particular service, see "Searching the Medicare coverage database," above.)

- Document the medical necessity of services, particularly if they could be perceived as elective or cosmetic. For example, a skin tag excision without documentation of pain, bleeding, irritation or other evidence of medical necessity could easily result in a denial.

- Clearly document and explain any deviation from evidence-based guidelines. For example, I know of a physician who once spent half an hour on the phone arguing with an HMO about a denial for a screening flexible sigmoidoscopy he performed on a 45-year-old patient. Had he simply mentioned on the prior authorization form or the clinical note he submitted to the HMO that the patient's family history included colon cancer in a first-degree relative at age 40, the denial could have been prevented.

- Find out which of your most common services are usually excluded by health plans. Many health plans do not cover services such as employment, sports, immigration and insurance physicals. Most do, however, pay for routine physicals for health maintenance. Encourage your patients to become familiar with their health plan's exclusions as well. You can view a sample list of exclusions at <http://www.aafp.org/fpm/20060600/45prec.html>.

- Don't assume that because a particular HMO paid for a service for one patient it will do the same

for all patients. Some services, such as chiropractic care and bariatric surgery, are supplemental benefits included only in the health plans of employers who purchased them in addition to basic health care coverage. So patients who belong to the same HMO but work for different companies may have different benefits. Each state has a list of basic services that health plans must cover, but employers may opt out of certain nonmandatory services to reduce their medical expenses.

- Inform patients up front that experimental or investigational interventions could be denied. Of course this doesn't mean you cannot provide these interventions; it simply means the health plan is unlikely to cover them. This includes any treatment, procedure, facility, equipment, drug, service or supply not generally and widely accepted in the practice of medicine in the United States and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the United States. For example, even an authorization request for a drug currently in phase-2 clinical trials for the treatment of obesity would probably be denied by most health plans because it would be considered experimental.

### Appeals

Whether a denial is based on medical necessity or benefit limitations, patients or their authorized representatives (such as their treating physicians) can appeal to health plans to reverse adverse decisions. In most cases, patients have up to 180 days from the service denial date to file an appeal. Health plans are required to notify their members of their appeal rights; however, many patients aren't aware of these rights or how effective the process can be. A study by the New York State Insurance Department found that of more than 10,000 decisions appealed in 2004 against

# Physicians should know all the facts about a denial before agreeing to help with the appeal.

16 HMOs, 39 percent were reversed.<sup>2</sup>

While patients often ask their physicians to file an appeal on their behalf, physician involvement does not necessarily improve the outcome. It makes sense for physicians to help their patients when they disagree with a health plan's decision. However, because the appeals process can be time consuming, physicians should know all the facts about a denial (particularly the reason for the denial) before agreeing to help with the appeal. Denials that result from the fact that a service isn't a benefit covered in the patient's contract with the health plan are rarely reversed when appealed. Because many patients do not know what is in their contract, the physician may want to review the patient's contract (usually the summary of benefits) before deciding whether to get involved.

In some situations, physicians do have an obligation to file an appeal on the patient's behalf. For example, if a physician directed a patient to the emergency department for an acute problem because the practice could not fit the patient in on a Friday afternoon, the practice bears some of the responsibility if the service is denied.

Appeals are classified as either pre-service appeals (for services not yet provided), post-service appeals (for services already provided) or expedited appeals (for services thought to be urgent, based on either the physician's judgment or a prudent layperson's judgment). If the health plan agrees to expedite an appeal, it must make a decision within 72 hours of the request.

## Appeal tips:

- Don't be afraid to appeal a decision. In many cases, a phone call to the health plan's medical director with additional information can change the outcome in your patient's favor.
- Before you embark on what can be a time-consuming process, make sure the service you are appealing is not one the patient's health

plan contract specifically excludes.

- Know the levels of appeal available for each health plan and the time frame for each level. It varies from state to state, but most states have three levels – two internal and one external.

- Try to stay calm, even though the appeals process can be frustrating. The process is intended to provide a fair method for resolving patients' disputes. Threatening to sue the health plan or yelling at the medical director usually does not help the outcome of the appeal.

- Keep a log organized by health plan of all the denials that occur for six to 12 months. Then analyze the data looking for trends. If a service is being denied by most health plans, you may have a systems problem such as improper coding practices. If the denial is coming from only one health plan, contact the plan and find out what their coverage position is on that particular procedure or drug. Large health plans usually have their coverage positions posted on their Web sites and offer provider portals, which you can use not only to check a claim's status but also to check your patients' benefits and communicate with the plan by e-mail.

## More time for patients

While utilization management isn't going away any time soon, its hassles can be minimized. By following the tips provided in this article, you can reduce the time you spend on utilization management and get back to your most important job: caring for patients. **FPM**

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

1. Utilization Review Accreditation Commission. *Trends and Practices in Medical Management: 2005 Industry Profile*. Available at: [http://www.urac.org/documents/URAC\\_MMRReport\\_2005.pdf](http://www.urac.org/documents/URAC_MMRReport_2005.pdf). Accessed April 26, 2006.

2. State of New York Department of Insurance. *2005 New York Consumer Guide to Health Insurers*. Available at: <http://www.ins.state.ny.us/acrobat/hg2005.pdf>. Accessed April 26, 2006.

■ One study found that 39 percent of appealed decisions were reversed.

■ Appeals that involve services specifically excluded by a health plan are rarely successful and probably not worth the physician's involvement.

■ Keeping a log of health plan denials can help you identify whether your practice has a systems or coding problem or whether a particular health plan's policy is problematic.