Behavioral Health Services
State Quality Committee

AGGREGATE ANALYSIS REPORT
PROVIDER DENIALS AND APPEALS

Final

Reporting Period **FROM:** July 1, 2014 **TO:** June 30, 2015
***FY 2015 Annual Summary**

Unit/Team/Department:
PIHP Quality Improvement

Topic/Project:
Provider Denials and Appeals
#9 Appeals Report

Monitoring Standard:
42 CFR 438.240 Quality Assessment and Performance Improvement Program
42 CFR 438.402 General requirements
42 CFR 438.404 Notice of Action
42 CFR 438.408 Resolution and notification
42 CFR 438.420 Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending
42 CFR 438.280 Effectuation of reversed appeals resolutions
42 CFR 438.420 Continuation of benefits while the MCO or PIHP appeal and the State Fair Hearing are pending
42 CFR 438.424 Effectuation of reversed appeal resolutions

Goal:
The ASO will track and report semi-annually to KDADS/BHS all provider denials and appeals that have occurred in a given timeframe including timeline compliance. The standards are:

- Standard for Denial letter notification:
  - Treatment modality Level I, II, and all others except Level III: Denial letters must be sent within 14 days of the determination (100%)
  - Treatment modality Level III: Denial letters must be sent within 3 days of the determination (100%)
- Appeals:
  - 95% resolved within 14 days receipt of all required documentation
  - 100% resolved within 45 calendar days

Objectives:
To assure the documentation is capturing both clinical (medical necessity) and administrative denials and appeals from providers
To evaluate for trends that may require system intervention or education
To allow data to be presented consistently for Committee evaluation and response

Data Collection Activities:
Data was collected from ValueOptions CareConnect System. Denials and Appeals reporting will be provided by overall state figures, regional data and by detail. Denials and Appeals are categorized as administrative and medical necessity. Reporting will also include State Fair Hearing data.

Definitions of Administrative and Medical Necessity denials:

Administrative Denial (or "Administrative Determination") – A denial of services, or claims payment for services, based on reasons other than a lack of medical necessity. Examples of administrative denials include the provider is not licensed to provide the service requested, the member is AAPS eligible but the service requested is only available to Medicaid recipients, or the continued stay review (CSR) was submitted late.

Medical Necessity Denial- A denial of services or claims payment for services based on a review of clinical criteria (ASAM) compared to documentation provided. Only a physician who is certified by ASAM or a psychologist/psychiatrist with extensive demonstrated substance abuse experience shall make decisions not to fully authorize a request for service based on medical necessity.

*More data available in Attachment A at the end of this report.

Results: See Next Page

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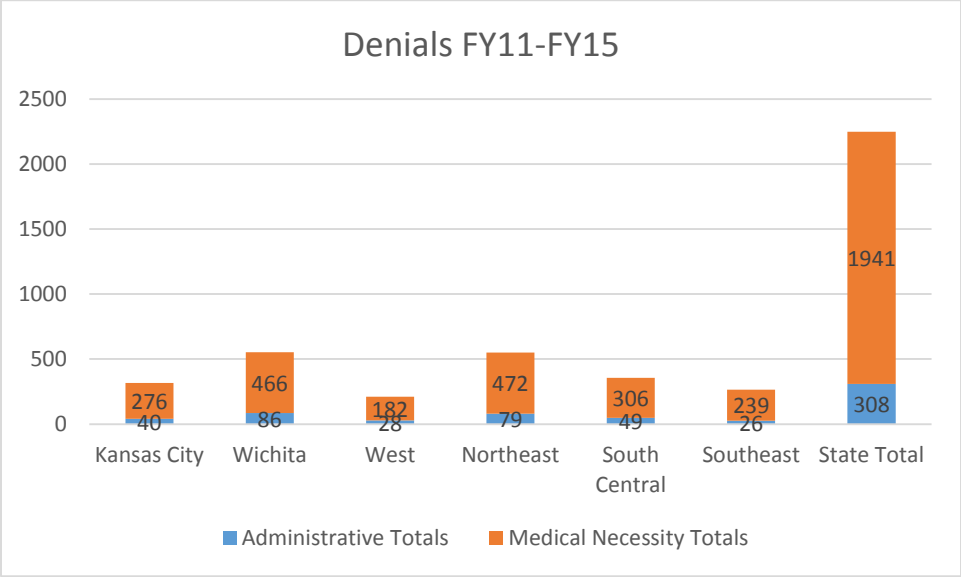
	5 year Administrative Totals	5 year Medical Necessity Totals		Yearly Administrative Denials					Yearly Medical Necessity Denials				
				FY11	FY12	FY13	FY14	FY15	FY11	FY12	FY13	FY14	FY15
Kansas City	40	276		21	8	4	1	6	72	92	47	35	30
Wichita	86	466		47	25	5	3	6	135	174	71	55	31
West	28	182		14	3	2	2	7	72	46	24	26	14
Northeast	79	472		31	26	0	4	18	112	152	108	62	38
South Central	49	306		27	9	4	2	7	84	117	56	30	19
Southeast	26	239		12	7	4	1	2	63	77	50	30	19
5 year Total	308	1941		152	78	19	13	46	538	658	356	238	151



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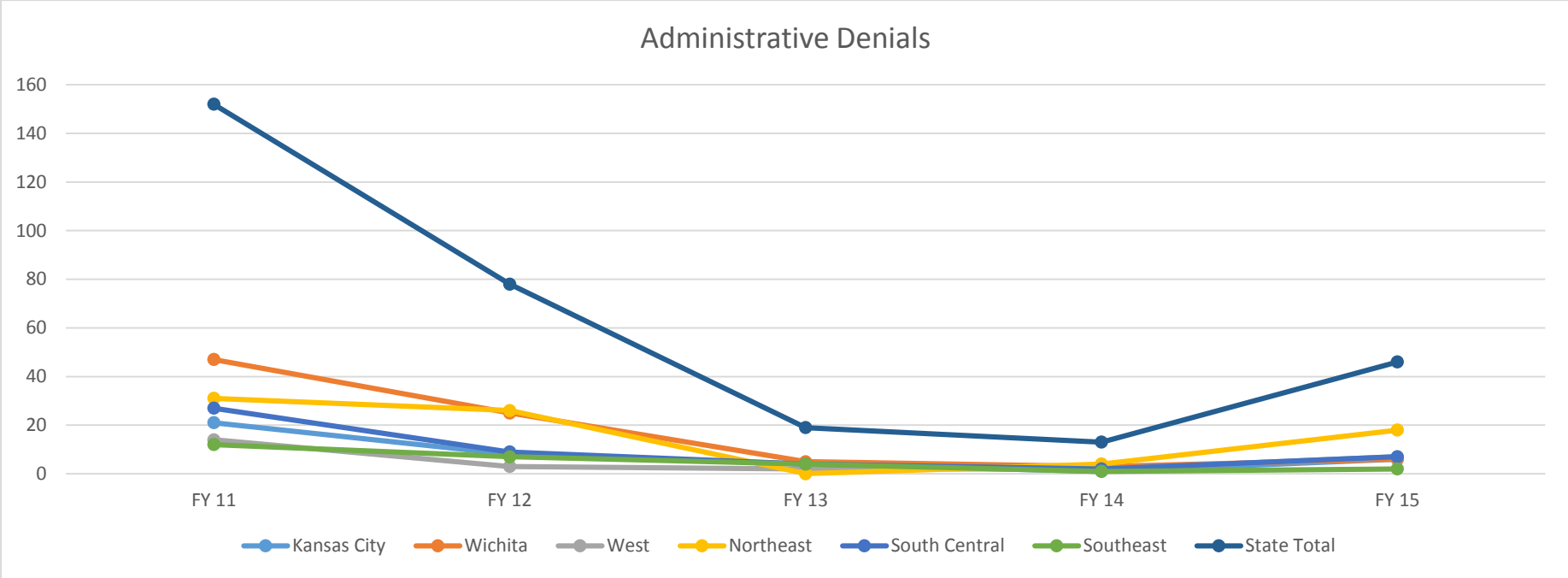
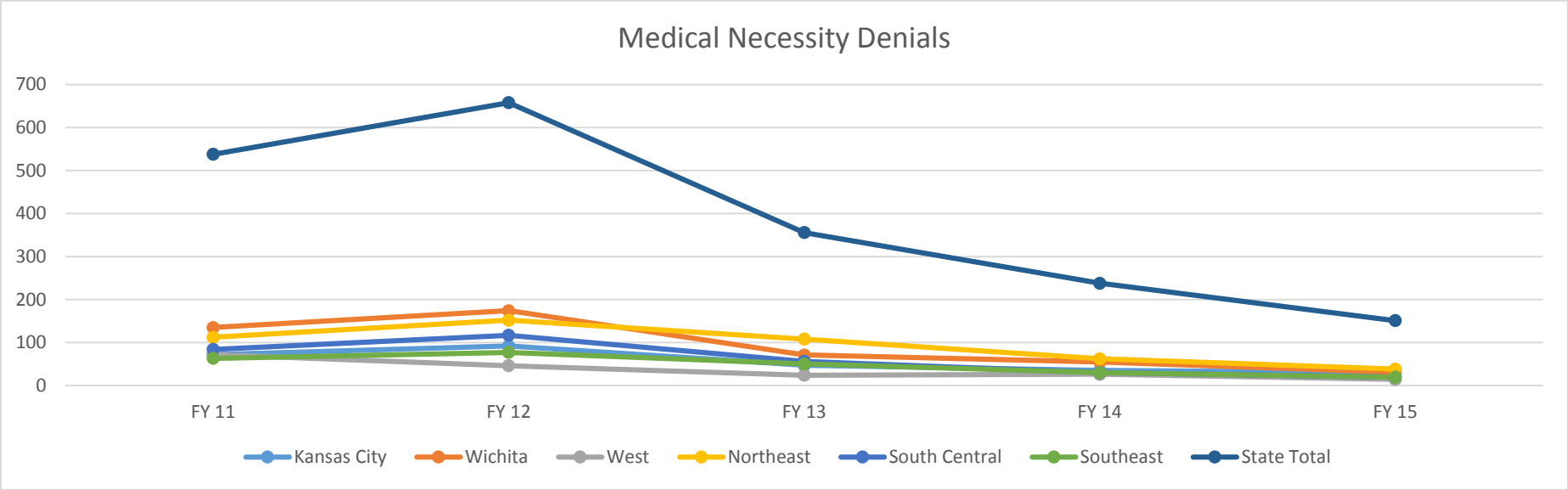
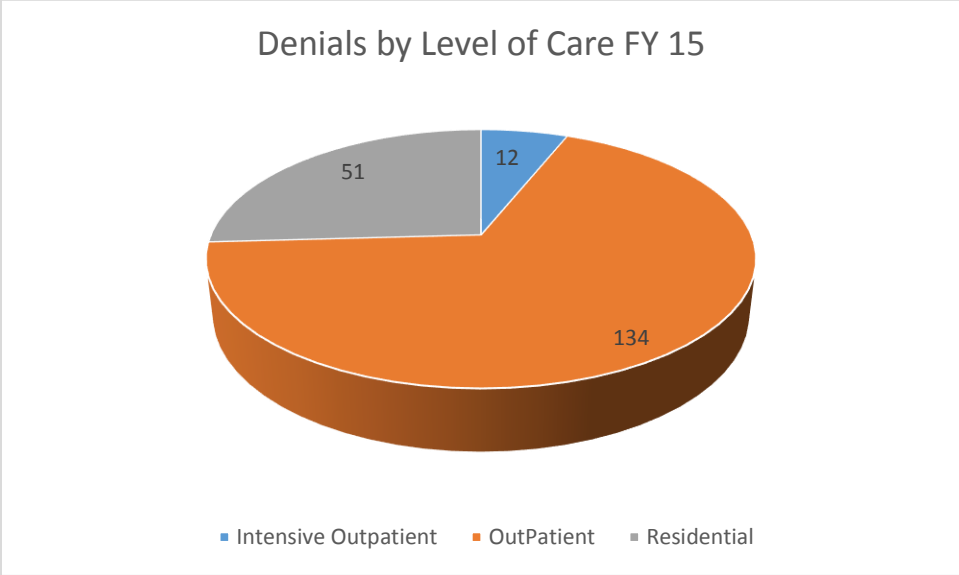



Medical Necessity Denials
700
600
500
400
300
200
100
0
FY 11
FY 12
FY 13
FY 14
FY 15
Kansas City
Wichita
West
Northeast
South Central
Southeast
State Total


Denials by Level of Care FY 15
51
12
134
Intensive Outpatient
OutPatient
Residential

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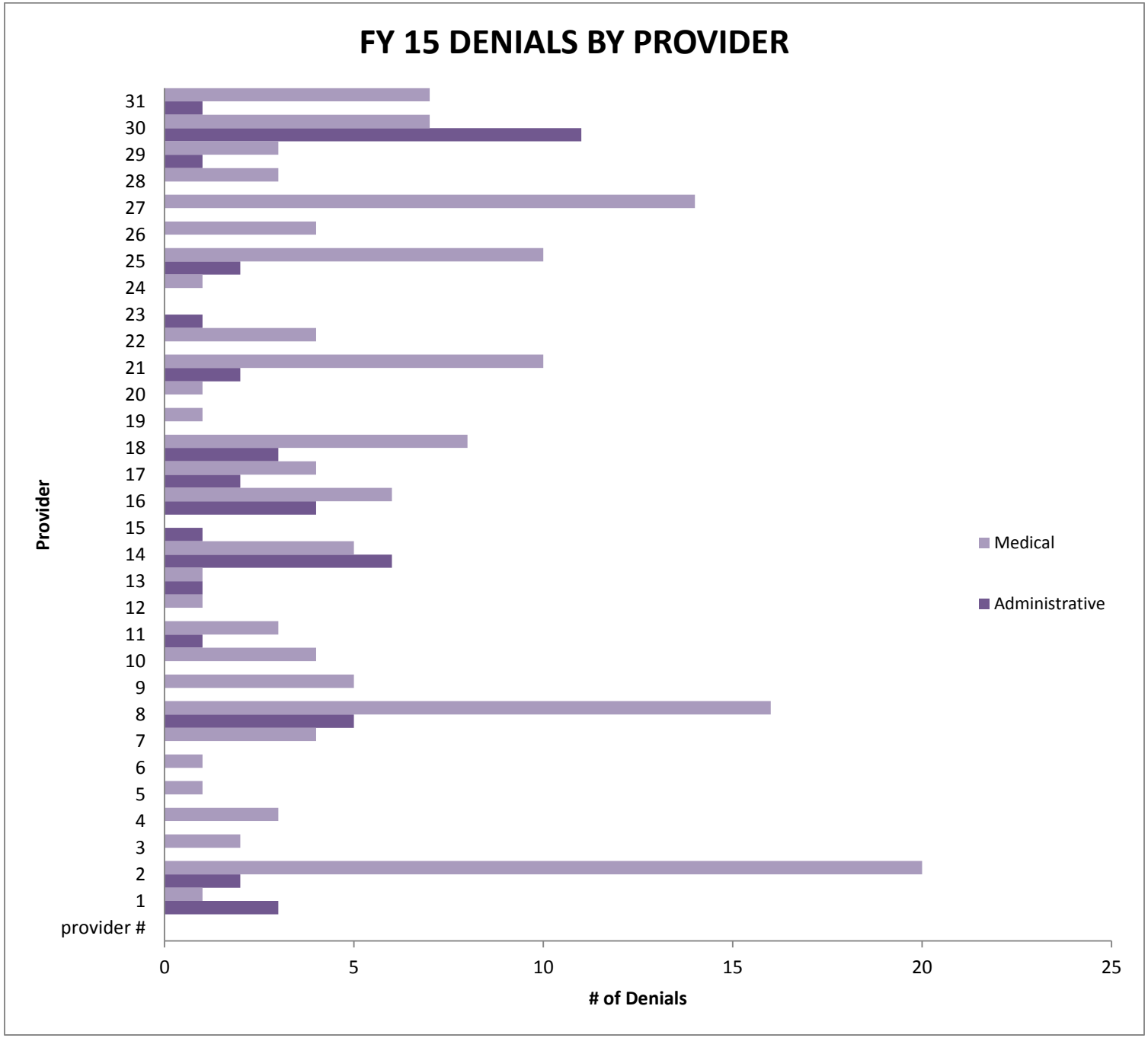


Denials Annual Summary FY15 (7/1/14 – 6/30/15):

- There were 197 denials reported in FY15. There were a total of 251 denials for FY14. That is almost a 21% reduction in denials from FY14 to FY15.
- Mid way into FY13 VO discontinued oversight of Medicaid which corresponds with the reduction in denials from FY12 to FY13.
  - Most denials in FY15 were for Medical Necessity (76.6%).
  - Denials for Administrative reasons increased 72% in FY15. There was a surge in denials for timeliness in both Jan and Feb of 2015.
  - Denials for Medical Necessity have decreased by about 1/3 for the last two FY's: decreasing 33% in FY14 and then decreasing another 37% in FY15.
  - 68% of the Denials in FY15 were for Outpatient treatment. This is a decrease from 74% in FY14.
  - 6% of denials in FY15 were for Intensive Outpatient and 26% were for Residential.
  - 70% of the current BG contract providers received no denials in FY 15.
  - Of those providers who received a denial, the statewide average denial, per provider, for FY15 is 2/year. This is a decrease from an average of 7/year in FY14.
  - There are 6 providers with 50% of the denials for the state. These 6 providers averaged 16.5 denials for FY15. This is a decrease from averaging 25 denials/year in FY14.

Provider	**# of denials**	**FY15 Level of Care(FY14)**
#2	FY14: 44 FY15: 22	15=OP (34) 4=RES (10) 3=IOP (0)
#8	FY14: 26 FY15: 21	12=OP (19) 8=RES (6) 1=IOP (1)
#18	FY14: 9 FY15: 18	3=OP (8) 15=RES (1)
#27	FY14: 19 FY15: 14	11=OP (12) 2=RES (6) 1=IOP (1)
#21 **#25**	FY14:20 FY15:12 FY14: 05 FY15: 12	12=OP (20) 12=OP (5)

Appeals Annual Summary FY15 (7/1/14-6/30/15):

	FY11	FY12	FY13	FY14	FY15		Total
Administrative	**19**	**15**	**1**	**5**	**2**		**42**
Medical Necessity	**29**	**44**	**11**	**5**	**5**		**94**
Total	**48**	**59**	**12**	**10**	**7**		**136**

- There were no requests for State Fair Hearings initiated in FY15.

Appeals:

- There were 7 appeals in FY15. 2 for Administrative reasons and 5 for Medical Need reasons.
    - 4 appeals were upheld and 3 appeals were overturned.
    - 43% chance of having a denial overturned.
    - 30% reduction in appeals from FY14 to FY15.

Standards:

- Standard for Denial letter notification:
    - Level III: All of the Level III denial letters met the timeframe (100%), therefore, met standard.
    - Other Denials (Level I and II): All other denial letters met the timeframe (100%), therefore, met standard.

- Appeals:
    - Appeal time frames were met at 100%, and therefore, met standard for both.

Conclusions:

- This data suggests the following may be needed:
    - Exploring cause of increase in denials which occurred at the first of the calendar year. Be mindful of any future tendency to increase during this time period.
    - Focused training for select programs on documenting medical necessity for the Outpatient modality

- Most Outpatient Denials are for:
  - No use
  - Minimal use
  - Minimal use pattern or use history
- Continued collaboration and communication with courts which require licensed clinicians to recommend treatment, even though the payer will deny the medical necessity of the recommendation. Education regarding the unneeded costs to both client and system.
- Consider adding 3rd category of denial to capture those assessments that are denied due to being referred to another funding source. I.e.: Provider using denial to access other funding like liquor tax dollars.
- Encourage programs to appeal a denial when/if there is an increase or miscommunication in a member's use pattern/history, may result in overturn of denial.

Preliminary Recommendations to Committee:

- Approval by the Committee is requested to post this aggregate analysis on the ValueOptions website for public access.

Date Presented to SQC: 4/29/2016 **BY:** Sheri Jurad

ATTACHMENT A: DATA

BHS Appeals

Reporting Period: July 1, 2014 through June 30, 2015

Funding Source	Number of Denials	Number of Appeals	Upheld	Overturned
BHS Block Grant	197	7	4	3
Total	197	7	4	3

Total Number of Denials Received in this Reporting Period:	197
Percentage of Level 3 Denial letters sent within 3 days:	100%
Percentage of Denial letters sent within 14 days:	100%
Total Number of Appeals Received in this Reporting Period:	7
Percentage of appeals resolved within 14 days:	100%
Percentage of appeals resolved within 45 days:	100%

No denials or appeals were requested to be expedited during this reporting period.

**This summary report only includes appeals submitted in this reporting period. The appeals which are pending for internal reviews or Fair Hearings are carried over and reported in the detailed reports under appropriate funding sources.

ATTESTATION:
I attest, based on my best knowledge, information and belief that the data and/or documents pertaining to Medicaid and the SAPT block grant comprising this report as of the date of

Brian J Barber

Engagement Center VP, ValueOptions-Kansas, 3/10/2016

Behavioral Health Services
State Quality Committee

BHS APPEALS BY REGION

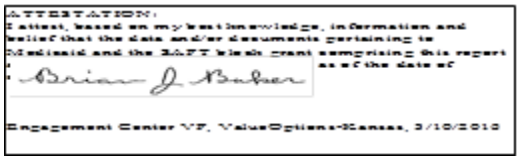
Reporting Period: July 1, 2014 through June 30, 2015

Region*	DENIALS		APPEALS		RESULTS	
	Administrative	Medical Necessity	Administrative	Medical Necessity	Upheld	Overturned
Kansas City	6	30	0	0	0	0
Wichita	6	31	0	2	1	1
West	7	14	0	0	0	0
Northeast	18	38	1	0	1	0
South Central	7	19	1	2	2	1
Southeast	2	19	0	1	0	1
Total	46	151	2	5	4	3

Total number of BHS Denials received within this reporting period:	197
Percentage of Denial letters sent within 3 days for residential or higher:	100%
Percentage of Denial letters sent within 14 days:	100%
Total number of BHS Appeals received within this reporting period:	7
Percentage of Appeals sent within 14 days:	100%
Percentage of Appeals sent within 45 days:	100%

There were no requests for a State Fair Hearing during this quarter.

**This summary report only includes appeals submitted in this reporting period. The appeals which are pending for internal reviews or Fair Hearings are carried over and reported in the detailed reports under appropriate funding sources.


ATTESTATION:
I attest, based on my best knowledge, information and belief that the data and/or documents pertaining to Medicaid and the SAFT block grant comprising this report are complete as of the date of
Brian J Barber
Engagement Center VP, ValueOptions-Kansas, 3/10/2016