Behavioral Health Services
State Quality Committee

AGGREGATE ANALYSIS REPORT
PROVIDER DENIALS AND APPEALS

Final

Reporting Period **FROM:** July 1, 2013 **TO:** June 30, 2014
***FY 2014 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 eligible for BG funding but the service requested is only available to Medicaid recipients, or the continued stay review (CSR) was submitted late.

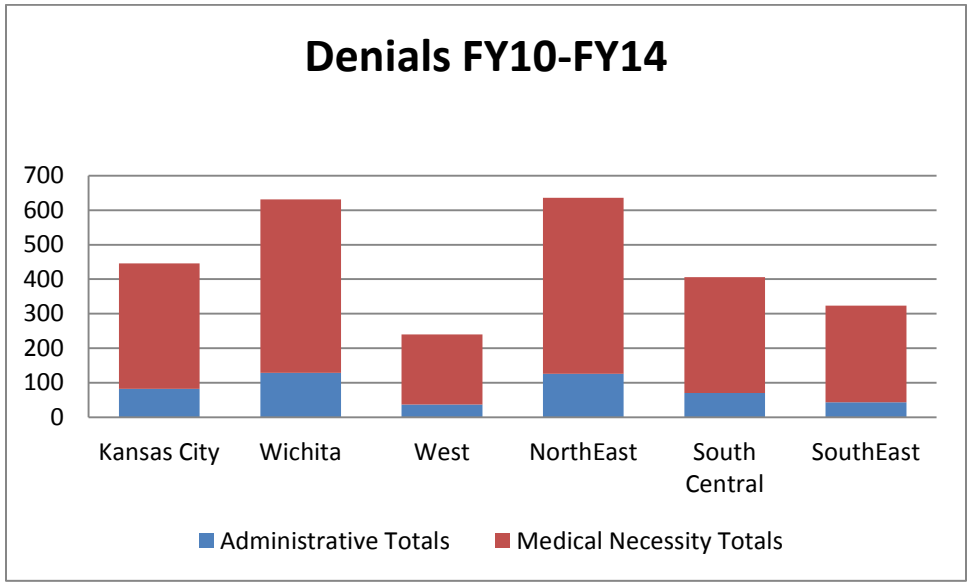
Medical Necessity Denial- A denial of services or claims payment for services based on a review of clinical criteria (ASAM) compared to documentation provided. Only a physician who is certified by ASAM or a psychologist/psychiatrist with extensive demonstrated substance abuse experience shall make decisions 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

Behavioral Health Services
State Quality Committee

	5 year Administrative Totals	5 year Medical Necessity Totals		Yearly Administrative Denials					Yearly Medical Necessity Denials				
				FY10	FY11	FY12	FY13	FY14	FY10	FY11	FY12	FY13	FY14
Kansas City	82	364		48	21	8	4	1	118	72	92	47	35
Wichita	129	502		49	47	25	5	3	67	135	174	71	55
West	37	203		16	14	3	2	2	35	72	46	24	26
Northeast	126	510		65	31	26	0	4	76	112	152	108	62
South Central	70	336		28	27	9	4	2	49	84	117	56	30
Southeast	43	280		19	12	7	4	1	60	63	77	50	30
5 year Total	487	2195		225	152	78	19	13	405	538	658	356	238



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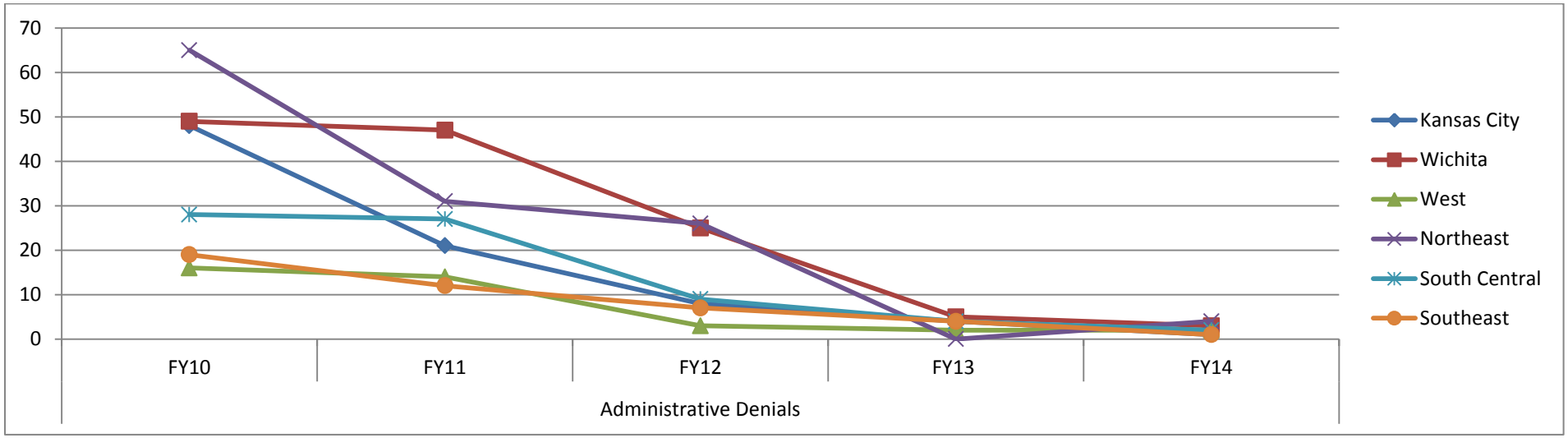

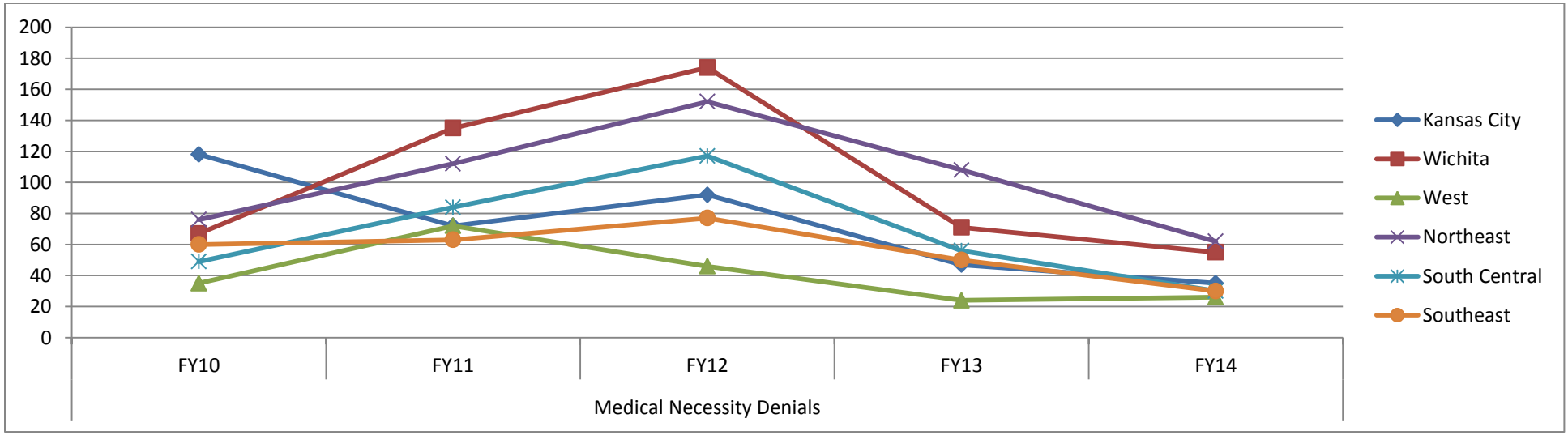

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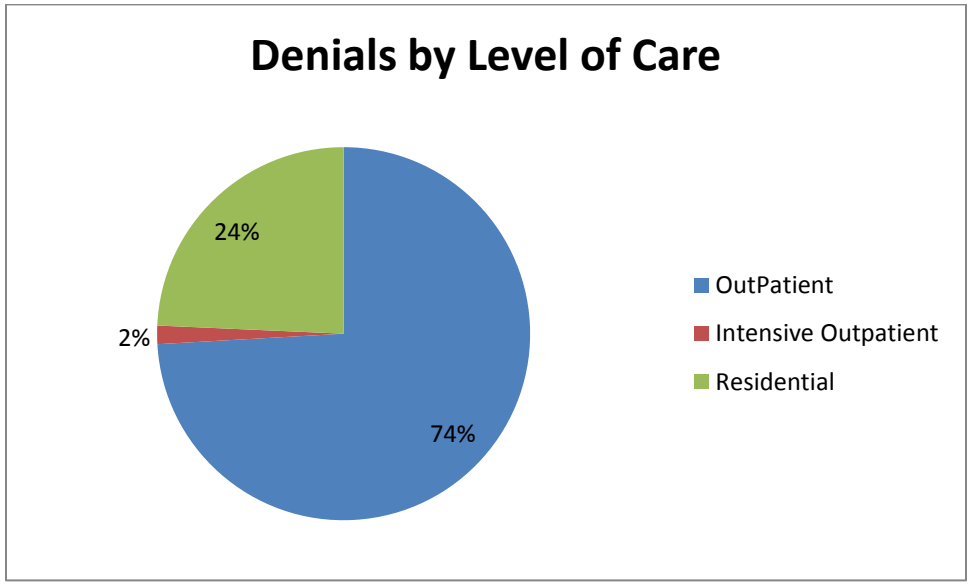

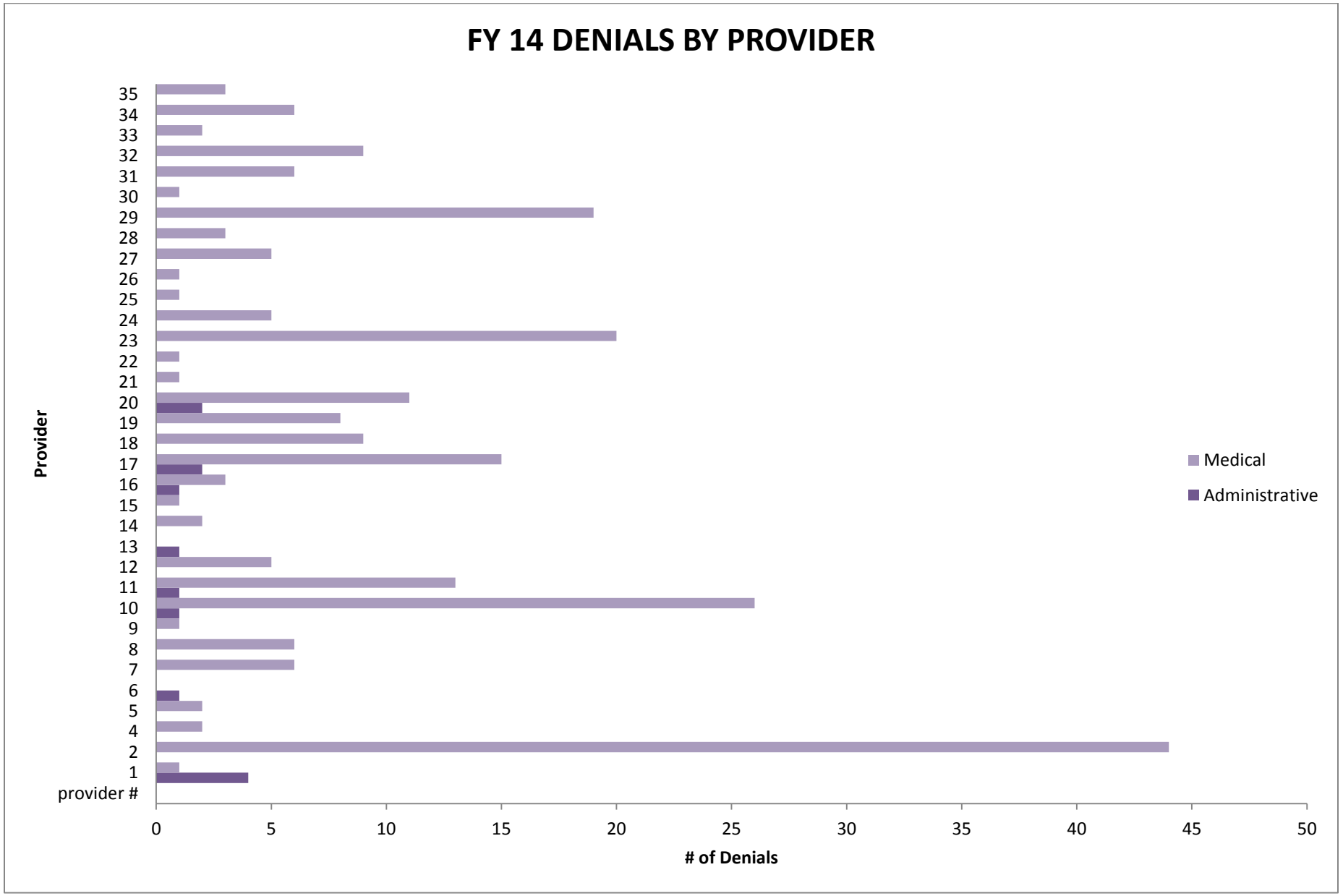
FY 14 DENIALS BY PROVIDER
Provider
35
34
33
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
2
1
provider #
0
5
10
15
20
25
30
35
40
45
50
# of Denials
Medical
Administrative

Annual FY Summary Provider Appeal Data:

	FY10	FY11	FY12	FY13	FY14		Total
Administrative	**37**	**19**	**15**	**1**	**5**		**77**
Medical Necessity	**27**	**29**	**44**	**11**	**5**		**116**
Total	**64**	**48**	**59**	**12**	**10**		**193**

- There have been no requests for State Fair Hearings initiated so far in FY14.

Conclusions:

Annual Summary FY14 (7/1/13 – 6/30/14):

Denials:

- There were 251 denials reported in FY14. There were a total of 375 denials for FY13. That is almost a 1/3 (33%) reduction in denials from FY13 to FY14.
- Mid way into FY13 VO discontinued oversight of Medicaid which corresponds with the reduction in denials.
  - Most denials are for Medical Necessity (94.8%)
  - Denials for Administrative reasons dropped 31%
  - Denials for Medical Necessity, overall, have decreased 33%
  - 74% of the Denials this Fiscal year were for Outpatient treatment. This is a slight increase from 73% in FY13
  - Statewide average denials, per provider, for FY14 is 7/year
  - There are 5 providers with 49.4% of the denials for the state. These 5 providers average 25 denials/year

Provider	# of denials	Level of Care
#2	44	34=OP 10=LEVEL 3
#10	26	19-OP 6=LEVEL 3 1=IOP
#23	20	20=OP
#29	19	12=OP 6=LEVEL 3 1=IOP
#17	15	5=OP 10=LEVEL 3

  - This data suggests the following may be needed:
    - 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

- Review denials for select programs to find trends i.e.: same clinician, reason for denial, need for training, court requirements, etc.
- Consider adding 3rd category of denial to capture assessments that are denied in order to be referred to another funding source. I.e.: Provider using denial to access other funding like liquor tax dollars. Collaboration and communication with courts that are requiring denials to access their funding. Education regarding the unneeded costs to both client and system.

Appeals:

- There were 10 appeals in FY14. 5 for Administrative reasons and 5 for Medical Need reasons.
    - 6 appeals were upheld and 4 appeals were overturned.
    - 40% chance of having a denial overturned.
    - 16% reduction in appeals from FY14 to FY13.

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.

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: 4/17/2015 **BY:** Sheri Jurad

Behavioral Health Services
State Quality Committee

ATTACHMENT A: DATA

Appeals by Funding

Date of Submission:
Reporting Period: July 1, 2013 through June 30, 2014

Funding Source	Number of Denials	Number of Appeals	Upheld	Overturned
BHS	251	10	6	4
Total	251	10	6	4

Total Number of Denials Received in this Reporting Period: 251
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: 10
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 are accurate, complete, and truthful, as of the date of submission.

Brian J Baber

Engagement Center VP, ValueOptions-Kansas, 10/15/2014

Behavioral Health Services
State Quality Committee

BHS APPEALS BY REGION

Reporting Period: July 1, 2013 through June 30, 2014

	DENIALS		APPEALS		RESULTS	
Region*	Administrative	Medical Necessity	Administrative	Medical Necessity	Upheld	Overturned
Kansas City	1	35	0	2	1	1
Wichita	3	55	2	1	2	1
West	2	26	1	1	2	0
Northeast	4	62	1	0	1	0
South Central	2	30	1	1	0	2
Southeast	1	30	0	0	0	0
Total	13	238	5	5	6	4

Total number of BHS Denials received within this reporting period: 251
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: 10
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 SAPT block grant comprising this report are accurate, complete, and truthful, as of the date of submission.

Brian J Baker

Engagement Center VP, ValueOptions-Kansas, 10/15/2014