Behavioral Health Services
State Quality Committee

AGGREGATE ANALYSIS REPORT
PROVIDER DENIALS AND APPEALS

Final

Reporting Period **FROM:** January 1, 2015 **TO:** June 30, 2015
***FY 2015 Mid-Year Review**

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.

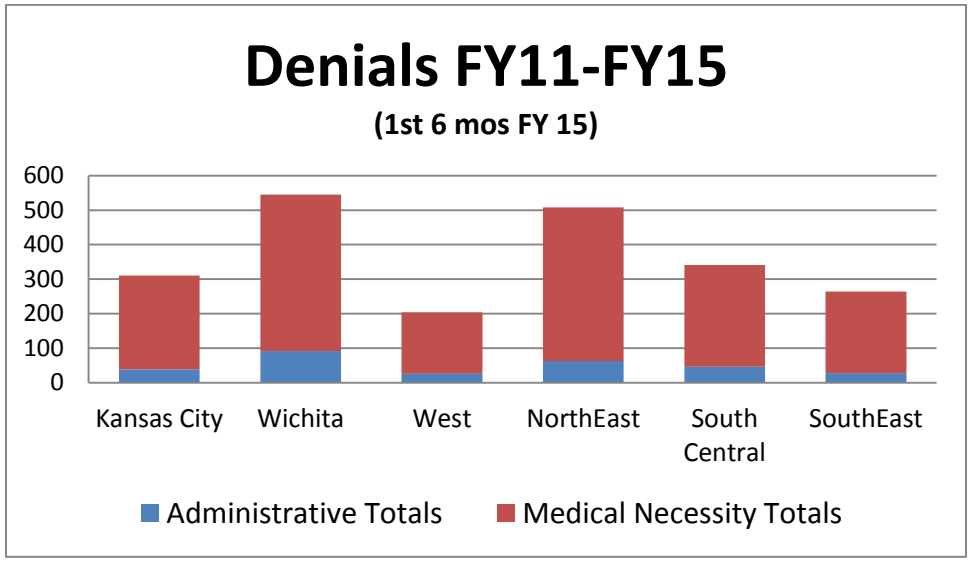
Medical Necessity Denial- A denial of services or claims payment for services based on a review of clinical criteria (ASAM) compared to documentation provided. Only a physician who is certified by ASAM or a psychologist/psychiatrist with extensive demonstrated substance abuse experience shall make decisions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

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

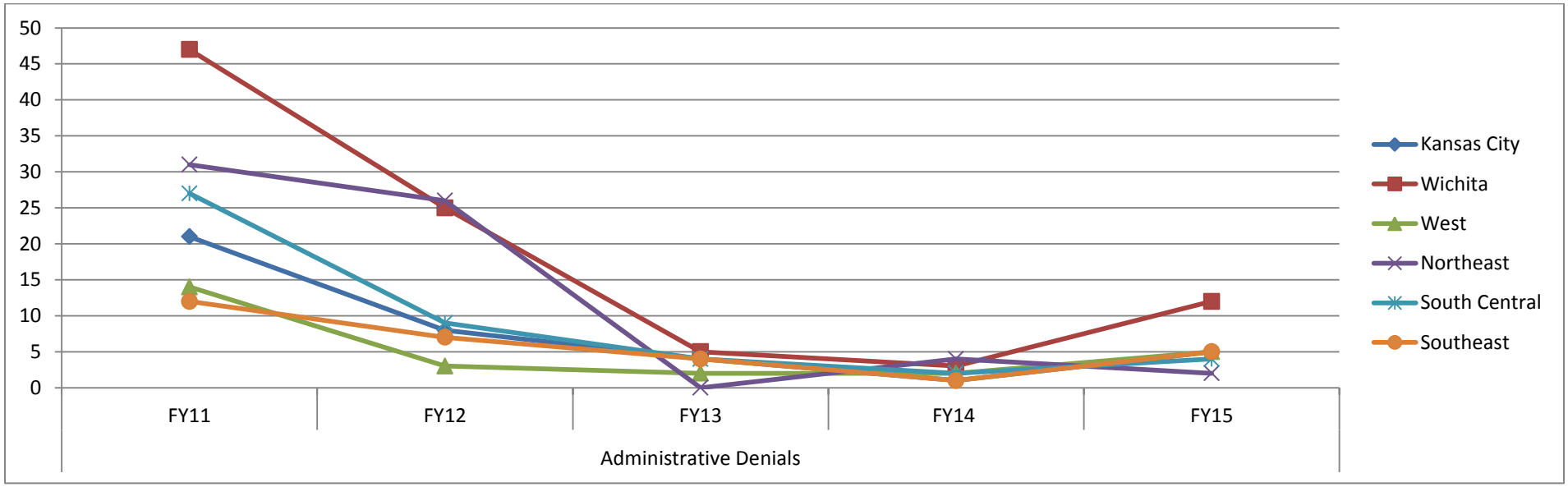
Results: See Next Page

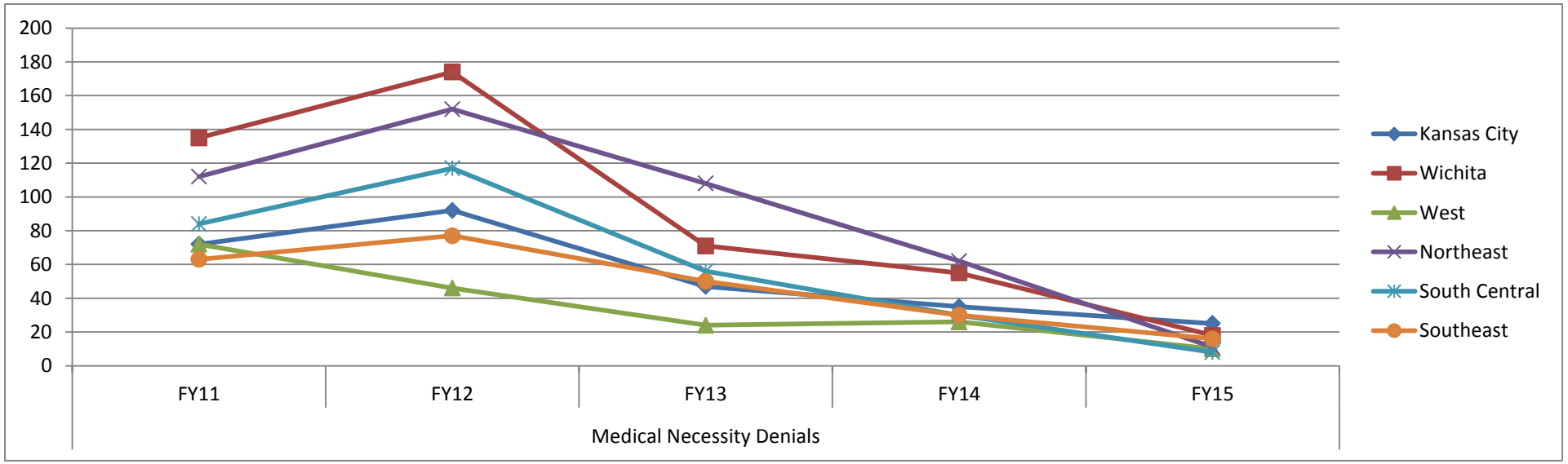
Behavioral Health Services
State Quality Committee

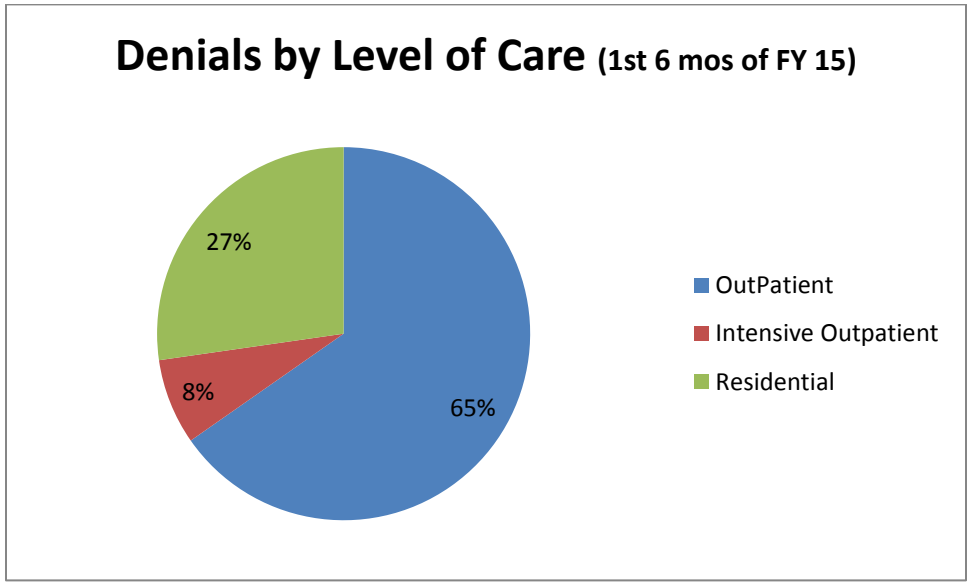
	5 year Administrative Totals	5 year Medical Necessity Totals		Yearly Administrative Denials					Yearly Medical Necessity Denials				
	*includes only 1st ½ of 2015	*includes only 1st ½ of 2015		FY11	FY12	FY13	FY14	FY15 (first 6 months)	FY11	FY12	FY13	FY14	FY15 (first 6 months)
Kansas City	39	271		21	8	4	1	5	72	92	47	35	25
Wichita	92	453		47	25	5	3	12	135	174	71	55	18
West	26	178		14	3	2	2	5	72	46	24	26	10
Northeast	63	445		31	26	0	4	2	112	152	108	62	11
South Central	46	295		27	9	4	2	4	84	117	56	30	8
Southeast	28	236		12	7	4	1	5	63	77	50	30	16
5 year Total	294	1878		152	78	19	13	33	538	658	356	238	88

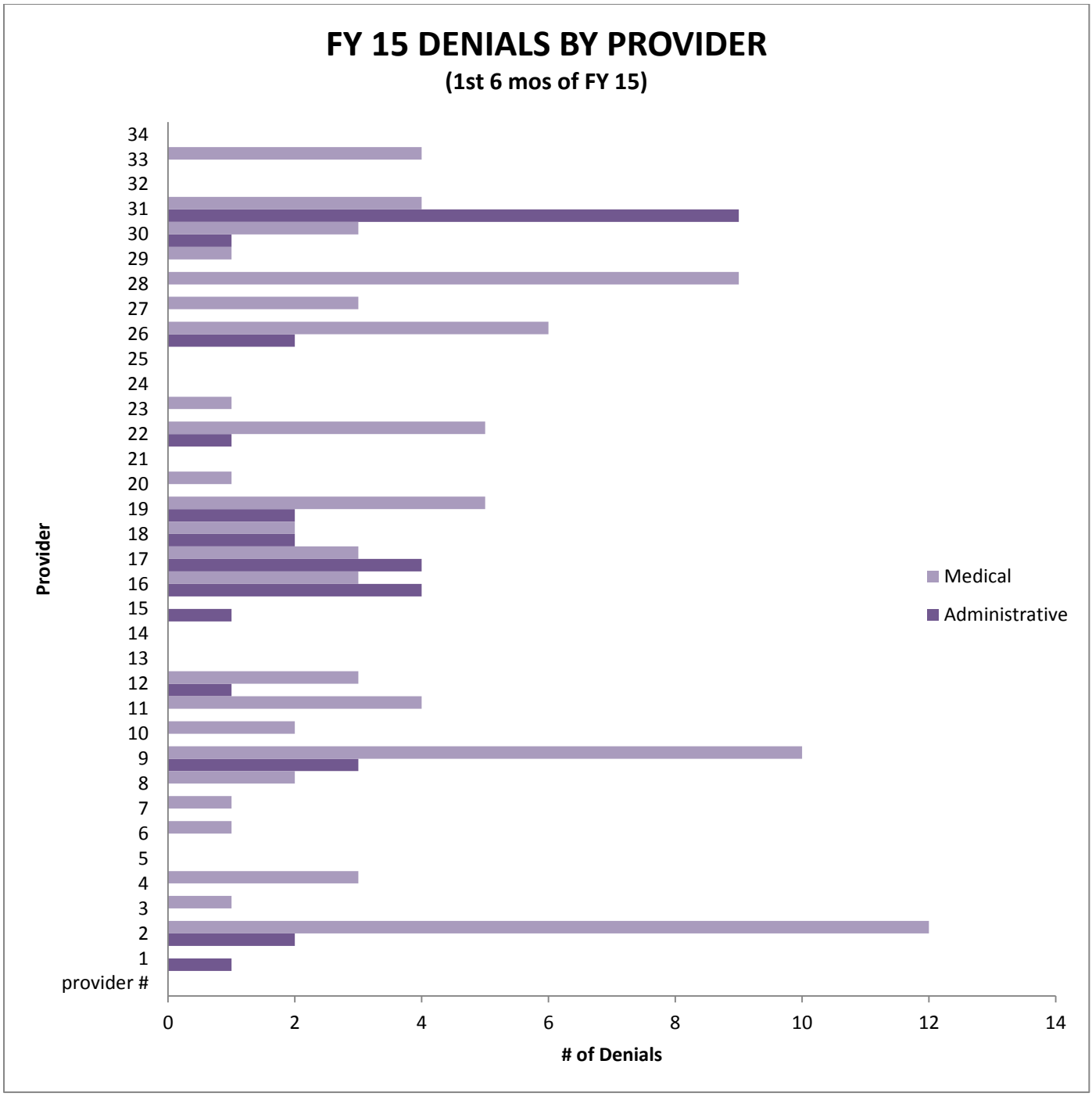


Behavioral Health Services
State Quality Committee






Denials by Level of Care (1st 6 mos of FY 15)
27%
8%
65%
OutPatient
Intensive Outpatient
Residential


FY 15 DENIALS BY PROVIDER
(1st 6 mos of FY 15)
Provider
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
3
2
1
provider #
0
2
4
6
8
10
12
14
# of Denials
Medical
Administrative

Annual FY Summary Provider Appeal Data:

	FY11	FY12	FY13	FY14	FY15		Total
Administrative	**19**	**15**	**1**	**5**	**2**		**42**
Medical Necessity	**29**	**44**	**11**	**5**	**4**		**93**
Total	**48**	**59**	**12**	**10**	**6**		**135**

- There have been no requests for State Fair Hearings initiated so far in FY15.

Conclusions:
Mid-Year Summary FY15 (1/1/15 – 6/30/15):
Denials:

- There have been 121 denials reported in the first half of FY15. There were a total of 351 denials for FY14. If this trend continues in FY15 we are on track to reduce denials by about 1/3 in FY15. (121= 33% less than 351.)
  - Most denials are for Medical Necessity (72.72% so far this year)
  - Denials for Medical Necessity have steadily declined in the last 3 years. There have been 83.55% fewer denials in 2015 than in 2012.
  - Denials for Administrative reasons, in all regions but South Central, have increased, so far, in 2015 compared to FY14.
  - 65% of the Denials, so far this year, have been for Outpatient treatment. This is a 14% decrease from FY 14. 8% of denials, so far this year, have been for Intensive Outpatient a 6% increase from FY 14.
  - There are 6 providers with 5 or more Medical Denials and 1 provider with 5 or more Administrative Denials so far this year:

Provider	Region	# of denials	Level of Care
#2	NE	12 Medical	7-OP 3=LEVEL 3 2=IOP
#9	KC	10 Medical	7=OP 2=LEVEL 3 1=IOP
#28	WI	9 Medical	6=OP 2=LEVEL3 1=IOP
#26	SE	6 Medical	6=OP
#9	KC & SC	5 Medical	2=OP 2=LEVEL 3 1=IOP
#22	WI	5 Medical	5=OP
#31	SC-1 NE=4 KC=4	9 Admin	1=OP 8=LEVEL 3

  - This data suggests the following:

- Technical assistance provided by VO has been beneficial
- Continued training may be needed for select programs on documenting medical necessity for the Outpatient modality
- Review denials for select programs to find trends i.e.: same clinician, reason for denial, need for training, court requirements, etc.
- Continued collaboration and education with outside funding sources i.e.: courts, accessing liquor tax dollars
- Support may be needed for programs having difficulty meeting Administrative requirements

Appeals:

- There have been 6 appeals so far in FY15. This is an increase of 2 appeals compared to this time last year.
    - 4 appeals have been upheld and 2 appeals have been overturned. Both overturned appeals were medical denials
    - Providers may need more encouragement to appeal a denial

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: 10/19/2015 **BY:** Sheri Jurad

ATTACHMENT A: DATA

BHS Appeals by Region

Reporting Period: January 1, 2015 through June 30, 2015

Region*	DENIALS		APPEALS		RESULTS	
	Administrative	Medical Necessity	Administrative	Medical Necessity	Upheld	Overturned
Kansas City	5	25	0	0	0	0
Northeast	12	18	1	0	1	0
South Central	5	10	1	2	2	1
Southeast	2	11	0	1	0	1
West	4	8	0	0	0	0
Wichita	5	16	0	1	1	0
Total	33	88	2	4	4	2

Total number of BHS Denials received within this reporting period: 121
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: 6
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.

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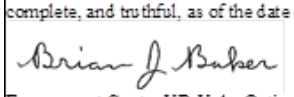
State Quality Committee

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.



Engagement Center VP, ValueOptions-Kansas, 8/14/2015