



InterQual Evidence-based Criteria Helps Reduce Denials as Health System Transitions to Value-based Care



Customer

Western Maryland Health System (WMHS),
Cumberland, Maryland

Challenge

In return for more predictable revenue, WMHS entered a pilot project with strong incentives to reduce readmissions and promote healthcare outside the walls of the hospital. However, WMSH had denial rates of nearly 5% and began losing money under the capitated arrangement. One outlier payer used a different criteria set with a denial rate above 10%.

Products

InterQual® Criteria

Results

- Reduced the average daily census of the hospital from 275 beds to 150
- Lowered denials from nearly 5% to almost 2% over a 3-year period
- Found no advantage switching to competing criteria to match that used by the outlier payer, but reduced denials by ensuring truly appropriate admissions and proper documentation

“By making evidence-based, objective criteria an integral part of the conversation... we were able to reduce denials and lower our average daily census.... We have improved the quality of care and the value that we deliver to our community.”

Barry P. Ronan
President and CEO
Western Maryland Health System

The Customer:

Western Maryland Health System (WMHS) is a regional health system that includes Western Maryland Regional Medical Center, the only hospital serving Maryland’s Allegany County, as well as a network of urgent care and primary care facilities and physician practices.

As a rural hospital system under financial pressure, WMHS joined the Total Patient Revenue pilot project, an early experiment in value-based reimbursement from the Maryland Health Services Cost Review Commission. In return for receiving guaranteed revenue for a geographically defined population, WMHS committed to serving that population within a fixed budget—producing a strong incentive to reduce unnecessary admissions, readmissions, emergency room visits, and other inappropriate hospital services. However, the hospital system was experiencing denial rates that were too high—nearly 5%—to make up the revenue under the capitated model.

Before joining the Total Payment Revenue pilot, WMHS was using InterQual criteria. For the most part, the evidence-based criteria were valuable for determining medical necessity and keeping denials low. However, with greater scrutiny of its metrics, WMHS found one managed Medicaid payer was denying more than 10% of claims—compared with less than 5% on average. The denials amounted to roughly \$216,000 per month or \$3.1 million annually. Because that payer used a competing criteria to review claims, WMHS decided to license the criteria that payer used in addition to InterQual and dedicate one staff member to handling those reviews. “The purchase of that software was minimal compared with the \$3.1 million we were losing,” says Carol Everhart, who served as Director of Quality Initiatives at WMHS.

The Challenge: Identifying the Real Cause of Denials

The idea that switching criteria sets would improve denial rates with one insurer didn’t prove valid for WMHS. “What I found was that it made absolutely no difference,” Everhart reports. “The denial rate continued steadily at the same rate it was with InterQual criteria.”



The true issue, Everhart uncovered, was that payers were looking for objective, clinical evidence documented in the chart, and often WMHS nurses were providing their own clinical judgment that was outside the scope of the criteria. The issue was widespread across all payers the health system worked with and stood out only because the outlier insurer focused on managed Medicaid. Upon closer examination, she found many cases where the criteria were misunderstood or applied incorrectly. The problem might have been most obvious with one particular payer, she says, but it was a broader one she needed to tackle with training and tightening of processes.

“Until the staff had that true understanding of, ‘Yes, it may be clinically clear to you, but it is not clinically documented therefore it may get denied,’ we couldn’t make progress,” says Everhart.

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Carol Everhart

former Director of Quality Initiatives,
Western Maryland Health System

In some cases, information supporting medical necessity was conveyed to a Utilization Review nurse working for the payer but was not being passed on to the physician assigned for secondary review. In other words, what the hospital considered critical, the UR nurse dismissed as insignificant. This motivated Everhart’s team to work on developing a better rapport and clearer communication with the payer, so they could agree on what was important. Overall, WMHS staff preferred InterQual as the product they were more familiar with and found easier to use.

Though the denial rate with that single payer remained stubbornly high, WMHS found other ways of coping, Everhart says. “We attacked it from a different angle and really focused on population health, rather than population illness,” she states. By reducing unnecessary admissions, WMHS reduced the cost of care for the population covered by that payer, which also reduced losses because the hospital was being paid a fixed amount of revenue. “When you reduce the number of admissions to just those that are appropriate, you’re expending less on resources that you’re not getting paid for,” she says.

Taking a broader focus on population health, WMHS worked harder to determine the causes of unnecessary admissions and readmissions. Did patients lack understanding of their disease and how to manage it? How could WMHS help connect them with sources of care outside of a hospitalization? Were patients missing follow-up appointments because of lack of transportation? If so, staff worked with a local community agency to help coordinate transportation for patients. “I think the hospital did some really wise things building up a bank of community services,” Everhart adds.

The Solution: Integrating InterQual throughout the Decision-making Process

The key to achieving results was integrating the criteria into the decision-making process, says Everhart. “My secret weapon was to use every component of the InterQual criteria,” she says. “We used it as the foundation to frame conversations with physicians. We also used it from a quality perspective. If we were looking at the components of medical necessity, we knew what that framework was, and we were able to ask the physicians intelligent questions about the plan of care.”

By eventually embedding case managers in the emergency department, 24x7, to consult with physicians on decisions such as admitting patients or holding them for observation, WMHS used InterQual criteria to help guide those decisions. The criteria also were used to help mediate disputes. For example, when an ED physician thought that a patient should be admitted but the hospitalist disagreed, InterQual was used to help determine the appropriate level of care based on the objective evidence-based criteria.

InterQual was also used as part of transition planning prior to discharge. The transition plan helped assist with determining the next most appropriate level of care, paying greater attention to follow-up care and community resources outside of the hospital.

Using InterQual effectively is not the same as letting it dictate decisions, Everhart says. Certainly, there were times when a doctor's judgment was to admit a patient or the patient should not be discharged, but the criteria said otherwise. "I would say, 'Okay, what's the risk? You need to spell it out.' In the beginning, that was a struggle. You know, 'Because I'm the doctor, and I say so.' But as we worked through this, they began to understand the importance of documentation and treatment plans," she says. If the decision was to overrule a recommendation based on the criteria, the reasons would be documented. Often, doctors had good evidence-based reasoning to point to—the relevant facts just hadn't been recorded properly. Other times, the care team would agree on an alternative plan, which sometimes meant "thinking outside the four walls of the hospital" to other community resources, Everhart reports.

Having that discussion was absolutely necessary to protect the financial health of the hospital, along with the health of the patient, Everhart says. "Under total revenue capitation you don't have any room for waste." InterQual provided a frame of reference for tactics aimed at reducing unnecessary admissions and driving down the average hospital length of stay.

The health system established a process for continuous improvement in the quality and cost-effectiveness of care. One such process was using InterQual to re-exam prior discharge plans after patient readmissions to determine whether important data was overlooked, the patient was

discharged prematurely, or the hospital failed the patient in some other way. Incorporating the InterQual criteria into the design of order sets for computerized physician order entry was a way of guiding patterns of treatment toward the standards.

"At WMHS, we underwent a significant turnaround as we adjusted to changes in what Medicare and private insurers were willing to pay for. By making evidence-based, objective criteria an integral part of the conversation related to whether patients should be admitted and to what level of care, how they should be treated, and when they should be discharged, we were able to reduce denials and lower our average daily census. By reducing inappropriate care, we have improved the quality of care and the value that we deliver to our community," says Barry P. Ronan, President and CEO, Western Maryland Health System.

The Result: Better Care, Better Value

Shortly after moving into a new 275-bed capacity hospital, WMHS was able to reduce its average daily census to 150 through the transition to value-based care delivery. As a result, it could provide more patients a private room and more individual attention. At the same time, WMHS invested in better care for patients outside of the hospital by partnering with other providers.

As part of this pilot project, WMHS served as a model for the Total Patient Revenue (TPR) value based reimbursement program that has been expanded statewide.

Everhart has since moved on to work for Change Healthcare as a Senior Clinical Consultant. The full WMHS story is one she shares often. She had worked with InterQual content since the 1990s in prior roles for hospitals, insurers and managed care plans, but WMHS is where she learned the criteria's true contribution to value-based healthcare and how to drive the best outcomes. Her experience at WMHS was what motivated her to join the InterQual team. "I'd like to be able to take what I did there and help other hospitals because healthcare reform is coming. Bundled payments are coming and we can't continue to function in the old fee-for-service mindset," she says.



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