

OBTAINING INSURANCE AUTHORIZATION AND MINIMIZING DENIALS: WHAT YOU CAN DO TO ASSURE YOUR PATIENTS RECEIVE APPROPRIATE CARE

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There once was a time a sleep study could be scheduled without consideration of the insurance carrier. Patients could be scheduled that night or the next day. Times have really changed as we have moved into an age of pre-authorizations and longer wait times for patients to have an overnight sleep study. Have we lost quality of care for the patient as insurance takes over and the request for a sleep study is denied? This article is meant to share information and tips to assist sleep centers with the authorization process, in hopes of minimizing denials, obtaining reimbursement for the study and improving quality care for our patients.

The first thing to do is gather your paperwork. An order is received, which is typically sent with a demographics page or face sheet. Next, print or request the history and physical (H & P) along with any previous tests that have been done and can be helpful, such as pulmonary function tests (PFTs), echocardiograms, cardiac stress tests and a sleep questionnaire completed by the patient. Be sure that your sleep history includes the patient's BMI, and height and weight, and obtain either an Epworth, Stop Bang or the Berlin questionnaire. I have noticed neck circumference is becoming the newest metric requested, so if it can be obtained, include this information.

Now that all of this paperwork has been gathered, what do you do with it? As you begin looking through the information gathered, review the order and note which testing/billing codes you will need to request. Note the insurance carrier and whether you will need prior authorization for the sleep study. If yes, be cognizant of how many days prior to the study date you have to get the authorization completed for that particular insurance company. There is nothing worse than having to reschedule a patient because the authorization is "still in review." So, for instance, Blue Cross and Blue Shield (BCBS) of Texas PPO plans typically do not require an authorization, so a study for a patient with this insurance can be scheduled the same day. United Health Care (UHC) requires 7-10 business days for the review process considering start time begins at the time all documents

are submitted. Care Centrix powered by Cigna typically requires 15 business days in review. Note that Cigna was previously the only plan that required an authorization for an adult HSAT but now BCBS-TX-HMO has recently begun to require an authorization for a home sleep apnea test (HSAT). It is important to know which insurers require authorization and for which tests. These requirements change frequently! Both the requirements and the days in review can vary from state to state, so be sure to ask the intake coordinator during the authorization process. Ask frequently if any new guidelines or changes have been implemented to the authorization process.

Review the patient demographics; be sure you have the patient's full name and personal information listed, you will need it during the authorization process. Check for the ordering physician's full name, address, phone and fax numbers, and have the NPI number for the ordering physician handy. (If you don't have it, go online to NPI lookup or request it from the physician's office). When looking up an NPI number, compare details to be sure you have the correct physician. Always have your own facility's NPI number, Tax ID number, and address available as well.

It's time now to review the clinical information gathered, such as results of previous testing, H & P and sleep questionnaire. Get your pen out and get ready to mark up your paperwork. The chances for approval increase considerably when you provide the insurer with supporting documents and good notes, so don't be afraid to mark up the information sheets. When reviewing the sleep questionnaire, the H & P and any previous testing, keep in mind the plethora of cases the intake coordinators and nurses at the insurance company must review per day. It is possible for important information to be missed while they are reviewing a case. Make your documents stand out and underline important things like co-morbidities, patient complaints and pertinent previous testing results. If you don't have enough supporting documentation, call the ordering physician to ask for an addendum. Circle, underline, or box things you really want to stand out so that it draws the immediate attention of the nurse or the medical director reading the documents you submitted. The person reviewing the case will see what you see and get a better picture of the request; this makes it more obvious why your patient requires an overnight study monitored by a sleep technologist versus a HSAT.

What exactly are they looking for? Clearly documented co-morbidities; things like: impaired cognition, moderate to severe congestive heart failure (CHF), cardiac arrhythmias not



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controlled by medication, pulmonary, neurological or cardiac disease, parasomnias and unexplained pulmonary hypertension. Patients or physicians should document symptoms and complaints in the sleep questionnaire or H & P, such as: snoring, choking and gasping, witnessed apnea, morning headaches, mood swings, irritability, decrease in sexual drive and/or erectile dysfunction, excessive daytime sleepiness, periodic limb movement disorder (PLMD), falling asleep at work or while driving, weight gain, and not wanting to get out for social activities. I have found many of these symptoms can be found in the insurer's "criteria" section, which lists indications for sleep studies. These are all important things to underline, or mark so that the nurse can see what the patient is enduring.

You should be familiar with and use ICD-10 codes for the symptoms that have been listed by the patient or physician. A good approach to learning and using ICD-10 codes is to make a table grouped by category, such as cardiac, sleep, pulmonary, and list the appropriate ICD-10 codes that fall under each category. That is my quick "go-to" template for using these codes. For some insurers, like UHC, the code you choose is the only opportunity you have to tell the story and plead your case. In my experience, when calling UHC, I am only able to provide specific information such as patient demographics, ordering physician and place of service information, testing code and ICD-10 code. That's it. Time to fax it all in. I have asked insurers if it helps if I list more than the obvious code of OSA, and I have been told more than once, YES! List what is documented using the appropriate codes so that the need for testing is obvious from the beginning.

Some insurers ask certain questions as part of their authorization process, based on their specific guidelines. Be ready to answer any questions the insurer might ask. You will generally find all your answers on the H & P and sleep questionnaire. It is always acceptable to say "I don't know" (if you don't see an answer for that question). Once all the questions have been answered, you may be given a reference number and be told someone will call when they are ready for the necessary clinical information. I ALWAYS ask for the fax number prior to ending the call, so that all documents can be faxed post call. I find this helps to expedite the process versus waiting for someone to call. It is still possible that someone will call to have the documents re-faxed, or faxed to another fax number, but at least the ball is rolling.

Let's talk denial. If the nurse calls and says there is intent to deny, that can be your final opportunity to submit any new documents to be considered. You have a choice here to agree with the denial and move to HSAT, or you can request elevation to the medical

director for review. Denial after review by the medical director can be escalated as well; request a peer to peer review if you think an in-lab study is what your patient requires. A peer-to-peer review is a scheduled teleconference type of appointment for the ordering physician to review the request with the medical director of the insurance company; in an effort to overturn the denial. It is possible for the request to be approved during the peer-to-peer process if the physician can provide additional information for the insurer's medical director to consider. There are times the insurer's medical director will indicate the in-lab test does not meet their medical necessity criteria, so it will remain denied and an HSAT will be scheduled. If the HSAT is non-diagnostic or positive for OSA, then a new request can be initiated for a PAP titration (95811) based on the results of the HSAT. Then the process repeats.

Helpful hints: for many insurers, a request can be submitted for a diagnostic study (95810) and if the patient meets criteria to split during the testing night they can be split. The patient advocate or authorization specialist must then call the insurer the next day to revise the code. This also works if a split code is approved but the patient does not meet criteria to be split. If you begin with a split code (95811) but perform a diagnostic study (95810), you will need to call the next day to have the code changed to a (95810) then you will be prompted to speak to the nurse to request a full night titration study (95811) in follow-up. Care Centrix powered by Cigna has recently changed their criteria on this method. According to Care Centrix new guidelines for initial requests, they no longer allow for a split night study (95811) on initial request. They will allow for a diagnostic study (95810) on initial request and if the patient meets criteria to split during the night, the technologist can split the patient. The next morning, the authorization specialist must call to up-code to the (95811) split study that was completed. I have found that one particular insurance will ask if an HSAT can be substituted for the in-lab study, and when a yes answer is given, that the insurer seems to default to HSAT and immediately send a denial for the in-laboratory study. If asked, and the answer is yes, you can expect most insurers to default to HSAT. It is important to indicate that the patient can have an HSAT ONLY in the event the patient doesn't meet criteria for the in-laboratory study. Those words are very important to say. You are saying they could have an HSAT but not until the insurance carrier has proven that they don't meet criteria. This process allows opportunity for review of the in-lab study request and a discussion with the nurse.

In summary, a few final thoughts to share. Keep in mind that many of these details can vary state to state, these are my

experiences. Always have your paperwork ready before you call the insurance company for authorization. Review it, and have your ICD-10 code table handy or open a tab on your computer that lists ICD-10 codes for the current year. Have the appropriate NPI numbers, an NPI look up list ready, or a tab opened on your computer in case you need the ordering physicians' NPI number. Open a BMI calculator or pre-calculate the patient's BMI; they will ask for it! Underline, box or arrow important details so the nurse reviewing the case sees what you really need them to see. Look for cardiac, neurologic, pulmonary, mental, and sleep issues, and the patient's complaints, and highlight those things. Keep up with insurance requirements for testing and changes; make sure you know the latest criteria for approval of sleep studies for each insurer.

Most important: be kind and courteous while speaking to the intake coordinator. Kindness will get you many places that rudeness will not. Have you heard the phrase, "you can catch

more bees with honey?" Remember, as the patient advocate or authorization specialist, you are the voice for the patient and the physician. The patient goes to the physician for help. The physician documents medical necessity for a sleep study. Next it is up to you to help paint the exact picture necessary to help the patient receive quality care. If you do it correctly, the patient will be able to come to an accredited sleep facility and be monitored by a credentialed sleep professional. It is acceptable to say the patient really needs to come to be monitored in the sleep center, let's schedule a peer-to-peer review or request to submit more documentation. We must be the voice for the patient. Let's be proactive in assisting our patients to receive high quality care for their sleep disorder. After all, what happens during sleep directly affects activities of daily living. It's a great feeling to receive an approval after all the information gathering and preparation, or to have a denial overturned as a result of our efforts. We can make a difference in our patients' care!

