Payer's gone WILD!
How to Tame with Technology!

Nebraska HFMA

Presented by:

AR Systems, Inc.

Day Egusquiza, President
AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.

Featuring technology interventions by:

“Hi everybody. Love being with you in our new virtual world. Mask on, smiling underneath, staying safe while we all stay connected. Perfect!”

Make up on, hair done, business.

Vs.

no make up, workout sweats…LOL

New definition of ‘business casual’

Most common phrases from 2020:

“Can you hear me?”

and the favorite, as we talk up a storm:

“You are still on mute.”

Today’s Presenters

DAY EGUSQUIZA
President, AR Systems, Inc.

TONY TIEFENTHALER
Regional VP of Sales, H4T

TAYA MOHEISER, EMBA, CMPE
Product Owner & Rev Cycle SME, H4T

Payer: Traditional Medicare

- MAJOR regulatory changes effective 1-1-21
  - *Who forgot to tell congress that we are still in the midst of national pandemic?*
- RAC audits are back
- New prior authorization rules
  - additional procedures & mandatory new electronic rules/govt payers
- Office visit E&M new criteria
  Final OPPS rules
- Loss of inpt only procedures + aggressively moving outpt approved procedures to ASC/ 11 in 2021. $ competitive. HUGE!
- No Surprise bills
- Gag clause lifted – all payer contracts
- Transparency- 1st 'warning' by CMS
- Readmission penalties

Payer: Traditional Medicare

RACS Are Back! Audits are Back!

"CMS expects to discontinue exercising enforcement of medical review audits regardless of the status of the PHE.' - 8/2020[1]

- RAC Examples: total hip and total knee: Medical necessity and documentation requirements. Duplex scans of extracranial arteries: Medical necessity & documentation requirements. Implantable auto defibrillator –inpt. (Same) All A/B MACS. (More listed) 20% are still doing all joints as inpt per PEPPER report/end of 2020.
- SMRC/supplemental medical review contractors has current projects and closed projects. Closed: Spinal fusion 25% error rate; Emergency ambulance 98% error rate; non-emergency ambulance 79% error rate. (Hint: Spinal fusion has now moved to prior-authorization 2021)
- MAC Examples: targeted probe and educate. Pre-claim reviews: prior authorization for 5 identified outpt procedures.
- Livanta- national contract for high weighted DRG and short stay audits for the country. 4-21

[1](www.cms.gov/research-statistics-data-and-systems/monitoring -program/medicare-ffs-compliance-programs/recovery-audit-program/approved-RAC-items)

Payer: Traditional Medicare

Final OPPS Highlights

#1 Outpt rates increased by 2.4% next year & phases out the inpt only surgeries.

#2 Approx 300, mostly musculoskeletal will be removed first. Totally gone by 2024. Procedures cut from this will be exempt from the site of service/inpt vs outpt denials ‘until Medicare claims data indicates that the procedure is more commonly performed in the outpt setting than the inpt setting. CMS. (audit??)

#3 340B payment is still 22.5% lower than the average sales price

#4 Prior auth starting 7-1-21 for cervical infusion w/disc removal and implanted spinal neurostimulators

#5 Star ratings revised methodology

#6 Big changes to physician payment

Financial Impacts of Change- Traditional Medicare – TKA

Critical Access Hospitals are paid differently

Facility Payment

Inpt DRG: 470

Avg: $10,630 (JJ-GA, AL, TN/34,777 cases J to J 2017)

Avg: $12,010

DRG is wage adjusted + teaching +++

APC Payment for CPT 27447/APC 5115

Avg: $10,122 *

APC is wage adjusted:

Higher = higher payment;

less than "1" wage factor = lower than base payment

Patient Responsibility

Inpt every 60 –day deductible:

$1408/2020 $1484/2021

APC frozen amt per CPT:

$2024/20% of APC$ -but cannot exceed inpt deductible. CMS pays the difference to the site.

Max amount due from pt:

Inpt Deductible –whether inpt or outpt.

PS: Physician is paid the same –inpt or outpt

Payer: Traditional Medicare

<u>Physician office E&M new guidelines, only</u>

- **Biggest** change to E&M since 1995/97
- **Only** impacts office E&M visits
- Audit risk: Carefully monitor bell curve.
- Medical decision-making vs <u>time for entire day</u>/all providers. Which is most accurate for each visit? Who is making the decision? What new /revised documentation was created?
- Patients over paperwork. Saves 2 min per visit/forecast.
- Suspended 2% payment adjustment (sequestration). Ex Order to delay implementation of the sequestration thru 2021. Increased cuts in 2030 to pay for the delay. 4-14-21

- G2211/ADD ON CODE IS NOW BUNDLED UNTIL JAN 2024 . G2212/PROLONGED (NEW)
- Winners and losers: proceduralist lost payment to allow for office visit providers to have gains. Relative value weights went up for office visit practices. Conversion factor down 10% from 2020 but thru end –of-year legislation, only 7% reduction for 1 yr. What about the other payers and their provider contracts? How are they paid?
- **New CV & RVU = significant potential increases in $ for primary care w/0 increase in volume. Impact to employed /contracted providers**.
- Post visit audits: Both compliance and revenue options. (1995 vs new time vs new MDM)

CMS guidance on Prior Authorization
2-18-21: Biden Adm "pause" rollout to assess

- **Final rule is out! Most provisions go into effect 1-1-23**. Payers slam as 'half baked'. Rushed as the sweeping rule revamping electronic prior authorization was finalized a scant 30 days from when it was proposed/Dec 10,2020. Codified just 5 days before the Biden administration.
- The rule requires all Medicaid, CHIPS and those plans operating on federal exchanges which are commercial insurance plans to use standardized application programing to give providers and patients electronic access to prior authorization data, including pending decisions. Payers also have to give faster decisions. In 2024, Maximum of 72 hrs for urgent and 7 days for standard requests.

- **BIG concern!!!** Medicare advantage plans aren't included in the final rule, but CMS is considering further rulemaking to make them similar. That omission was a major hang-up for hospital groups which argues excluding the private plans –which cover about a 1/3 of the Medicare beneficiaries – could result in more variation in prior authorization processes in the U.S. and reduce incentives for providers to adopt the new standard methodology, per AHA.
- *Per a 2019 AMA survey of physicians – 14 hrs of each week is dedicated to trying to get prior authorization for care the physician believes is necessary for the patient's care…including ongoing drug therapy. Didn't even ask the hospitals about their costs with prior authorizations!*
- *Faxing vs creating secure portal to 'place' all medical records for payers. Control what is seen but also allow for rapid review and decisions.*

Payer: Medicare Advantage
This is a **not** a 'mini-Medicare plan"

- CMS estimates enrollment will increase 10% to 26.9 M in 2021, a rate that's on par with growth in 2021 to 40% of all Medicare enrollees. Humana and UHC are the largest national plans.
- There will be 4,800 plans in the Medicare Advantage market, with an average of 47 plans per county – up from 39 plans this year. Medicare Advantage open enrollment begins 10-5 and ends 12-7, for coverage beginning Jan 1, 2021
- +++United accounted for 16x more inpt downgrades/denials than other payers. Humana 8x more. (SC hospital)
- New star program rating recommended/2021. Large 1x a yr bonuses to payers. Rated by subscribers. (3.5-5 ratings)
- TRADITIONAL MEDICARE RULES ARE THE BASIC BENEFIT. BUT THEN EACH MA HAS CONTRACT LANGUAGE THAT ADDRESS SPECIFIC PROCESS ISSUES AND ENHANCED BENEFITS. EACH PAYER CAN USE INTERQUAL OR MCG OR THEIR OWN CLINICAL GUIDELINES TO SUPPORT – WHAT IS A INPT? CRAP.. DEVELOP A PAYER MATRIX!
- CMS FORM 1696- APPOINTS A DEDICATED PERSON/LIKE THE PHYSICIAN ADVISOR TO REPRESENT THE PATIENT WITH ALL CONTACT, DENIALS, APPEALS , ETC FOR THE PT. GOOD PRACTICE IS TO HAVE ALL MA PATIENTS SIGN AT THE POINT OF REGISTRATION. SEND WITH ALL APPEALS, ETC. (DEC 2020- CMS MEMO TO EXPECT TO 'CONDUCT ROUTINE AUDIT ACTIVITIES' FOR PART C& D IN 2021)
- IF THE PROVIDER IS NOT-CONTRACTED WITH THE PAYER – TRADITIONAL MEDICARE RULES APPLY. YES, SIREE!! *SEE SLIDE*
- **If the provider has approved inpt thru prior approval, then post-discharge, request for record and denied inpt – not allowed. Yes, siree! *see slide.**
- Lastly, Contract language needs revised or include addendum with specific issues addressed
- Did we mention re-admission 'guidelines' that are specific to the MA plans? How do you protect yourself from 'related?"

Regulations 42 C.F.R. § 422.214
If non-contracting with a MA plan….

§ 422.214 Special rules for services furnished by noncontract providers.

a) Services furnished by non-section 1861(u) providers.
   1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.
   2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

CRITICAL NEWS

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: September 18, 2020

TO: All Medicare Advantage Organizations

FROM: Jerry Mulcahy

Director, Medicare Enrollment and Appeals Group

SUBJECT: Non-Contract Provider Access to Medicare Administrative Appeals Process

The purpose of this memorandum is to remind Medicare Advantage organizations (MAOs) of the applicability of the administrative appeals process at 42 C.F.R. Part 422 Subpart M if a non-contracted provider (NCP) who has furnished a service to an enrollee requests reconsideration of an organization determination.

Medicare Advantage – Provider WINS –

Use Regulations

If the plan approved the furnishing of a service thru an advantage determination of coverage, <u>it MAY NOT deny</u> coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. Section 10.6.

- Approved for inpt. 10-18-18. Resulted in 1 day stay. Hired company to audit – denied and told to downgrade to obs. Not medically necessary for inpt. 9-19. Nope.
- Approved for obs 8-8-19. Did P2Pcall. Overturned and approved for inpt. 8-12-19. Indept firm (paid to deny) audited and stated downgrade to obs –could be treated in a lower level of care. 2-1-20. Nope.
- Of course, payer says you understood that this prior authorization was not a 'guarantee of payment' thru the contract language. Same language with commercial prior authorizations. But Medicare Mgd Care Manual adds more strength to the provider.

"Payers Gone Wild": Understanding the contract, website posted policy updates, appeal language and when to just say 'heck no"!

1) **"All stays under 48 hrs are observation." Where does it say that in the contract?** If not contracted, Traditional Medicare rules apply. What to do if continues to deny all inpt until more than 48 hrs has occurred?
2) **"The patient can be treated in a lower level of care without endangering their health. Or How long do you think they will need to be in the hospital?" Wow – that is tough** as which UR nurse would say that the care is different in OBS vs inpt. But that is not the reason for inpt: The patient's condition met their clinical guidelines. Not LOS; met clinical guideline +++
3) **"If changes to pt status are made after d/c, the facility cannot bill anything. Provider liability and absorb. Just like traditional Medicare." Nope**!
4) **"We only speak to the attending physician for P2P calls. CMS Form 1696**
5) **"We don't do P2P. Just file an appeal." Contracting**.
6) **"Let's just access pertinent parts of your EHR so you don't have to send us records."** *(Hint: When is the payer making the decision? ER to inpt = decision. The longer they 'see', the pt can recover and then obs.)*

CMS FORM 1696

- Must be accepted by all Medicare Advantage plans – cannot require a different form
- Sections 4 not applicable to Medicare Advantage because the Plan's Evidence of Coverage dictates any cost-sharing responsibility, unchanged by this form
- Providers cannot charge a fee for representing enrollee
- Valid for 1 year, and for life of an appeal
- **Use when a payer says – we will only speak to the ATTENDING! NOPE!**
- **USE THE FORM TO BE PRO-ACTIVE**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, ________________, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, ________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ________________

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing ________________ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

DRG = 1 payment for the entire stay

- **Traditional Medicare** for larger facilities = DRG. Each DRG has a mean LOS that the payment is based on. The diagnosis and inpt procedures are grouped into a single DRG payment. Some DRGs have higher payments based on co-morbid conditions. There is a small variation for each site but: **1 stay = 1 $.**
- **Medicare Advantage** pays= same DRG methodology –with coding rules controlled by the HIPAA Standard Transactions 2003. 1 stay = 1 pre-determined payment for the dx and procedures done.
- **Re-evaluate – why battling for additional 'days' when the inpt has already been confirmed?** Exception – need for SNF and Outlier $/additional $ based on very long LOS/outside the norm for the dx.
- **EX: Aetna approved 2 days**. Hospital is pd DRG. They requested 3rd day. Denied. Aetna denied and reduced payment by $1200. WHAT?

And more crazies…

Non-traditional Medicare/Other payer surgical inpts

Inpt approved. DRG payer. Payer granted two days; a 3rd one was requested. Payer denied. Hospital bills as inpt with 3 days. Payer refuses to pay any charges. **WHY**? “Days’ does not equate DRG payment.* (What if the hospital just bills with 2 days? Same DRG payment. Why anguish?)

Inpt approved. DRG payer. Procedure ordered was submitted. During the case, another procedure was conducted. Payer requires to be told of the additional procedure. If not, denied inpt. **WHY**? Inpt was already approved.

Inpt requested. Inpt was denied. Hospital tries P2P call. Told can’t bill outpt as inpt was denied. **WHY**? Absolutely a medically appropriate procedure. Pt status – inpt vs outpt – was in dispute. Hospital can a) accept the downgrade to outpt surgery and bill type 131/outpt or b) use a physician to appeal. Must always know what the payer is using to determine ‘inpt surgery’ – what clinical guidelines?

Inpt denied. But did approve 72 hrs of obs. What is the contract for payment for obs hrs and other related services? Does it equal an inpt surgery? Do not accept.

Massive Requests for Records

- First: If contracted, what does the contract state regarding request? Volume? Frequency? Reason? ALWAYS validate with each request. (EX: NY health system)
- Second: If no contract, why send the records? If MA plan with no contract, what would 'traditional Medicare do' with the same issue? Threats to not pay or recoupment payment? **IMMEDIATELY report to CMS /abuse**.
- Third: Track and trend all requests. Why? What is the finding? Report to contract management ASAP.
- **DENIAL PREVENTION:** HIPAA Standard Transaction and Privacy (2003ish) – only send 'minimally necessary information.' Never the full record. If prior authorized (all are) – then why do they need the record POST care? PS Some payers = "Pt signed document allowing us to request full record." **Ask to see it.** PHI

Readmission Denials- CMS Policy

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital **and is readmitted to the same acute care PPS hospital on the same day for symptoms related t**o, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

30-Day Readmission Traditional CMS
Yearly penalties, not each case as MA Plans are doing

CMS Hospital Readmissions Reduction Program (HRRP)

The Social Security Act establishes the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions**, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection (d) hospital **within 30 days of a discharge from the same or another subsection (d) hospital;**
- Adopted **readmission measures for the applicable conditions of acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN).**

In the FY 2014 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2015 program to include:

(1) patients admitted for an acute exacerbation of **chronic obstructive pulmonary disease (COPD);** and

(2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA).**

In the FY 2015 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2017 program to include patients admitted for **coronary artery bypass graft (CABG) surgery.**

READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES.

83% OF 3080 HOSPITALS EVALUATED. COULD CUT UP TO 3% FROM EACH MEDICARE CASE DURING FISCAL YEAR 2021

United Health Care Readmission- generally use a required combination of 2 ‘related’ w/in 30 days

- A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system.
- **Aetna MD/CA case in court** did not do review of case/just read recommendation by clinical team. AG’s investigating.
- **FULL DENIALS** of the 2nd admission by MA PLANS and other COMMERCIAL PAYERS.

Proactive Ideas for all non-Traditional Medicare/TM Contracting

Usually in Operational Addendum & Appeals

Outline key elements prior to signing the contract. Re-visit throughout the contract year if concerns arise. Rates are not included in this list.

1. **Timeline for submission of clinicals**. Week days, weekends, obs conversion request to inpt.
2. **Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
3. **Timelines for reply of request**. Weekends same as weekdays. 4-8 hrs maximum
4. **Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known – i.e. qualifying stay. (DRG)
5. **If granting access to the provider's electronic medical record**, critical to have a very limited review (ER if from the ER/labs/imaging/notes) with a firm timeline for decision. 4- 8 hrs maximum. Continued delay yields risk of the pt 'recovering in a lower level of care/obs." If in obs, grant access when the pt's condition needs reassessed. 8 hrs maximum.
6. **DRG hot spots**: Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
7. **MA plans**: Ensure there is understanding that a disputed status may not resolved while the pt is in-house. TM rules do not apply. Status can be changed post discharge will full billing as inpt or outpt/131 bill type.
8. **P2P:** Any provider may discuss the account on the patient's behalf. All contracts allow both concurrent and post-discharge P2P. Once the request is made, a time is agreed to /recommended. Identify timeline with penalties if not adhered to. Agree to the qualifications of the payer MD. Outline the scope of the Payer MD can use –beyond meeting the clinical guidelines. No minimum LOS to be an inpt. (EX: all accts under 48 hrs are obs.)
9. **Re-admission deni**als. Outline exactly what is a 'related' case within 30 days. "Same as Medicare' = same day, same facility, same dx. Chronic dx are excluded. Identify which dx must be the same and in which 'spot' of the up to 10 dx

CMS Contacts for Specific Plans and General Contact

File complaints – squeak – with excellent examples of abuse

Blue Cross Blue Shield Anthem Med C:
Edgar Buyao
Chicago Regional Office
Phone: 312-353-5968
Edgar.buyao@cms.hhs.gov

Coventry Health Care Med C/Aetna Med C
Donald Marik
Health Insurance Specialist
Denver Regional Office
Phone: 303-844-2646
Donald.Marik@cms.hhs.gov

General CMS Contact:
Melanie Xiao
Health Insurance Specialist
Medicare Advantage Branch
Division of Medicare Health Plans Operations
Centers for Medicare & Medicaid Services
CMS San Francisco Regional Office
90 7th Street, 5-300 (5W)
San Francisco, CA 94103-6708
Phone: 415-744-3613
FAX: 443-380-6371
melanie.xiao@cms.hhs.gov

Humana MED C Contact at Medicare:
Uvonda Meinholdt
Health Insurance Specialist
Kansas City Regional Office
Phone: 816-426-6544
FAX: 443-380-6020
Uvonda.Meinholdt@cms.hhs.gov

UHC MED C Contact at Medicare:
Nicole Edwards
Phone: 415-744-3672
Nicole.edwards@cms.hhs.gov

Payer: United Health Care

- Optum is owned by UHC. Optum has purchased many companies that work directly with healthcare providers.
- Optum purchasing Change healthcare. (McKesson was part of CHC which owns Interqual.) 2-21   Dept of Justice is investigating $13B purchase by UHC/optum. 4-21. aha supports.
- UHC announces moving to Interqual effective 5-1-21. (No longer using MCG)
- READMISSIONS 'RELATED' PLUS 'PREVENTABLE'.
- Site of service- limit outpt services in hospitals. Move to ASC and imaging centers. Saves 60% on average.
- Prior authorization- temporary suspension of prior authorization for inpt to in-network sNF ends on 1-31-21. *Humana has followed.*
- UHC's unique lab coding system – delayed until 1-22.
- Effective 7-1, United is requiring free standing labs and hospitals outpt labs to have new Designated diagnostic provider/DDP status. Providers have until 2-28 to meet certain quality & efficiency metrics to be a DDP. If the in-network provider is not a DDP, the claim is denied. Major pt hit!   Imaging: CT, MRI, Nuc Med, Pet - expect 2022.

More ‘hot off the press- CDI”

(Clinical documentation integrity)

- Integra filed a False Claims Act lawsuit Aug 10,2019 in the US District Court of Central CA against Providence Health & Services. The lawsuit allege Providence routinely used **unwarranted major complications and comorbidity secondary codes on Medicare claims to inflate reimbursement.**
- **According to the 100-pg lawsuit, Integra discovered the unwarranted** secondary **codes** during an analysis of Medicare claims dated back to 2011.
- Integra said an investigation of the business practices of Providence and its consultant, clinical documentation improvement company, JA Thomas & Associates, confirmed that Providence’s false Medicare claims were not only intentional but were part of a systematic effort to boost its Medicare revenue.
- Pushed doctors to make unwarranted dx and used leading queries.
- UPDATE: Court will not reopen the whistle blower case. 5-21 Appeal?

Short Term Health Insurance – 4 things to know (Becker Hospital Review 8-18)

- Trump Administration released FINAL rule for short term health insurance plans/STP. Open ended with coverage.
- "State Relief & Empowerment Waiver/1332" – state can offer less **10-18 (Judge upheld selling 7-19)**
- Previously could only offer 3 months, now can last up to 3 yrs.
- 1) **STP do not have to abide by the rules by the ACA requiring coverage of essential health benefits and pre-existing protection. Nor do they have to abide by insurance plans imposing limits on how much care is covered or the requirement that at least 80% of premium money go toward care.**
- 2) Not abide by ACA, STP do not cover as much as more comprehensive plans. **They tend to not cover: maternity, prenatal care, mental health, drug treatment and prescription drugs. May not cover sports injuries and other specific services like cataract treatment, immunizations, and chronic fatigue or pain treatment.**
- 3) Some do not cover $250,000 - $2M. Others only covered inpt on weekdays, others with waiting periods.
- 4) Generally they are cheaper than the ACA plans. Kaiser study found ex) 40 yr old single man in Atlanta was $371/ACA compared with $47 for STP.
- **BUYER BEWARE!** Less coverage = more out of pocket if healthcare is used.
- 1/3 of all small employers state that health insurance and healthcare costs are their major concern. 3-21 (Healthcare Dive)

A day in a life of 'junk insurance' and coronavirus/COVID-19

FL patient, 3-20

- Been to China recently. Had flu-like symptoms. He followed advise of public health experts and went to the hospital for testing.
- He tested positive. Staff said needed to have a CT scan too.
- He received a bill for $3270. Insured but with 'junk insurance' which offered limited benefits and DID NOT COVER PRE-EXISTING.
- Based on his ins, he has to pay $1400. BUT to get the claim paid, at all, he had to send THREE YEARS of medical records to prove that this 'flu' was not related to a pre-existing condition.
- He pays $180 a month in premiums.

Change of payer/provider/patient relationships
Convergence

Walmart Moving BIG into healthcare

Walmart 'taps' HUMANA executive to head up health unit. *Put more focus on its wellness business* 7-18 (Sean Slovenski)

- Joining with Anthem's MA plans to pay for over- the -counter items – braces, etc.
- "Walmart to launch Medicare Insurance agency" 7-20 Explore narrow network 3-20
- "Walmart's launch of a Medicare Advantage plan will likely impact provider service volumes."   **Cloverhealth.** 7-20 HFMA
- ******Walmart moves deeper into primary care market- New clinic called WALMART HEALTH is in Dallas, GA. Appts start in 9-19. Will offer primary care including lab, x-rays, dental, counseling, etc. Low cost primary services – next to Walmart.*****

Rise of "Convergence" in healthcare. Means?

- Cigna Corp agrees to buy Express Scripts, the nation's largest pharmacy benefit manager.
- Apple does own clinics for employees.
- Humana to open 100+ Medicare centers by 2023 thru its partners in primary care unit within Humana. Located in underserved areas/srs.
- ***Convergence:* *Where a company merges its capabilities with another organization in an adjacent industry. Only works if the industry's solutions are not comprehensive, compelling or able to satisfy customer needs.***
- Expand group purchasing efforts.

New competition- New patient outreach

Impacting the ‘front door’ of the revenue cycle for outpt services.
Think RIPPLE revenue with lab, x-ray, other ancillary services. Competition at the front door of the revenue cycle. WOW!

“Walmart Health vs. CVS Minute Clinic”
4 key differences between CVS and Walmart (3-20)

Staffing
- CVS Health Corp/Minute Clinic staffed by **mid levels**
- Walmart health **primary care MDs** including x-rays, dental, counseling.

Care
- CVS designed to provide ‘**episodic care**”.
- Walmart wants MD **to replace primary care providers**.

Walmart Additional Info
- In underserved areas –for high deductible pts and no insurance
- Walmart creating narrow networks for employees 3-20
- “Centers for Excellence’ for joints/identified hospitals only.

“Insurer Clinic Competition ‘very worrisome for hospitals” (3-20)

- UnitedHealthcare’s new plan in CA that is built around Optum physicians.
- Aetna’s decision to drop copayments for member who use CVS Minute Clinic.
- BCBS of TX offer free primary care at clinics it opened with a partner in Houston and Dallas.

Clinics run by UnitedHealth Group, Blue Cross and Blue Shield and CVS Health/Aetna have hospitals worried that **patients may be steered away** from their doors.(Wall Street Journal)

More Convergence - Walgreens & Microsoft

Walgreens: Consumer Facing Care

- "Walgreens to provide primary care via **VillageMD clinics** in 500-700 of its drugstores. 7-20
- In-store visual clinics, lab services, retail clinics. Telehealth services. Using 'smart technology".
- Partnering with payers/Humana and local providers/Seattle area.

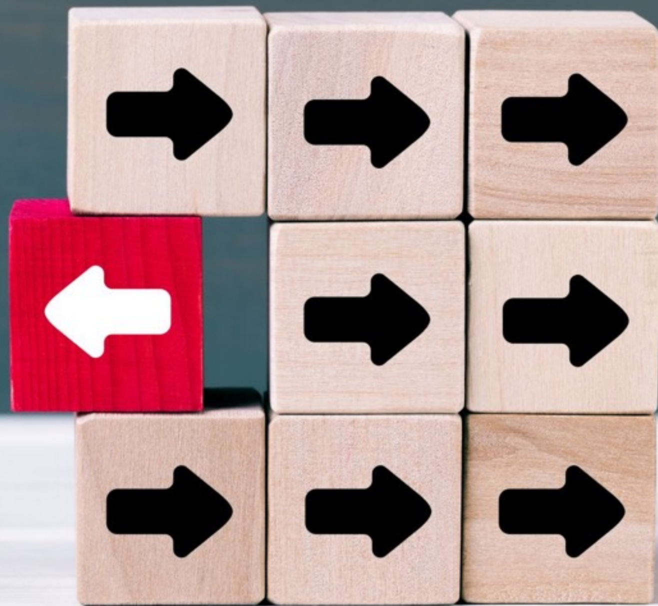
"Walgreens partners with Microsoft to develop new Healthcare delivery models"

1-15-19

- **Walgreens Boots Alliance** and Microsoft signed a seven-year deal ' to develop new healthcare delivery models, technology, and retail innovations to advance and improve the future of healthcare."
- Walgreens will test 'digital health centers' in some of its stores, which are aimed at merchandising and sale of select healthcare-related hardware devices. They will also collaborate on software research.
- "WBA will work with Microsoft to harness the information that exists between payers and healthcare providers to leverage, in the interest of patients and with consent, our extraordinary network of accessible and convenient locations to deliver new innovations, greater value and better health outcomes in healthcare systems across the world."

More Payer Challenges- Anthem and Imaging

Anthem is the largest for-profit organization of BCBS



- Anthem BC – Discontinuing coverage of outpt imaging at hospital. **"Imaging Clinical Site of Care."**
- Directing patients to Free Standing Imaging Center for CT and MRI.
- 2017- KY, IN, MO, WI. Added CO, GA, NV, NY, OH, CA. March 2018- added CT, Maine and VA. 13 states impacted
- Pt steerage, limiting patient choice and labor cost to do prior authorization for CT and MRI. Some exceptions – Rural, tied to pre-op services.
- Quality of care, availability of the reports, interoperability limitations, Rad provider interpreting = all listed as concerns.
- CONCERN: Service is authorized but not at the hospital requested/ Insurance picks cheapest site of service.

Payers- United – Largest payer

Contract and Policies/Webpage. Mid –year changes?

United revenues will hit $243B-$245B in 2019. 4-21/1st Q Reports profit increase of 44% $5B

United Healthcare

- Continues to buy companies that work directly with hospitals. Advisory Group, Optum, physician groups, physician advisor groups. Change healthcare 2-21
- NEW: Site of Service determinations for outpt procedures. *URG-11.03 eff 5-18.*
- *"UnitedHealthcare's Policy will limit outpatient surgery to hospitals…will only pay in an outpt hospital setting if the insurer determines the site of service is MEDICALLY NECESSARY. ..'hopes to guide patients to ambulatory surgery centers. " 10-19*

United Healthcare owns Optum

- Effective 3-18, **ER Facility E&M** Coding Revision for commercial and Medicare Advantage plans.
- Polices focus on ED level 4/99284 and level 5/99285 – whether the provider is contracted or not.
- Using Optum ED Claim (EDC) Analyzer tool which uses presenting problems, dx services provided, and associated pt's co-morbidities.

****Humana added this audit as well 8-20****

Payers – Changing Climate

"**CVS agrees to buy Aetna in $69B deal** that could shake up healthcare industry." 2018

"We want to get closer to the community as all healthcare is local. "

CVS would provide a broad range of health services to Aetna's 22 M member at its nationwide network of pharmacies and walk-in clinics.

Think out of network for other pharmacies.

Amerigroup/An Anthem company

- Effective 7-20/non-participating; 9-1-20/participating. Applicable to ED services provided.
- Emergency Condition: Condition that a lay-person with an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in serious health jeopardy.
- Prudent layperson: To reasonably determine whether an emergency condition exists. Does not have healthcare training with a HC education.
- Only process ED facility claim as emergent.
- Criteria: ICD-10 Emergent Dx have been identified in 'specific' claim fields- **Primary DX =field 67.** **https:**//providers.Amerigroup.com/TX

Payer + Provider: ‘Long road from Contention to Cooperation.”
Money=Power

‘**Anthem/BC (Indianapolis-based) determines ER visits are not covered for 300+ diagnosis. *Non-emergent* 2018>**

- Impacts Kentucky, GA, Ohio, Indiana and Missouri. 40M+ BC members.
- Exceptions: under 14, on IV/new, no other care weekends, physician referrals to the ER, a lack of urgent care available.

American College of ER Physicians:

*“The changes do not address the underlying problem… pts have to decide if their symptoms are medical emergencies or not **BEFORE** they seek treatment.”*

- If the diagnosis does not warrant ‘emergent’ under the payer-specific guidelines, there is on payment to the hospital and providers.
- **EX:** ***Pt in Frankfort, KY –after experiencing increasing pain on her right side of her stomach, thought appendix had ruptured. ER tested, diagnosed with ovarian cysts.***
- ***Patient owed full $12,000***
- Denials are based on **FINAL** diagnosis; with little ‘weight’ for presenting diagnosis.
- ANTHEM BELIEVES 10% REVIEWED/4% DENIED

*“This will create **deaths**. This will make the pt think twice before going to the ER.”- **BCBS TX Physicians***

More Payer-Provider Challenges - Cigna
No longer paying drug administration

Effective 5-19: Reimbursement policy for infusion and injection

- *"We routinely review our coverages, reimbursement and administrative policies… In that review, we take into consideration one or more of the following: evidence-based medicine, professional society recommendations, CMS guidance, industry standards and our other existing policies."*
- *'As a result of this review, we want to make you aware that we will NO LONGER SEPARATELY REIMBURSE infusion and injection administration services billed by facilities because infusion and injections administration services are considered INCIDENTAL TO THE PRIMARY SERVICE and are not separately reimbursable."*
- *"The affected CPT codes: 96360-96379 and 96521 thru 96523. This aligns with our current reimbursement policies for facility routine supplies. (EXCLUDES: Chemo 96400-530 and sub-inj 96372)"*
- **NOTE**: *"In Nov, 2018, we began applying this update to claims from the ER DEPARTMENTS. This updates expands to all areas within a facility."*
  - (No observation or ER. What if have chemo and non-chemo drugs at the same treatment time?)
- **WOW!** A) What is the primary service that is being paid? B) If it is drugs, are you getting full billed charges as it must now cover all visit and all infusion costs C) What about the ER visit or HBC visit?

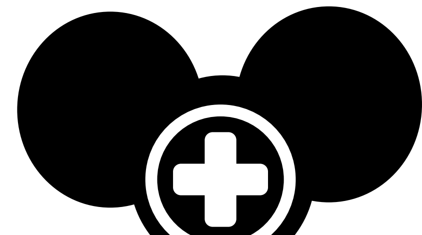
Payer + Provider = New payment relationships

AHA, AHIP and 4 other associations (AMA, BC/BS and MGMA) join to improve prior authorization processes. 1-18

- Six healthcare groups agreed to take steps to make prior authorization processes more effective and efficient.
- Decrease the # of providers required to comply with prior authorization based on their 'performance, adherence to evidence-based medical practices or participation in a value-based agreement with the health insurance provider."
- Prior authorizing only "high value services'. Insurance plan is determining what value-based payment looks like… is this really value based care based on the physician's assessment & believes best care plan? Who decides?

Disney partners with 2 Florida health systems to offer HMO. 2-18

- **Directly contracted** with Orlando Health/6 acute hospitals and Florida hospital, Orlando/20 campuses to roll out two insurance plans for Disney employees.
- **Goal**: lower healthcare costs, higher outcomes
- Using Cigna/Allegiance to administer the program.
- **NOTE**: Remember employer-owned insurance is still looking for ways to reduce their costs..
- 11% of employers are looking at Direct to health system./ National Bus Group
- 2021- increase in employer direct to provider contracts



Denials and being the patient advocate

And when the payer decides to deny a claim, the patient is overwhelmed.

Who is the provider navigator to help defend the denial?

Ex #1 Pt had a burn on lower leg. Insurance paid for the dressing but then stopped paying. Denied as not medically necessary. Didn't know where to go or who to help. Ended up calling their insurance agent/who sold the MA plan. The agent called the insurance and told the pt – nothing they can do. **He paid out of pocket for multiple months.**

Ex #2 Pt's insurance changed after the pt had 3 corrective surgeries. Specialized surgeon and procedures. A 4th surgery was necessary, but out of network. Pt asked their human resource /broker –nothing to help. Then directed to call the insurance directly and ask for help. After another denial, a navigator –advocate stepped in. Outlined the surgery, involved the surgeon to discuss the case directly with the payer, and asked for exception to continue with the same pt care and surgeon. Insurance plan said – there are plenty of in-network ortho surgeons. Now the battle to prove – can't change and no surgeon would take over this level of complexity. After many calls, the pt and advocate did get limited approval. **Then after care denied**. (Can't make this stuff up!)

Ex #3 Pt had muscle pain with inability to dx without a test. A Vit D test was ordered as this was the accepted course of dx work- up for uncontrolled muscle pain. Insurance denied as not medically necessary and they had their own indept company who confirmed same. When told that the doctor needed to determine the level of Vit D –as it is directly related to the reason for muscle pain – didn't matter. **Pt was told they had to pay it and other services related to the Vit D test**. Pt asked the provider –what can they do? They stepped in and did do an appeal. All for a simple Vit D test.. Otherwise, the pt is left paying.

The complexity of healthcare – the relationship between the payer and the patient –all difficult for the pt who only believes:
If the physician ordered it, why did the insurance declare it as not medically necessary?
Physician directed care vs payer directed care. So very hard on the patient. Who can help them? Who actually knows what to ask?
Payer's going wild directly impacts the most vulnerable – the patient.

Use Real Time Data

Real time data means it reflects your current state.

Use RTD to pull out essential KPIs to identify trends and invaluable insight into your organization:

- Days in A/R (Patient and Payer)
- Time from Date of Claim to Date of Payment
- Time from Date of Service to Date of Claim
- Top 20 Denial Reasons (CARCs & RARCs)
- Top 20 Denied Procedure Codes

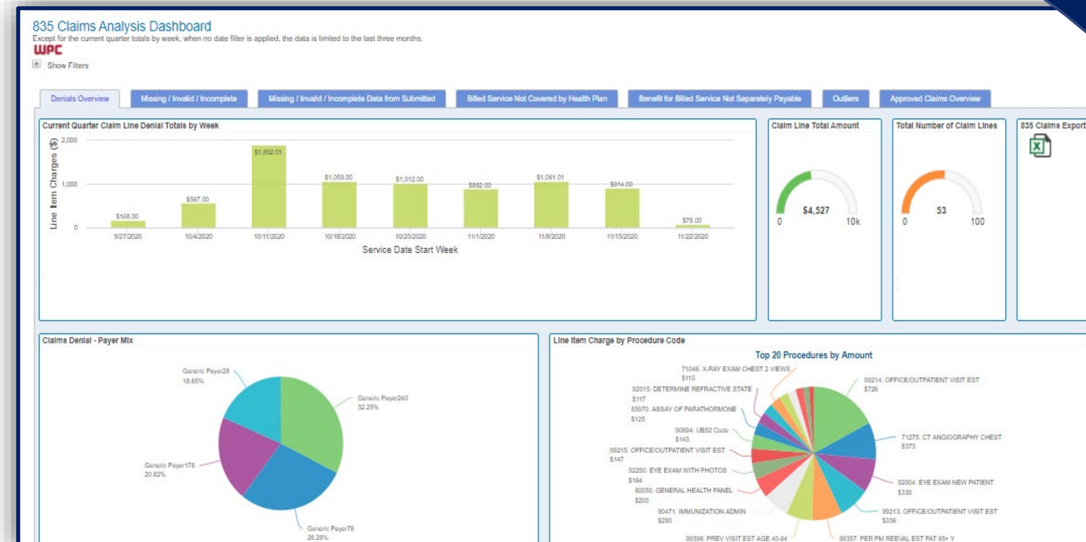
Example Use Case:

Use a pie chart to evaluate the most frequently denied procedure codes and dive deeper to evaluate the cause.

Is it a global service?
Did it lack required documentation?
Did we fail to perform a required authorization?

Once you know, you can act.

Pro Tip: Use a variety visuals to help quickly identify problem areas or reflect on changes overtime



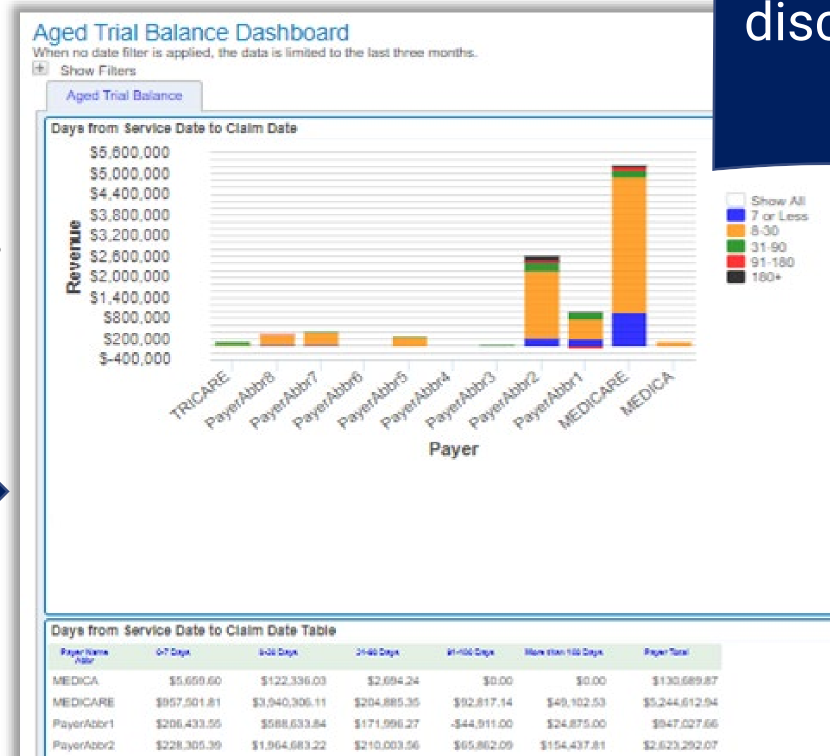
Evaluate Payer Performance

Define what performance success means to you and score your payers.

Assess your payers based upon denial rates and payment velocity

- Days in A/R
- Filter by Payer
- Filter by Plan
- Identify New Denial Trends
- Identify Missing/Partial Payments

Pro Tip: Use color-coded stacked charts to identify A/R buckets quickly alongside the total impact to revenue



Days from Service Date to Claim Date Table

Payer Name Abbr	0-7 Days	8-30 Days	31-90 Days	91-180 Days	More than 180 Days	Payer Total
MEDICA	$5,659.60	$122,336.03	$2,694.24	$0.00	$0.00	$130,689.87
MEDICARE	$957,501.81	$3,940,306.11	$204,885.35	$92,817.14	$49,102.53	$5,244,612.94
PayerAbbr1	$206,433.55	$588,633.84	$171,996.27	-$44,911.00	$24,875.00	$947,027.66
PayerAbbr2	$228,305.39	$1,964,683.22	$210,003.56	$65,862.09	$154,437.81	$2,623,292.07

Example Use Case:

Use harsh colors like red or orange to indicate lengthy payment turnaround.

Train your staff to evaluate and to notify you of negative trends. Engage payer reps in your discussions and in ways to improve.

Know faster, **Solve** faster.

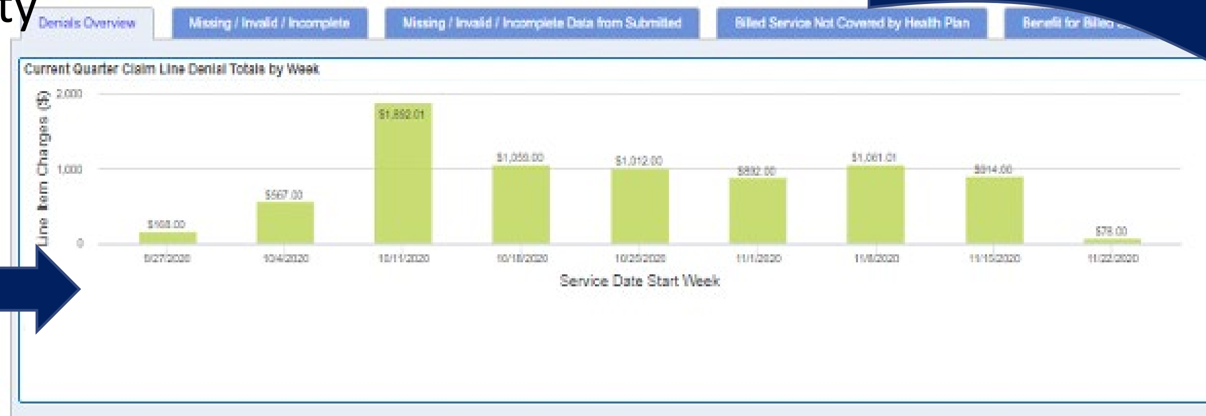
Create Actionable Work Lists

Having data isn't enough, it must be shared in an actionable way.

Once you've assessed the areas for improvement, support those improvement efforts by exporting or pushing out worklists to your staff:

- Group by payers
- Group by denial reasons
- Group by A/R buckets
- Assign to staff for accountability
- Track performance

Pro Tip: Create internal metrics for performance evaluation and check them against staff performance



Example Use Case:

Assign one specific staff member the job of evaluating the cause and impact of the largest three denials from the payer you receive the most denials from.

Brainstorm internal improvement methods and pilot changes.

Accountability and Direction drive Performance

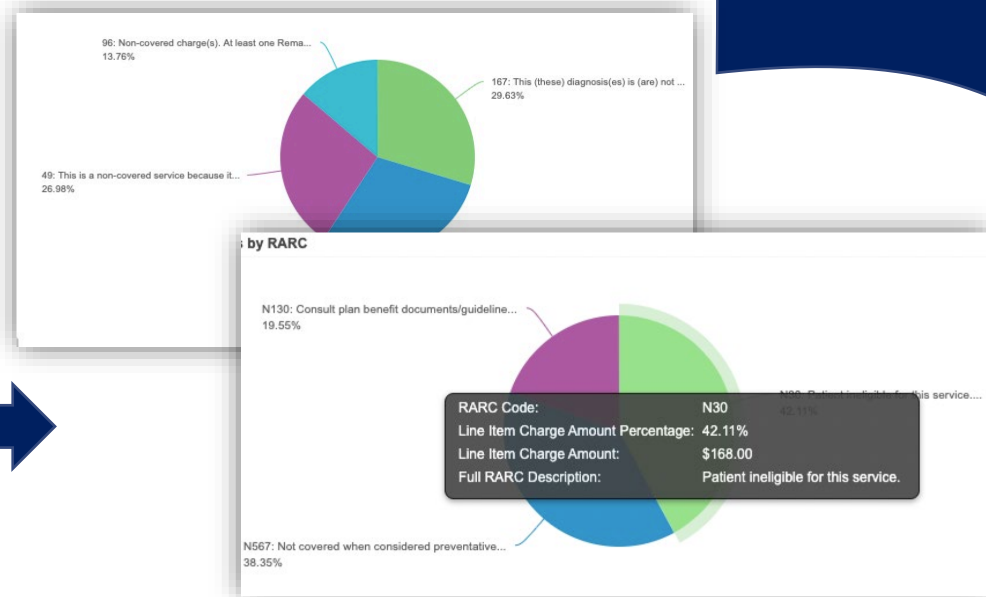
Create Preventive Processes

Don't just manage denials, prevent them.

Most denials are received are due to internal actions. Create processes that prevent denials by educating front line staff on:

- Full Eligibility & Verification Processes
- Complete Demographic Entry
- Bad Data In = Bad Data Out
- Their Impact on the Revenue Cycle
- Required Documentation (ex. ABNs)

Pro Tip: Use CARC and RARC Data to identify internal issues.



Example Use Case:

Filter for denials and group by CARC and RARC.

Evaluate your findings, for example: a significant number of eligibility relate claims may indicate additional education needed at the front desk.

Go from Reactive to Proactive

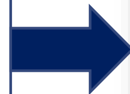
Stay Current on Legislation

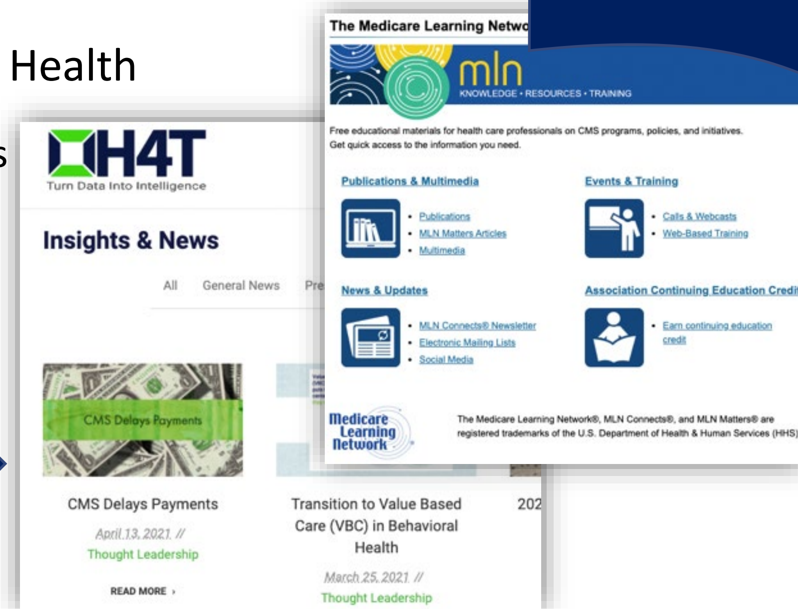
2020 is over, but rapid legislative changes are not.

There are critical pieces of legislation that have recently passed as well as pending legislation:

- March 9th – The AMA released E/M documentation clarity and changes retroactively effective to 1/1/21
- April 13th – The sequestration delay was extended through December 2021
- April 21st - The current expiration date for the public Health Emergency (PHE). PHE has been extended /every 90 days
- July – CMS will issue proposed rules for 2022

Pro Tip: Use trusted blogs, listservs, and feeds to stay abreast of proposed and finalized changes.





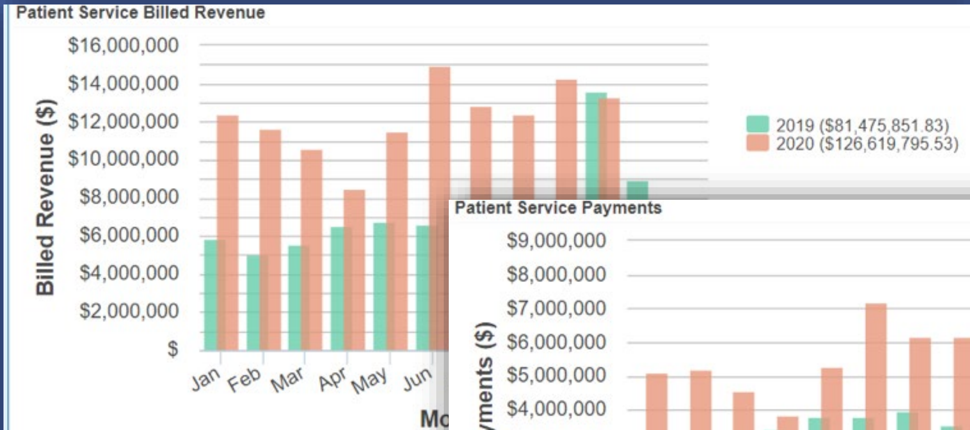
Example Use Case:

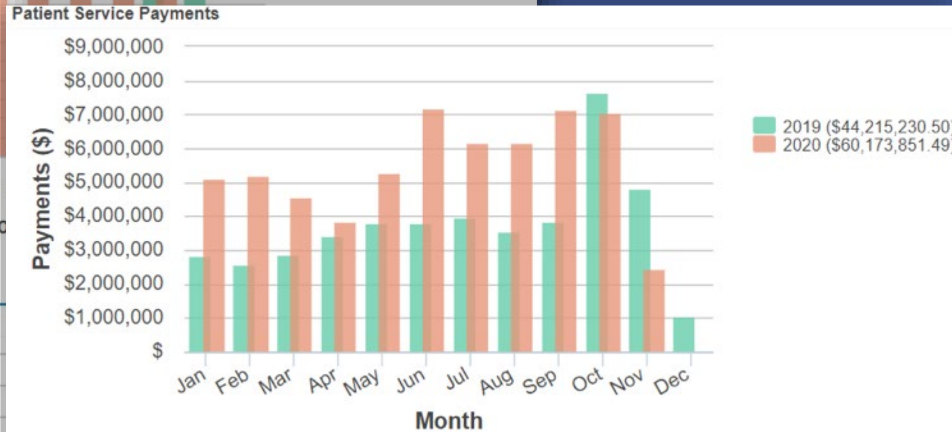
March 30th CMS instructed all MACs to hold payment on claims with DOS 4/1 or later until the house voted 4/13 to extend.

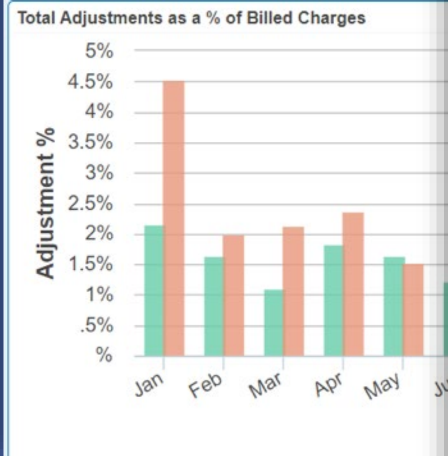
This created a delay in payments to all recipients of CMS funding from 4/1 through 4/13.

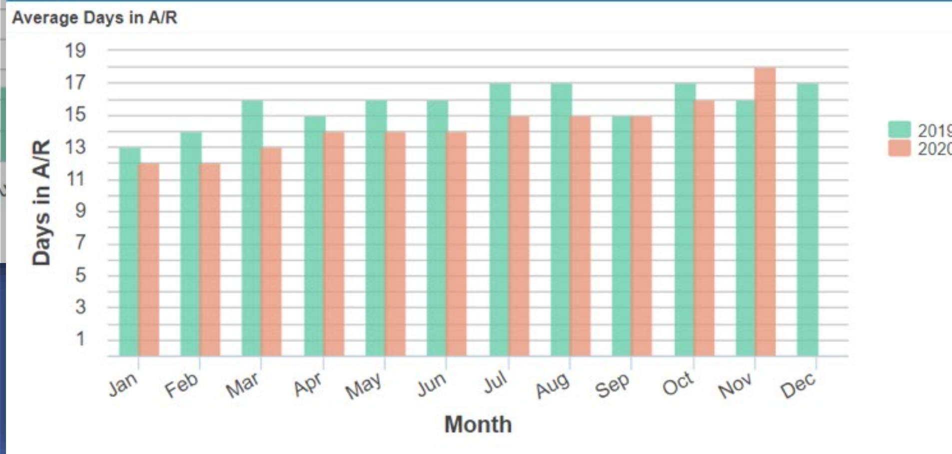
Knowledge + Planning = **Power**

Revenue Cycle: Comparing Year-Over-Year









End users have a variety of actionable ways to use the data and services provided with this offering:

- Quickly access KPIs
- View Payer data by plan or in summary
- View total adjustments as a percentage of billed charges
- Assess accuracy of patient demographic entry through the CARC and RARC data
- Analyze A/R and Aging
- Generate exported data to create actionable work lists
- View patient responsibilities and aging

H4T

Top Strategies

Use Real Time Data to Evaluate KPIs

Real time data means it reflects your current state.
Once you know you can act.

Evaluate Payer Performance - Speed

Define what performance success means to you and score your payers.
Know faster, solve faster.

Create Actionable Work Lists

Having data isn't enough, it must be shared in an actionable way.
Accountability and direction drive performance.

Create Processes for Denial Prevention

Don't just manage denials, prevent them.
Go from reactive to proactive.

Stay Current on Key Legislation

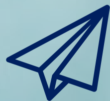
2020 is over, but rapid legislative changes are not.
Knowledge and planning create power.

Compare Year over Year

Trending data can show you a lot.

Thank You for Joining Us in this Educational Journey

DAY EGUSQUIZA
President, AR Systems, Inc.



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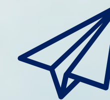

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