Payer's (Still) Going WILD!!

Presented by:

AR Systems, Inc.

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Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.
Let me be the Patient Financial Navigator!

“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.”

“Signs of Disruption in the Revenue Cycle”

- **What are three C’s that keep CFO’s up at night?**
- Compliance?
- Cash flow?
- Customer service?
- Cybersecurity?
- Complaints?
- Competition?

HINT: How about Cash flow, Customer service and CRAP… yep, just plain CRAP!!

- Or Claims Requiring Additional Processing/CRAP!
- Instead of ‘without margin there is no mission.’ How about re-thinking the new world of revenue cycle.
- PS Bet the Revenue Cycle Leaders have a few ‘keeping me up at night too!”

SETTING TRENDS FOR SUCCESS – Every payer issue is ALWAYS a patient issue. Patients pay the premiums and are ultimately responsible for the bill. How much do they know about their plan’s coverage? How to get what providers are in-network/No surprise bill? What will they owe?

Our “A Game” just got more complex…

- Mission Drives Margin. Why do patients pay? What is their perception of value for the healthcare they received?

David Johnson: Cracks in the Foundation (Part 6) — Overcoming inadequate leadership (hfm/9-22)

The American Hospital Association's (AHA) April 2022 *Cost of Caring* report pleads for more funding to offset double-digit increases in labor, supply and drug costs. Meanwhile, the latest West Health-Gallup Healthcare Value Index found that 95% of American adults find the perceived value of the healthcare they receive is "inconsistent" or "poor." Healthcare's leaders, including board leadership, should sit up and take notice.

A failure of healthcare leadership

- The economic principle is not complicated and applies to all industries. Demanding more money for overpriced services is no way to win consumers' hearts, minds and wallets. Warren Buffett famously observed, "Price is what you pay. Value is what you get."

7 strategies for health systems to apply (**Day's Hint: Be the patient!)**

- Here are seven strategies that health systems can apply to create inspired leadership for advancing transformative change:

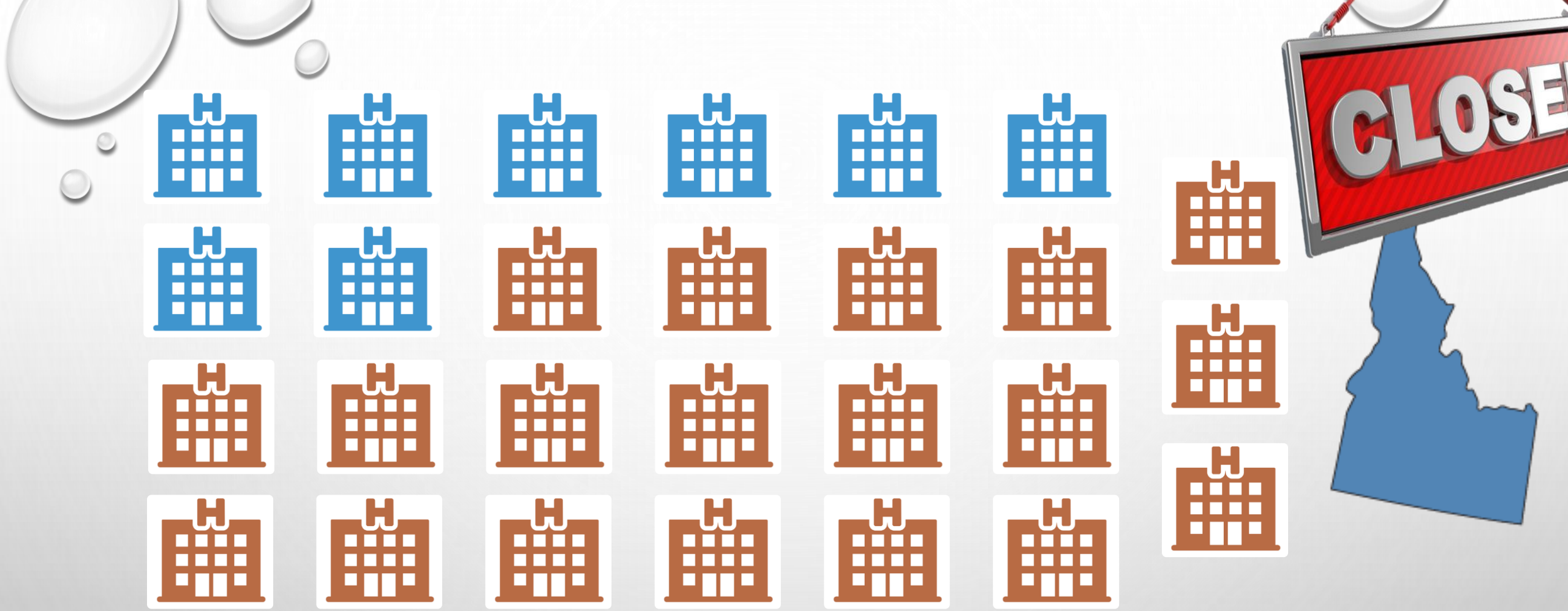
1. Have the courage to lead revolutionary transformation.
2. Streamline organizational governance.
3. Determine and articulate the "just cause" that will guide organizational strategy.
4. Undertake comprehensive culture change to educate and engage employees.
5. Tap the community for support and inspiration.
6. Remember that sacred cows make the best hamburger.
7. Start yesterday.

LET'S CATCH UP ON THE BIG PICTURE ISSUES FIRST

1. Rural emergency hospitals may not furnish acute care inpatient services. What they can provide, however, are emergency department services, observation care and certain outpatient services as permitted by scope. When the category becomes effective in 2023, rural emergency hospital services will be reimbursed at 105% of the Medicare Hospital Outpatient Prospective Payment System amount for covered outpatient services. In addition, rural emergency hospitals will also receive a monthly facility payment amount that increases annually by the hospital market basket percentage.

2. Delay in split visit payment for hospital visits when both physicians and non-physician providers see patients/set for Jan 2023/now 2024. Requirement that TIME SPENT with the patient would determine which provider can bill. Mid-levels/non-physicians are paid 85% of the fee schedule. Therefore, if only time, and NP/PA/ Mid-level bills has more than the MD –results in 15% reduction from 100% that MDs receive. Proposals to use Medical Decision Making/complexity and time to determine which clinician ran the substantive portion of a visit. Stay tuned…

3. CDC: 80% of long COVID/LC pts struggle to complete daily tasks. Of the nearly 24M people suffering from LC, 1 in 4 adults reported difficulty in daily tasks. For Black, Latino, and disabled pts = jumps from 20-40%. Nearly 30% of adults infected with Covid, reported having symptoms beyond the 2 week initial period. **Up to 4M are estimated to be out of work** because of LC symptoms such as: Shortness of breath, difficult sleeping, racing heart rate, exercise intolerance, gastrointestinal, cognitive difficulties and symptoms that worsen even with minimal physical or mental effort-a primary indicator of chronic fatigue syndrome. LC Is classified as a disability but to get coverage, must have test to prove---which does not exist. (New medical bills! Employment status!) 9-22



IDAHO'S RURAL COMMUNITY HOSPITALS

ONLY 8 OF 27 HOSPITALS ARE FINANCIALLY VIABLE, PER IHA, 2018

OUTCOME: LEGISLATURE SAID NO TO FUNDING EXPANDED MEDICAID. VOTE OF THE PEOPLE SAID YES WITH 67% IN FAVOR.

LET'S CATCH UP ON THE BIG PICTURE ISSUES-NEXT

The Inflation Reduction Act: Congress passes bill extending ACA subsidies, adding Traditional Medicare's ability to negotiate for pharmacy/Part D pricing for some drugs and provide a new cap. YAHOO- FINALLY! But the Senate GOP did block a measure to bill a cap for insulin at $35 for Americans and private medical insurance. Medicare pts will have the potential benefit. Bill extends the Marketplace subsidies thru 2025. Approx 14.5M enrollees were lured with help with premiums. Lowest uninsured at 8%.

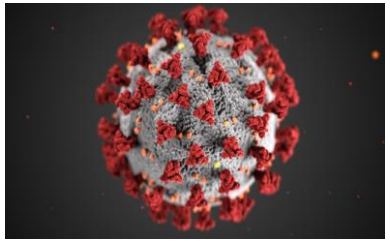
Improving Senior's Access to Care Act of 2022- Working thru the process of tweaking the version of last year's Medicare Advantage prior authorization reform. Lots of attention!

Lots of national focus on:

Medicare Advantage inappropriate denials. 18% denied that would have been approved with TM/ cane & MRI ex. Remember – MA plans can offer more than traditional Medicare, not less.

Prior authorization. Plenty of 'e' options being discussed; automated vs fax; but bigger problem is not how it is sent, but why? What are the 'medically necessary 'rules each payer has developed for coverage? Rapid reply with jointly agreed to criteria = contracting.

COVID-19 QUICK HIGHLIGHTS



Public health emergency /PHE extended . Waivers as outlined by CMS are still in effect. (Thru Jan 2023/renew every 90 days). Administration said they would give 60 day notice if it was going to change.

- NOTE: During PHE, Medicaid recipients were not removed from the active roles. No screening or loss of insurance during PHE.
- Many waivers have been in effect since 1st PHE – 2 + years. Plenty to unwind. Including will telehealth to continue in any setting?? BIG!

CARES ACT= no charge for the vaccine or administration. Insurance billed/they pay. If no insurance/HRSA. But no 'cost share' to the pt for administration of the vaccine. Add-on Booster approved. $40 for adm cost payment.

Cost of testing for COVID: ranges from $240/ARK with many averaging around $145. If the pt goes to the ER or urgent care center, there will likely also be a facility fee. Billed to insurance/pt. *Most payers waived, some no longer are. Some providers waived OOP.

20% add on to DRG for confirmed test in record. Lots of challenges with transfers, indept labs, locations, EMR, etc. FOR MEDICARE Patients. (ID: ave age 72; now 58. Different payers)

US Death toll:

As of Oct 6, 2022: 1,062,130 Daily ave: 343

Ave daily new cases: 43,692 W/O counting self tests. (New Booster is now available! YAHOO!)

Long COVID means symptoms beyond initial positive case

Some can have symptoms up to 2 yrs later. Biden calls for an –all-hands-on-deck effort to study Long COVID/HHS. These symptoms can include fatigue, cognitive dysfunction, chronic pain, neurological issues, organ damage and many others. 4 M are unable to work. (Time, 8-3-22; 3 min read/Healing American Healthcare Coalition.)

1. People can get COVID More than once. (Auto Immune daughter – 3x; different variants each time. Fully vaccinated but just can't fight it off.)
2. Long COVID is different for different people. If there is a pre-existing condition, the virus attaches itself to that 'risk area' and symptoms vary.
3. Women appear to suffer more persistent symptoms than men.
4. The study found even mild COVID cases resulted in chronic, long-term issues.

AND START WITH A LITTLE "PAYER FUN"

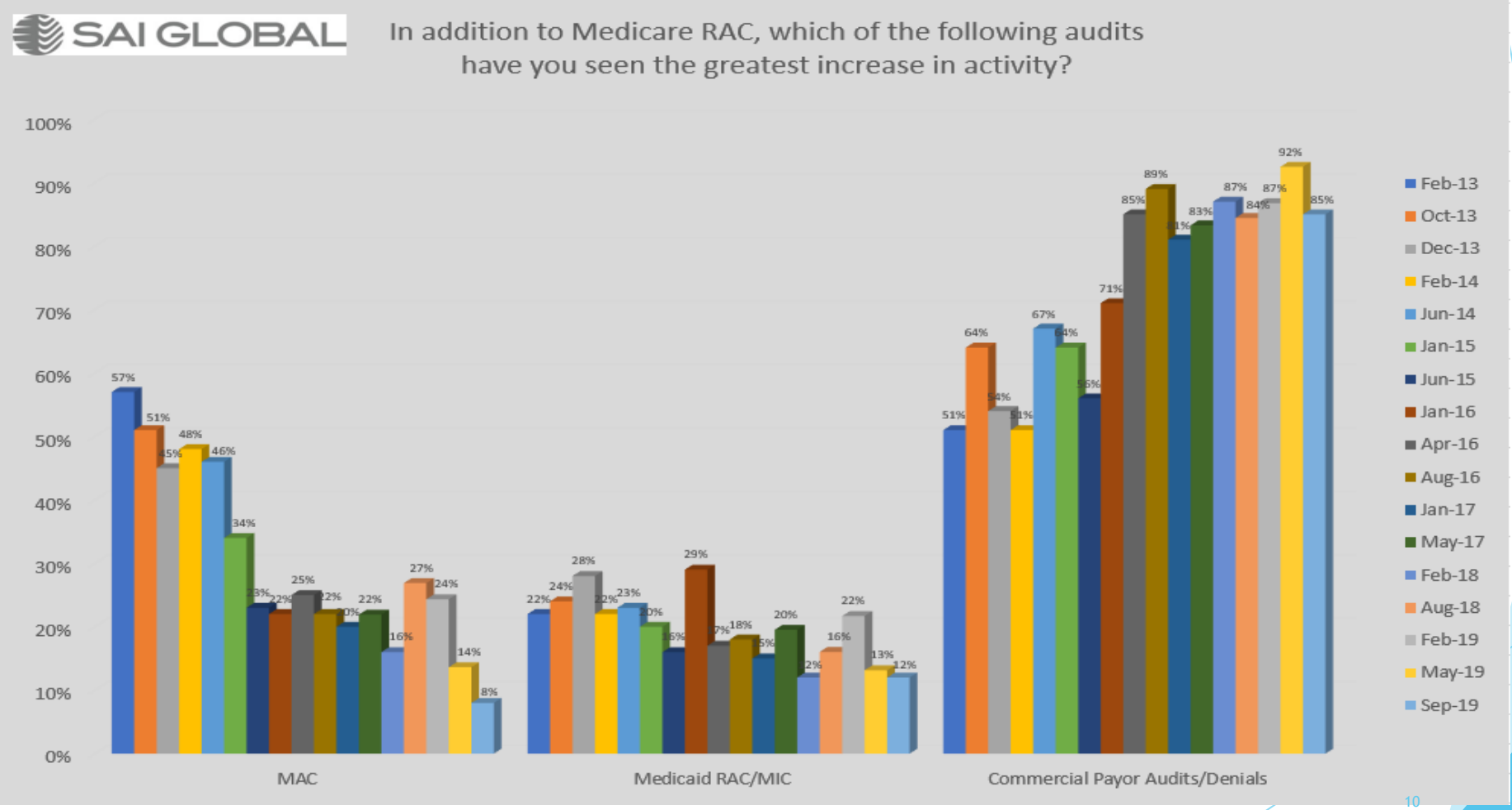
THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U	usually
N	nine
I	in
T	ten
E	experience
D	denials…..

C	called
I	in
G	got
N	no
A	answer

++All time favorite: Singing the"Blues "

8 year history with Compliance 360
SAI Global – free webinars… Recorded*



Payer: Traditional Medicare

- RAC audits are back
- Prior authorization rules
  - additional procedures & mandatory new electronic rules/govt payers/PAUSE
- Office visit E&M new criteria, effective 1-21
- ER non-emergent issues
- Loss of ALL inpt only procedures/CANCELLED. Aggressively moving outpt approv procedures to ASC/ 11 in 2021. 1-22 new list of removals from inpt only CPTs published.
- No Surprise bills- effective 1-22* Payer, provider & patient impact.
- Transparency- 1st 'warning' by CMS/with fines& PAUSE/publish of non-compliant hospitals, 2021 -updated penalties *larger facilities, higher penalties/proposed. 95% hospitals non-compliant/ Washington Post 7-22. Payers now impacted 7-22. CMS begins issuing fines. 8-22
- 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/TPE. Pre-claim reviews: prior authorization for 5 identified outpt procedures. (TPE – common issues on CMS webpage.)
- 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)

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 +++ upward of $15,000-$30,000

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

PRIOR AUTHORIZATION HAS COME TO TRADITIONAL MEDICARE – CERTAIN OUTPT PROCEDURES 7-1-20

Hospital outpt impacted only. No surgery centers, no in-office procedures.

Five groups: Blepharoplasty,Botulinum Toxin Injection, Panniculectomy, Rhinoplasty, Vein Ablation.

Submit required information to A/B MAC. No required form. Mailed, faxed or electronic

Initial or resubmission review. Decision within 10 Bus days.

Unique tracking #. Claims must have the UTN. ??FL 1-18 but check with MAC.

Provisional valid for 120 days from decision.

If no UTN, denied. If not prior approved, denied.

2021 Discontinue all inpt only Surgeries within 3 years. All fall to 2 MN rules or outpt. Or new prior authorization? 2021 – move 300 musculoskeletal off. Increase OPPS $ by 2.6% in 2021. Also allow ASC to perform 11 more procedures –including hip arthroplasty – making 28 new procedures being allowed in ASC/ambulatory surgery centers. WOW!

1-2022. List of CPTs no longer on the inpt-only list are published/active. However, the original rule to eliminate all inpt only CPTs is not going into effect. Per usual yearly updates. 8-22 Report says $48B paid incorrectly for cosmetic-type procedures/MACs/CMS need to do more oversight

Payer: All payers – new CPT guidance

Physician office E&M new guidelines, only

- **Biggest** change to E&M since 1995/97
- **Only** impacts office E&M visits
- Audit risk: Carefully monitor bell curve.
- Medical decision-making vs time for entire day/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)
- **BEWARE BUDGET NEUTRAL**! 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) ****Increase in 99204/99214**

Anguish of Prior Authorization – High Value vs Low Value with many payer approvals. *Fed Legislation*

- Delays in medically necessary, physician ordered, patient specific care
- 21% of 182 M authorization transactions were full electronic in 2020.
- Provider authorization processes:
  - Eligibility verification check - 12 min
  - Determine if an authorization request was already filed.- 3 mins
  - Inquire if an authorization request was already filed. – 2 mins
  - Submit authorization request – 11 min
  - Process payer's clinical questions and requests for additional information – 15 mins
  - Inquire concerning authorization request status – 2 mins = 45 mins. (CAGH index 2020)

And what if the initial request is denied? Now alternatives? Patient notified? Provider tried to appeal? Cost and impact to pts' health.

What about the hospital UR, Cancer, Imaging, etc. other departments? Is this cost even tracked?

- "AHA urges CMS to address Prior authorization issues affecting Medicare Advantage patients."
- New, input request to the Biden Adm on the need for mandatory electronic submission and timelines for replying. (Question: Who sets the rules for what services need prior auth? What are they and how can the providers know the rationale behind)
- Value based care = focusing on high value procedures, not excessive outpt volume. (Problem – many payers requires low acuity procedures, ex xrays, prior to approving a higher acuity procedure, ex. MRI. Overutilization? And patient pays due to high deductibles. How does that drive down the cost of healthcare –to the system and the pt?) High value determined by ea payer.
- **Denials steadily rising, up to 10.8% 2ndQ 2020 - ½ of claim denials are caused by front end RCM such as prior authorization**. (Change healthcare 2016-2020)
- AMA research – 14 hrs weekly spent trying to get prior authorization. Impact to pt care.

CMS guidance on Prior Authorization- NEW LEGISLATION
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.*

Regulations 42 C.F.R. § 422.214
If non-contracting with a Medicare Advantage/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.)

Anguish with MA plans –Not Contracted- sent CMS traditional Medicare rates to MA plans.

- Not being paid correctly according to the CMS/Traditional Medicare/TM rate.
- EX) Each claim, the hospital is sending the letter to actual payment rate issued by CMS/TM.
- EX) Each claim is not being paid correctly EVEN with the additional cost of manual intervention.
- EX) Southwestern states- MA plan said they 'did not like the new format of the CMS/TM rate letter.' Wanted it in a different format before they accepted it. WHAT?
- Each example – the hospital had submitted the CMS letter to the appropriate person/per the MA plan. Still required the per-claim proof.
- File complaint; in violation of previous slide 42 CFR 422.214 .
- Noteworthy:
  Many examples were Critical Access hospitals – who have daily rates with CMS TM. MA plans must follow all CMS TM for all services as there is no contract.

Medicare Advantage – Provider WINS –

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

If the plan approved the furnishing

of a service thru an advantage

determination of coverage,

it MAY NOT deny

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

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Mgd Care Manual/Medical

Necessity, Chpt 4. Section 10.6.

- **New process: With each request for records from the MA plans, leadership reviews: was this already prior approved? Yes. Send attorney letter telling the MA plan/or their representative they are in violation of the above section. Discontinue requesting and any subsequent denials or recoupments or a formal complaint will be filed with CMS. Track and trend by payer.**

- 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.

Payer‘mis-information’ for Medicare Advantage plans

- “Recently we received a denial for a status 3 years after the encounter. The pt was here for an OP Hemorrhoid procedure developing vomiting with distension of a colonic ileus. History of Olgilvie syndrome failed 48 hrs of outpt treatment. Inpt was approved thru payer contact prior to billing/3 years ago. Now the 3rd party vendor is stating he did not meet inpatient criteria.”
- Medicare Managed Care Manual, Cpt 4, Section 10.16. And Program Integrity, Cpt 6, Section 6.1.3 Medical necessity applies:
- **“If the plan approved the furnishing of a service thru an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity.” YAHOO!**
- Turn in abuse to CMS – as oversight for all MA Plans.

More payer anguish -Place of service Audits

- “One carrier has enlisted HDI to audit place of service. They sent us 10 cases, all Medicare Advantage, DOS vary from 2016-2018, only one case had a 1 day LOS and they all say the same thing: “The patient could have been safely and appropriately cared for in an outpt level of care.” Now that sounds like a medical necessity denial to me. The kicker? I have already been denied 4 of these cases (back in 2016 and 17) and one was overturned by peer to peer, the other three were overturned on written appeal. How can this be possible? “ Western Conn. 8-18
- SEE PG 18. It can’t! But think of the wasted administrative costs to continue to a) track, b) defend and c) repeat defend. Track and trend and turn all costs into Contracting.

More payer anguish - Outpt

- "For the last month or so, we have been getting letters from UHC wanting the medical records on all our outpt services and even if they are the 2nd payer and owe us under $100, they want the records. They are asking for records for a simple CBC, strep test, drug screening, mammo,and colonoscopies. In many cases, it is costing us more to send them the medical record than what our actual reimbursement would be. I filed a complaint with our UHC Advocate and we have a phone call set up. They are calling it "pre-payment letters.' In many cases we have a prior authorization and they are still wanting the complete medical records. Now other payers are starting to do the same thing." Ill 80 bed hospital

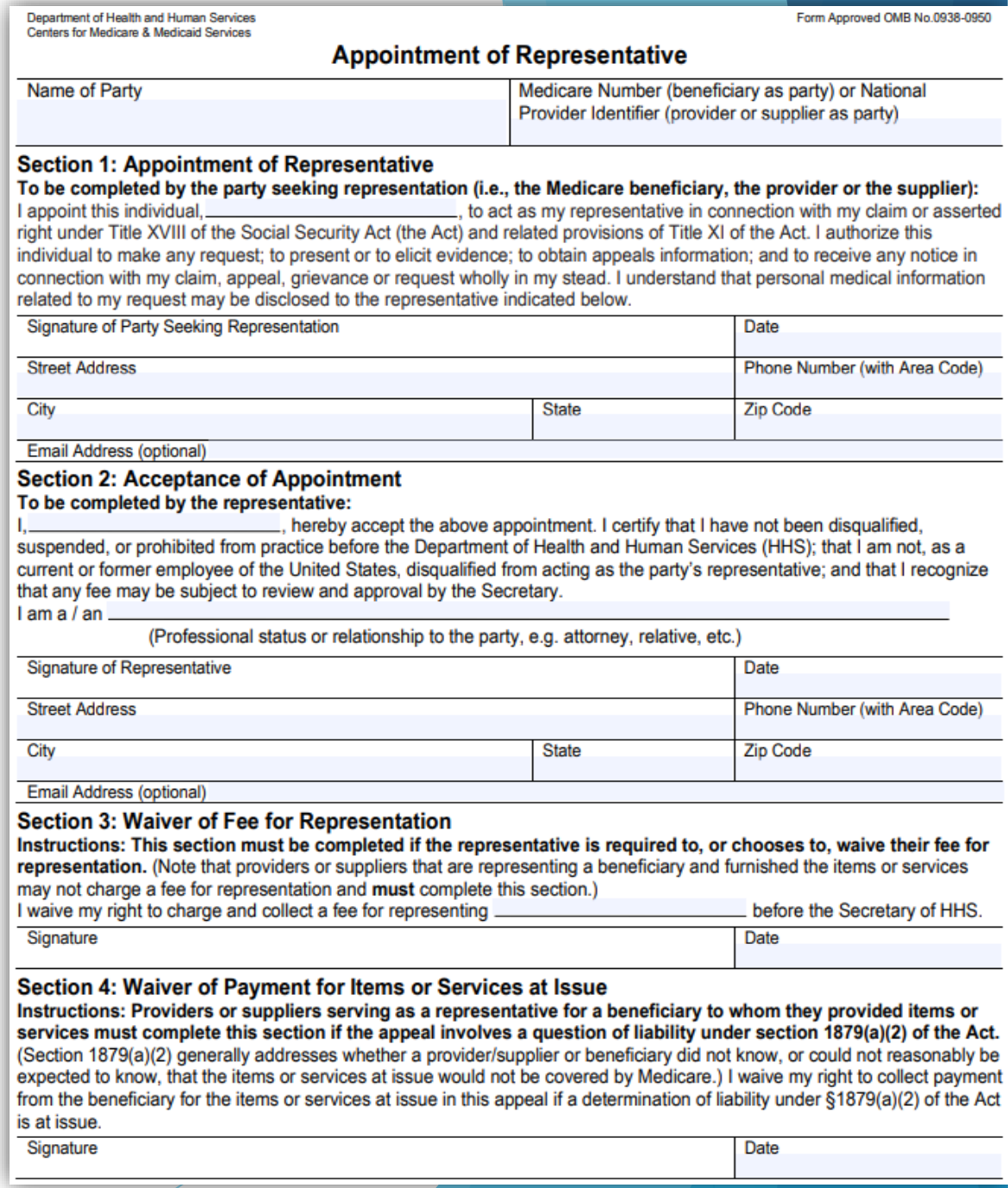
- Most are commercial UHC and we are contracted..
- Why asking? More dx = better long term payments for MA plans
- No idea why we would agree to this but under PROTOCOL, we have to respond.

"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
Appointment of Representative (AOR)

- 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

Specifics – Disputes with payers.
Internal MD/Physician Advisor with the Payer's MD

- **What is a Peer to Peer call? Trained internal physician advisor speaking to the payer's physician. Goal: Resolve dispute from initial request for inpt. All done prior to claim submission.**
- **Re-evaluate the initial 'submission' to the payer for prior authorization. *1st touch* Submit cover letter with initial submission – WHY an inpt!**
- **Payer's use some type of clinical guideline to determine first decision: Inpt or Obs**
- **EX) Aetna denial letter/NC. 'We reviewed information against MCG guidelines for inpt and surgical care. The requirements are … The member doesn't meet any of these requirements."**
- **Important to a) Know what the individual payer is using. B) Present the case as it appears from the ER/Acute level including the 'meet' and other co-morbid conditions, risk factors as not all cases 'fit' into MCG or IQ.**
- **CDI work usually happens AFTER the records have been sent in the initial ask. How does this information get updated to the payer? Absolutely use in the P2P call. "New information!" Powerful.**

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… CONTRACT, CONTRACT, etc

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 done. 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.

Payer Uglies – In Contract. Watch and ensure there is an understanding prior to signing. HUGE!

- Humana – Claims Payment Policy
- Subject: Inpt to outpt Rebilling
- Published: 9-2016 Policy # CP2015018
- Claim for inpt services when an inpt admission was not medically necessary. ***(PS Based on their decision and guidelines. Do you know it?)***
- ***Humana's Medicare Advantage plans follow the CMS guidelines for inpatient Part B rebilling. (PS- they do not use the 2MN rule, they require records sent for prior auth, delays in replying)***
- When an acute care hospital determines **BEFORE discharge t**hat the pt should not have been admitted as an inpt, Humana will ONLY accept services submitted on an appropriate outpt bill type (131) or 85X and will allow the provider to submit all codes for a normal outpt situation and required Condition code 44. (Again, not following TM rules but applying CC here. Even with this ruling, delays in ruling and time to get CC 44 done, which means pt notified, UR committee done, attending doc/notified and order changed – then can bill obs. UG!)
- When an acute care hospital or Humana determines **AFTER discharge** that the pt should not have been an inpt, Humana will only accept inpt bill type 121. This billing should reflect the reasonable and necessary Part B services and provide CPT codes where appropriate. Report condition code W2 to indicate this is a Part B claim and include "A/B Rebilling" in the treatment authorization field.
- For pre-admission services in the 3-day payment window, the hospital may separately bill for services prior to an inpt admission and should report "A/B Rebilling" in the treatment authorization field of the appropriate outpt TOB 131 or 851.

WOW and DOUBLE WOW! Additional Thoughts:

Did contracting know of this clause? Why allowed?

How long is it taking to get initial decision? 3-5 days? What are the chances of getting the P2P scheduled, done and decided PRIOR to the pt leaving?

Order says inpt? How did the provider bill?

Patterns from payer determination letters: Aetna (ex)

- Aetna: MA account. Using clinical guidelines. 'We use national recognized clinical guidelines such as MCG, as well as ***clinical policy bulletins to support these coverage decisions***. Coverage has been denied for the following reasons:
- We used inpt and surgical care MCG guidelines. The requirements for coverage are: (1) active bleeding w or w/o high-risk endoscopic features; (2) hemodynamic instability; (3)severe anemia causing heart failure, cardiopulmonary symptoms and /or cognitive impairment; (4) severe liver disease or abnormal coagulation; (5) treatment intensity or monitoring that requires inpatient treatment; (6) severe thrombocytopenia; (7) inability to tolerate oral hydration; (8) previous aortic graft placement or known aortic aneurysm; or (9) documentation of significant active comorbid conditions requiring hospitalization. The member did not meet any of these requirements.

- PLUS: Peer to peer: 'It you are a treating practitioner and you disagree with a coverage denial, you may request a peer to peer with the Medical Director who made the decision. Follow fax: Scheduled P2P call within 14 days to speak to Med Director. (**DOS: 5-18 Rec Ltr: 5-24. 6 days)**

***Change of internal request for inpt. Develop a payer matrix to know exactly what every payer is using. MA plans – use CMS form to create a representative for each MA pt/ internal PAs.

Is patient still inhouse? (ex)

- United. MA plan. Level of care determination/while in house.
  Note: Moved from MCG to IQ, May 2021. Bought Optum who owns IQ.

- "Not met? My determination is based on the health plans and *Medicare criteria* that says a member *must show signs and/or symptoms severe enough to need services that can only be provided safely and effectively on an inpt basis. (Major subjective!)*
- Based on my review, these criteria haven't been met. My rationale: this pt was admitted on 4-7-21 with sepsis unspecified organism. We reviewed the medical information made available to use, as well as the health plan criteria for admission to the hospital, and have determined that this does stay does not meet inpt admission.
- The reason is there was no hemodynamic instability. Hypoxemia, altered mental status, bacteremia, parenteral antimicrobial regimen that must be implemented on an inpt basis. Consequently, acute inpt hospital admission is not covered." (IQ guidelines + UHC)
- What to do if disagree? You can request a P2P review. Send secure email or call #.
- Can a claim be submitted for this claim? If you submit an inpt claim, it will automatically be denied. You will received reconsideration process on your remittance. **DOS: 4-17 Ltr Rcd: 4-21 4 days**

You can still submit an outpt claim for all medically necessary services. Look to Medicare Claims Processing Manual, 100-04, Chapter 1, Section 50.3.2. (Condition code 44/TM)

WOW! UHC is using their own criteria, **not the 2 MN rule**, requiring hospitals to submit for review and then requiring the hospital to follow Traditional Guidelines/CC 44 when denying. WOW! NO WAY!

A little bit on No Surprise Bill – Impact to the pt to know –is the new provider in my network?

- Shortly – just shoot me now!
- Goal is to prevent surprise bills by helping patients know - what providers are in my network?
- Thought that was easy? It never has been and it appears it is still too complex for patients.

- EX) Pt had referral to a regional hospital for testing/workup. First time going there – checking to ensure this hospital was in her employer's network.
- 1st: Checked webpage. Asked for provider list, with insurance, in so Idaho. Could not find it this way.
- 2nd: Went to the ins name.org, then prompted to find care, then find a doctor, and input employer. Still nothing.
- 3rd: Called HR, said to call insurance plan. Employer does not have a source of who is in-network.
- 4th: Called insurance plan. 2 different calls: 1st answer, after 4 transfers, yes in network but had to look under a new,enhanced benefit plan name: ___. Asked, what employee would know this was how to look up or ask when it is not the name of their insurance? (Benefit plan vs actual insurance name)
- 5th: Called insurance /2nd person. Told not in-network with regional hospital. Also asked employer VP of finance/contracting, nope, not in- network.
- 6th: Called regional hospital. Asked for PFS Director. Yes, all commercial and MA plans are in-network.
- 7th: Who to believe? When we say – patients need to be more accountable to stay in-network – plz advise how that is to be done, exactly? Employer = no. 1 payer call = yes, and then no. Website – didn't bring up. Finally call new provider = yes, they knew. But what if it is does deny anyway?

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

Post –discharge, outlier payment, **line item audits.** Commercial, MA, Medicaid Mgt Care. Each payer has their own list, their own justification, internal.

- If paid by DRG and an outlier payment is expected, here come the line item audits. If paid a % of billed charges, here come the audits.
- Absolutely a contract issue. Join other providers. Strategize. Charge the payer for sending records, make decision to severe contract, etc. What to expect? CMS: R&B covers routine nursing. Defined?

Unbundling: Disallowing any separate nursing charges. R&B covers all nursing inpt uniquely ordered services. Separately ordered, separate CPT coded during obs or inpt not covered. NO venipuncture, in-room pt specific ordered treatments/blood transfusion, ICU/ ventilator daily, drug adm, Conscious sedation, assisting provider with procedures/any setting, CPR, suctioning.

Routine: Surgeries. Disallowing many unique supplies to the patient, unique to the unique to surgery charges. All covered in the per procedure/per time charge

What to do with line item audits?

- Some payers are strictly using the itemized statement to disallow. *They have to request them as they are not submitted with 837/claims.
- **How pt friendly are the descriptors**?
- OR levels – have you developed an outline of what is covered in each level? Procedure level vs time – what is included, reducing price of multiple procedures. (Set up, clean up, routine supplies, all staff in attendance, sterilization, preference card items, 02)
- Nursing services – have you developed what is covered in R&B rate? ICU will be different than medical/surgical. (Medical: 8 hrs direct pt care, CN A, usage/equipment in the room, IV items, cleaning, adm meds.)
- NON ROUTINE: Separately ordered for the pt, specific to the patient, usually CPT, documented.
- Assume the payer 's team does not know what is included in ANY CPT code or how it is used.
- What is the payer's definition of routine, unbundling, etc? Need their policy ahead of time to review

- If requesting a full medical record,validate prior to sending. If records are sent, charge fee and get payment prior to sending. $150 ea
- OR OR OR – require all line- item audits be done onsite. Have a trained nurse /revenue cycle internal staff sit with the payer. Every line item is discussed, with the internal staff noting all variances.
- This internal control will ensure a) variances are known immediately, b) challenges are ready to be sent and c) anything need clarified?
- Is there a fee for having your staff away from their regular job?
- **Be ready to discontinue contract. Where does it say this is allowed? Join with others.**

ROUTINE VS NON-ROUTINE SUPPLIES & ROUTINE NURSING

The Medicare Reimbursement Manual defines Routine Services in 2202.6 on page 22-7:

"Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

"In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. " (See § 2203.1 for further discussion of routine services in an SNF.)

Fighting Itemized Bill Reviews/Forensic Audits

(Thanks, Chris Louftin, Regional BO Director, Baptist Memorial/SE, HFMA Region 8)

Most large payers are now using vendors to perform itemized bill/forensic audits in an attempt to remove billed charges for the sole purpose of reducing the hospital's inpatient outlier payment.

- The most common vendors used by payers are as follows:
  - Equian (owned by Optum)
  - CERiS
  - MedReview
- The vendors attempt to use the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) to justify their tactics.
- Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The regulations governing for operating costs under the Inpatient Prospective Payment System (IPPS) are located at 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86. CMS publishes the outlier threshold in the annual IPPS Final Rule.
- The Centers for Medicaid and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) gives providers the latitude on creating and maintaining a charge structure as long as the charge structure is charged consistently to all patients. The PRM does not mandate or give the MA Plan the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- The best way to fight itemized bill reviews/forensic audits is through your payer contract.
  - Threaten to terminate your contract unless they remove the itemized bill reviews/forensic audits.
  - Update your payer contract with language that gives you the option to terminate the agreement if the payer implements a cost-containment strategy not clearly defined and agreed to in the contract.

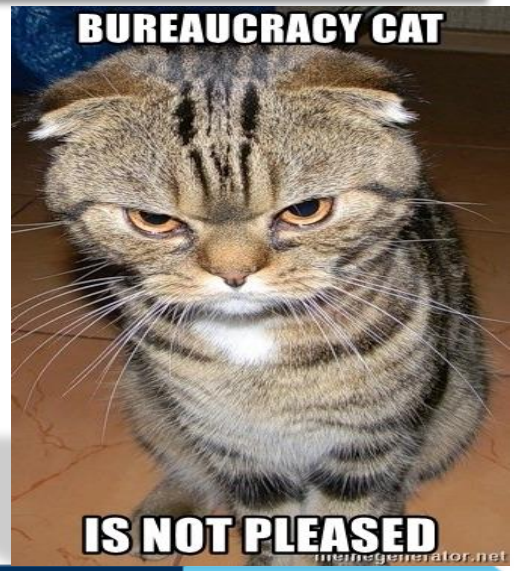
Payer Challenges: It's All About the Money!

Health Insurance Companies are reporting record profits at the expense of providers.

Insurance	2017 revenue	2018 revenue	2019 revenue	2020 revenue	Revenue increase from 2017 to 2020	% Revenue Increase (2017 to 2020)	2017 net income	2018 net income	2019 net income	2020 net income	Net Income increase from 2017 to 2020	% Net Income Increase (2017 to 2020)
United Healthcare	$201.16 billion	$226.25 billion	$242.16 billion	$257.14 billion	$55.98 billion	27.83%	$10.56 billion	$11.99 billion	$13.84 billion	$15.40 billion	$4.84 billion	45.83%
Cigna	$41.81 billion	$48.65 billion	$153.57 billion	$160.40 billion	$118.59 billion	283.64%	$2.27 billion	$2.64 billion	$5.10 billion	$8.46 billion	$6.19 billion	272.69%
Anthem	$90.04 billion	$92.10 billion	$104.21 billion	$121.87 billion	$31.83 billion	35.35%	$3.84 billion	$3.75 billion	$4.81 billion	$4.57 billion	$0.73 billion	19.01%
Humana	$53.77 billion	$56.91 billion	$64.89 billion	$77.16 billion	$23.39 billion	43.50%	$2.45 billion	$1.68 billion	$2.71 billion	$3.37 billion	$920 million	37.55%
Centene	$48.38 billion	$60.12 billion	$74.64 billion	$111.12 billion	$62.74 billion	129.68%	$828 million	$900 million	$1.32 billion	$1.81 billion	$982 million	118.60%
Molina	$19.88 billion	$18.89 billion	$16.83 billion	$19.42 billion	$-0.46 billion	-2.31%	$-512 million (loss)	$707 million	$737 million	$673 million	$1.19 billion	231.45%

Average Claim Denial Rate for Large Hospitals

Geographic Region	Denial Rate
Northern Plains	10.58%
South Central	8.88%
Midwest	7.89%
Southern Plains	7.72%
Pacific	7.58%
Northeast	7.21%
Mountain	7.18%
Southeast	7.14%



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 to**, 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. Chpt 3 Sec 40 2.5

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.

United Health Care Readmission- 30 days for any related reasons *common language. Paid for only 1 of the 2 admissions.

- 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…**
- **Exclude ALL CHRONIC CONDITIONS from readmission penalties.**
- **Finalize which of the up to 10 dx/order of have to be 'same/similar' for rejection.**

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 denials.** 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.

Creating a Payer-Specific Matrix

Great tool in the toolbox

<u>Key elements in having the inpatient vs outpt observation discussion with non-Traditional Medicare payers</u>. (HINT: Better practice ideas)

- Each payer has their definition of 'what is an inpt.' ***Traditional Medicare is the only one using 2 Midnight rule; not IQ or MCG.***
- Each payer should have published what they are using in making that determination. (EX: Humana/MCG; United/MCG sort of/moving to IQ in May 2021; Indept BX plans/IQ-some moved to MCG)
- Each payer should have a way to request and complete a P2P challenge of patient status. (Contracted or within polices on webpage)
- Once this information is created as an internal matrix, now both the UR and the PA team know – what is this payer's unique definition of an inpt.
- **Oh, not so simple -you say**. YEP – as there is unlikely anything tied directly to a contact payment or penalty if they don't follow their own guidelines. BUT – it is the beginning step of a) requesting an inpt based on their own published clinical guidelines, b) UR's efforts to confirm the inpt and c) talking points if a P2P call must occur.

PAYOR	HEALTH PLAN	PLAN TYPE	CONTRACT IN PLACE	UM CRITERIA	DRG	SURGICAL LIST REFERENCE	IP NOTIFICATION/ AUTHORIZATION	INTAKE-IP NOTIFICATION CONTACT
Who is the primary Insurance Payor?	**What is the name of the Health Plan? UM should look at & start to think about what Payer and Plan Type does this patient have?**	**What type of plan is this? Knowing the type of plan can assist UM to think - Medicare regulation vs State Regulation vs Commercial contractual obligations vs. Corpoarte policy adherance in the absence of a contract**	**Is there a Contract with this payer/plan? A Yes vs No can prompt UM to think Contract specific rules at play vs. having to adhere to Plan's Corporate Policies**	**What UM Screening Tool does the Payer/Plan Use? Interqual, Millimen, CMS 2 MN Rule? Any other guidelines - IE: Medicare C list, Plan Specific Surgical Lists? Etc.**	**What DRG System is used - APR, MS, AP, Per Diem?**	**For Surgical Preadmissions - what does the plan reference for surgical bookings. EI: Medicare C-List, Medicaid IP Only list, Interqual, etc.**	**Who is responsible for the initial Notification of an IP Admission & Authorization Set-up? Financial Counseling, Patient Accounts, Business Office, Social Work, UM? *This information is important when retrospective denials occur for the technicality of "No Authorization Secured"; helps to get the visit back to the responsible party to attempt to rectify/update**	**If UM is responsible for any Inpatient Admission Notifications & Initial Auth Requests then who is the contact & how do they reach them?**
MVP	MVP Gold MVP Medicare	Medicare	YES	Interqual	MS-DRG	Medicare C-List	**Financial Counseling** - responsible for Notification of all ED Inpatient Amissions. **UM** - responsible for Notification of all Obs to IP upgrades occuring on Floor Units	For Obs to IP upgrade occuring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679

CMS Contacts for Regions 1-10 (7-21)

File complaints – squeak – with excellent examples of abuse

Will require the provider try to work it out with the payer first. Then file.. *Cannot be regarding rates*

Region 1	Robosora@cms.hhs.gov	CT, ME, MA, NH, RI, VT
Region 2	Ronycora@cms.hhs.gov	NJ, NY, Puerto Rico, Vir Islands
Region 3	Rophiora@cms.hhs.gov	DE, Dis of CO, MD, PA, VA, WV
Region 4	Roatlora@cms.hhs.gov	AL, FL, GA, KY, MS, NC, SC, TN
Region 5	Rochiora@cms.hhs.gov	Ill, IN, MI, MN, OH, WI
Region 6	Rodalora@cms.hhs.gov	Ark, LA, NM, OK, TX
Region 7	Rokcmora@cms.hhs.gov	IA, KS, MO, NE
Region 8	Roreaora@cms.hhs.gov	CO, MT, ND, SD, UT, WY
Region 9	Rosfoora@cms.hhs.gov	AZ, CA, HI, NV, Pacific Territories
Region 10	Rosea_ora2@cms.hhs.gov	AK, ID, OR, WA

Payer: United Health Care-largest plan in country. For-profit , on stock exchange as one of the top profit companies..

- 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. ALLOWED! 9-22**
- UHC announces moving to Interqual effective 5-1-21. (No longer using MCG. **Now owns IQ/conflict?)**
- READMISSIONS 'RELATED' PLUS 'PREVENTABLE'.
- Site of service- limit outpt services in hospitals. Move to ASC and imaging centers. Saves 60% on average.
- UHC's unique lab coding system & Imaging – delayed until 1-22./now 'until further notice'
- UHC Delays ER policy until end of PHE/6-21. Retro review of ER visits for 'emergent dx/reason.' Expected 1 in 10 denied.

- Significant request for records: "CMS requires UHC to submit complete dx data for MA members". Clarify, always!
- "*A federal appeals court has ruled against UHC, the biggest private payer in the US, and REVERSED a 2018 decision overturning Medicare's overpayment rule requiring REFUNDING reimbursement to CMS within 60 days if they learn a dx lacks medical record support.*" MA plans pd by CMS per-member-per month then adjusts payments based on acuity or severity of their member's health status as supported by dx codes. (Healthcare Dive 8-21) YAHOO

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/AC compared with $47 for STP.
- **BUYER BEWARE!** Less coverage = more out of pocket if healthcare is used. (Biden Adm. assessing/allowing. 6-21)
- 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.

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 & more
- 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.
- HUGE THREAT TO REVENUE THROUGH OUTPT SERVICES. "Front Door" is being impacted by payers and new competitors /non-traditional.
- **With Site of Service referrals – what is the WIN for the providers in return for giving reduction from billed charges? CONTRACT, CONTRACT, etc.**

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/Sound. 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*
- *Post ED Audits for "emergent coverage." CMS states in violation of Surprise Billing rules. Other payers too with like issues… get our A Game on!*

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****

- Surprise Bill Leg: Watch for post-denial regulatory issues.. Surprise bill to the pt…

Change of payer/provider/patient relationships
Convergence

Walmart Moving BIG into healthcare

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.**
- **Amazon buys One Medical/Huge primary care. What now? 8-22**

New competition- New patient outreach

Impacting the 'front door' of the revenue cycle for outpt services. STEERING AWAY!!!
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

Imagine a day when 45% of our Walgreens stores…where you can walk in and see a primary care physician that's attached to Walgreens. ..there are 8 exam rooms with all testing done that day. That is our goal" CEO Brewer 11-21

- "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".
- Walgreen's Boots Alliance has invested $5.2B in primary care startup VillageMD to rollout physician-staffed models. The company announced in Oct that it is making a $330M investment in post-acute and homecare company CareCentrix. 11-21

"Walgreens partners with Microsoft to develop new Healthcare delivery models" 11-19

- **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."

AMAZON EXPANDS PUSH INTO HEALTH CARE WITH ONLINE PHARMACY – 11/20 AND PURCHASING OF HUGE PRIMARY CARE COMPANY: ONE MEDICAL 8/22

Amazon bought Pillpack /2018- online pharmacy who organizes prescriptions into packets. Set up for more direct competition with Walgreens Boots Alliance & CVS Health Corp. Other drug companies stocks fell with announcement.

Amazon pharmacy, selling prescription drugs with discounts for US Prime members.

Shoppers can pay using their health insurance. If they don't use their insurance, eligible for discounts on generic & brand-name drugs on Amazon.com or at about 50,000 participating pharmacies.

Patients like talking to their pharmacists about their prescriptions. Amazon will likely try to recreate digitally.

Amazon, JP Morgan, Berkshire form new company to tackle healthcare costs." 1-18 (**Haven) 2-21/Dissolved. Each will do their own 'thing.' JP starting: Morgan Health 6-21**

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. (And more nationwide rollout)
- 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. Believe 4% denied
- *"This will create **deaths**. This will make the pt think twice before going to the ER."- **BCBS TX Physicians***

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**
- **TRUST IS THE KEY WITH NEW VALUE BASED RISK CONTRACTS- provider and payers. Who is developing the quality matrix, non-compliant patients, IT functionality, patients understanding of the term VALUE BASED, providing all services to keep leakage from occurring, provider choice, etc. Value over volume.**
- **Learn from AHIP - Insurance plan/companies themselves**

Denials and being the patient advocate. A Financial Navigator for the most vulnerable. Pt loyalty means? BE THE PATIENT – Changes perspective!

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

Who is the provider navigator to help defend the denial or dispute w/payer?

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.

Thank You for Joining Us in this Educational Journey

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