Leveraging Case Management to Improve Revenue Cycle

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Questions for the Group:

Do you have a front-end denials prevention process?

Are you invited to your organizations URC? If you attend, does the meeting supply actionable data?

Does your UR/ CM team have access to contract language?

Objectives:

At the conclusion of this presentation, participants will be able to…

- Recognize the importance of contract language and UM/ CM access to apply to the patient progression of care
- Assess denials prevention strategies and front-end access management strategies at their organization
- Understand the application and role of the Utilization Review Committee

Denials Prevention Goals

Front end denials prevention is the key to all revenue integrity efforts.

The goal is to reduce impactable and avoidable denials.

The process must be deliberate, repetitive, and understood among invested and involved teams.

Developing an Internal Denials Process

Failure to develop a robust denials program will impact the financial success of the organization.

- Evaluate electronic means for tracking and mapping denials
- Ensure that all denials are coming into your system to a central contact whether by mail, phone, email, or fax
- Your contracts outline where denials are sent to-Ensure these are all aligned and consistent
- Develop a centralized denials team to standardize people, definitions, and process
- Billers, denials team, and UR should all have access to logs and a central depository where denials are tracked

Denials Additional Steps

When the payer does not want to work with the provider, work with the patient and utilize their appeal rights.

Identify data that can be tracked to be used to prevent denials through internal workflows and meetings with payers.

Notify MDs of denied cases. Send letter with denials info and copy CMO/ CFO and sign letter from the UM Committee.

Appeal Retrospective Denials:

- Obtain your 835 data to identify the reasons for denials and underpayments
- Create thresholds determining when appeals should be completed and recognize that not every denial is worth fighting
- Clearly define the expectations of the denials team
- Understand and utilize the reconsideration process for accepting observation payment- W2s
- Understand your contracts and timelines for denials, appeals, appeal levels, and arbitration rights
- Utilize the data to create information that highlights the wins of the denials group. Include prevention they are achieving with actionable steps as it pertains to denials and appeals and trending over time.

Are you asking the right questions?

- Does your data show volume by payer? Have you separated your Medicare FFS from MA plans?
- Can you separate denials by DRG/CPT, service line, and attending physician to identify trends?
- Are physicians aware of their denials and do you can you educate based on accurate data?

Access Management

- A well-defined access management process combines business and clinical activities to ensure up-front compliance with federal, state, and contractual requirements for all patients seeking hospital care.
- Potential financial risks to the patient and the organization are considered. Prospective screening occurs at all entry points as part of the gate keeping process.

Front End Denials Prevention AKA: Access Management

- Case Management in the ED
- Case Management involvement in the pre auth process
- Medical necessity review prior to “head in a bed”
- Appropriate staffing of resources to peak hours
- Tools to ensure appropriate admission status for optimal payment

Inpatient Only Procedure List (IPO)

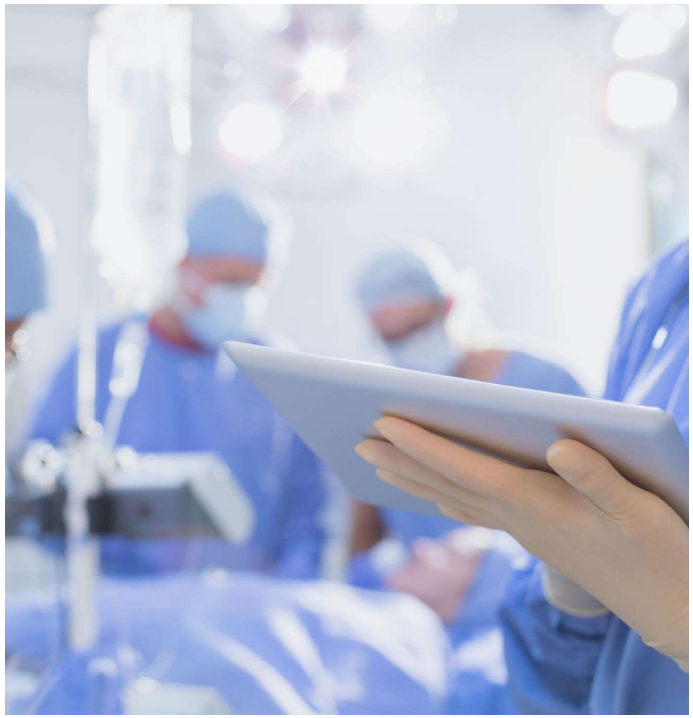
CMS Inpatient Only List (IPO) is published in the Outpatient Prospective Payment System Final Rule each year

IPO list is posted by CMS therefore applies to Medicare FFS patients

The 2023 IPO list is currently posted on the CMS website

Inpatient Only List (IPO): Importance to the pre-auth process

- Medicare FFS surgeries and procedures on the IPO list must discharge with an inpatient order for payment.
- Medicare Advantage Plans are not required to follow the published IPO list
  - Case Management experts are not aware of any MA plans that currently follow the IPO list.



Inpatient Only List (IPO) Confusion

The IPO list should always be reviewed for Medicare FFS patients. All other payers, including Medicare advantage, can decide whether they follow the IPO list.

Each facility should have a contract grid outlining the process for their top 10 commercial payers to be utilized by CM/ UR.

Understand contracts and provider manuals for guidance on IPO use and surgical and procedural payment of inpatient status.

Inpatient Considerations Affecting Placement

3 MN consecutive inpatient stay required for SNF placement for Medicare FFS

- CMS states that any procedure not IPO can be done either inpatient or outpatient based on medical necessity– just because it is off the list doesn't mean you can't do it inpatient. Need to document medical necessity for admission.
- SNF may still be achieved if medically necessary to keep patient as inpatient due to comorbid conditions or other medically necessary reasons.

Medicare Advantage Plans

Medicare Advantage Plans are not required to follow the published IPO list.

If a MAP plan uses the IPO list, all inpatient hospitalizations still require authorization.

ED cases require a concurrent auth, planned procedures require a prior auth.

To be Aware…

- Pre auth does not ensure payment!

Private Payer considerations:

- The representative at payer providing the pre-auth is likely not clinical. They are not completing a review of chart for medical necessity.
  - Hospital asks for auth, payer says yes. Physician needs to document medical necessity for status he places patient in. If medically necessity is not documented, procedure will be denied.
  - What if you require more than one auth?

Contractual Implications

- UR, CM, Physician Advisor and your denials team must have access to the contracts.
- Every provision in a contract is negotiable and needs to be reviewed carefully.
- Creation of a grid should include information to forementioned team members for knowledge of top 5-10 payers.

Anything that states "per payer policy or guideline" Request a copy!

Digging Through the Contracts

UR manual- criteria used by each payer (MCG/InterQual)

Observation payment methodology

Inpatient payment methodology

Carve Outs & Stop Loss

Payer Notification Requirements (surgical/ ED/ LOC changes)

Recertification Requirements

Time Frame while Inpatient for concurrent reviews

Notification of Discharge Requirements

P2P Process (is it allowed, can it be completed by a PA)

Denials Appeal Process (Concurrent/ Retro/ Reconsiderations)

Rebills allowed for outpatient if IP is denied

Can P2Ps occur in denial- appeal process?

Timeframe to appeal for inpt days are denied?

Payer denial reply timeframe

Readmission penalty

Chronic care manager contact number

Days allowed to review prior to auth for post-acute placement

Payer contact information (Address, fax, phone, medical director name and contact)
EMR Access?

Contract Grid Considerations:

- May be nationally or regionally based
  - May incorporate key provider manual requirements
  - May supplement provider manual requirements
- Contract may say, “Company may at any time modify any company rules, policies and procedures, and will advise Hospital in writing of such changes.
  - Hospitals need to include in their language a 90 notice of any changes to contract language.
- Contracts are often ‘ever green’. Automatically renew unless formal notice of renegotiation is given by provider well in advance.
  - Internal electronic programs may notify contract owner of renewal dates.

Elevating Denials Team Data

- Denials data is a reliable barometer of the hospital's efficiency, the practices of its medical staff and its capacity to coordinate care.
- Denials data should reach the UM committee on a regular basis with actionable information reported from the 835 EOP.
- Actionable information includes data reported with the names of the insurance companies denying the cases; how much are they denying; what is the reason for the denials; who are the attending physicians associated with the denied cases; etc.
- Actionable data drives performance improvement. If a trend or pattern emerges, the denials team/ PA can work with specific physicians to tackle the cause of the denials, whether its documentation, delayed responses from consultants or ancillary departments, etc. Likewise, the Physician Advisor could work with the payer's Medical Director to seek insights on the payer's denial processes.

CoP: 482.30 UR Plan

Address activities to monitor "Professional services furnished, including drugs and biologicals." (resource utilization) 42 *CFR* 482.30

- If the hospital has a progressive care coordination program, resource utilization is often included as an advocacy obligation of the care manager.

Does not tell the hospital HOW to do it, simply WHAT it must do.

Each hospital develops its own plan—one that meets all regulatory requirements but reflects the culture and customs of the organizations.

Utilization Review Committee

- Utilization review committee (URC) is required per CoP 483.20 as a condition to participate in the Medicare and Medicaid programs. Requires plan to review services, speak to processes in place to improve outcomes.

  - Minutes elevated to Med Exec and The Board
  - Discussion and actionable data related to utilization and management of the hospital's resources
  - Focus: Overutilization, denials, best practice, patient status, utilization review data, management of complex cases

Who Should Attend URC

- 2 Physicians (MD or DO) are required to attend the URC. Standards are:
  - CMO
  - Hospitalist Medical Director
  - Physician Advisor (PA)
  - ED Medical Director
- Compliance Leader
- CFO
- CM/ UR Director
- Chief Clinical Officer
- Nursing Leader
- Denials/ Audit Leader
- HIM/ EMR Leader
- Clinical Leaders: Pharmacy, Imaging, Laboratory
- Affiliated Post Acute Leaders

URC: Improve utilization of hospital resources

- Review of medical necessity for Medicare and Medicaid patients
- Review outlier patients, 20 day stay process
- Review Medicare inpatient admission status- use of 2 MN
- Notification of Code 44s and compliant process
- Access management (gate keeping in the ED)
- Use of notification letters
  - Important Message from Medicare (IMM)
  - Medicare Observation Outpatient Notification (MOON)
  - Hospital Issuance of Non-Coverage Notification (HINN)
- Other topics for utilization of resources as determined a priority for your organization

URC Actionable Data:

URC Standard: The committee must review professional services provided, to determine medical necessity and to promote the most efficient of health facilities and services

- Blood usage report out by Laboratory Director
- Advance imaging overuse by Imaging Director
- Gate keeping/ prevention of inappropriate admissions from the emergency department
- Avoidable days data by Case Management Director
- Denials review for patterns and targets, medical necessity, level of care denials
- Physician behavior data- must be actionable and reflect physician details

URC and changing behaviors:

- URC should be used to build relationships.
- URC minutes are reported up through medical executive committee and the board.
- Denials can be prevented by changing behaviors.
  - Share data with leaders and physicians.
    - Review charts to understand physician practices
    - Provide suggestions for improvement
    - Elevate or involve CMO as needed to educate and inform
    - Accurate data review at URC then shared via physician leaders

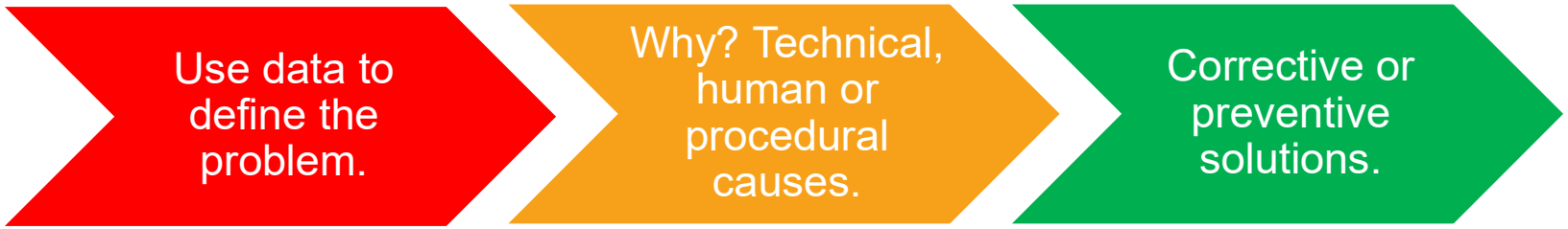
Transition to Preventions Strategy

- Break down silos among departments and build relationships. Work together and start from scratch if needed!
  - Track, Share, and make data actionable
  - UR- Denials-CM- CDI- Revenue Cycle
  - Monthly meetings. Outline current process flow. Where are you disconnected? Holes in process?
- Move from a reactive process to a prevention focused strategy
- Enlist the support of the physician advisor and the URC
- Utilize support staff for duties that do not require a professional license
- Vet data for accuracy and share at URC. Physician leadership can share data with physicians requiring education and mentoring
- Broadcast general findings to hospital associates
- Report outcomes at each URC meeting—do not blind data and watch committee attendance grow

Root Cause Analysis

Once denials are categorized and the URC engaged, the question must be asked “Why are denials occurring?”

No Fast Answers – But good data generates good questions!



Monitor over time

Quint Studer-

Don’t Give Up!

Tenacious low performers aggressively work to recruit middle performer to their cause: resisting change.

High performers tire and begin to pace themselves or move elsewhere if leaders don’t hold low performers accountable.

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