Revenue Cycle Junk Drawer
Helpful Tips & Tricks

January 19th, 2024

Nebraska HFMA

2024 Virtual Winter Meeting

ruralMED
REVENUE CYCLE RESOURCES

DISCLAIMER

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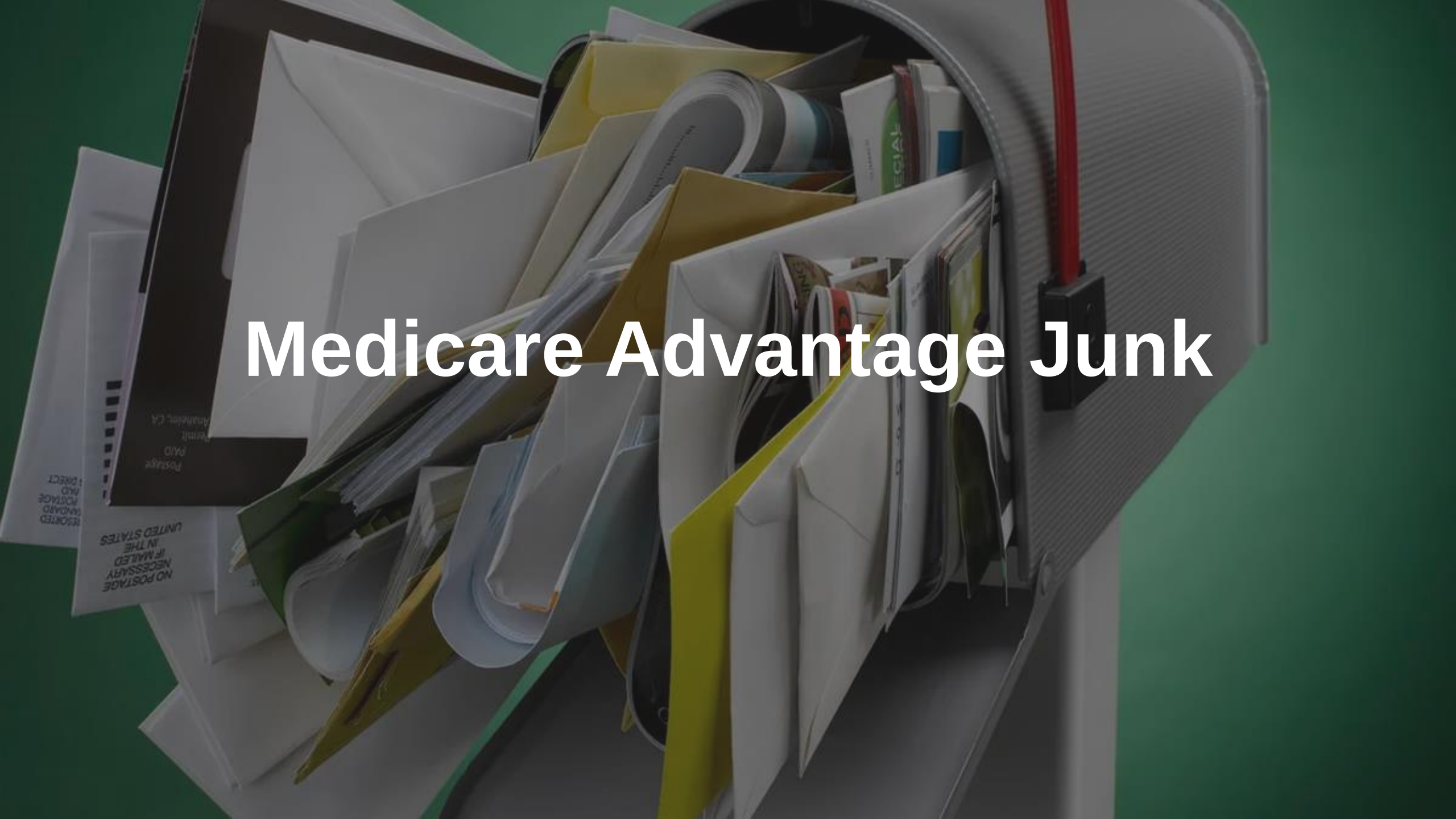
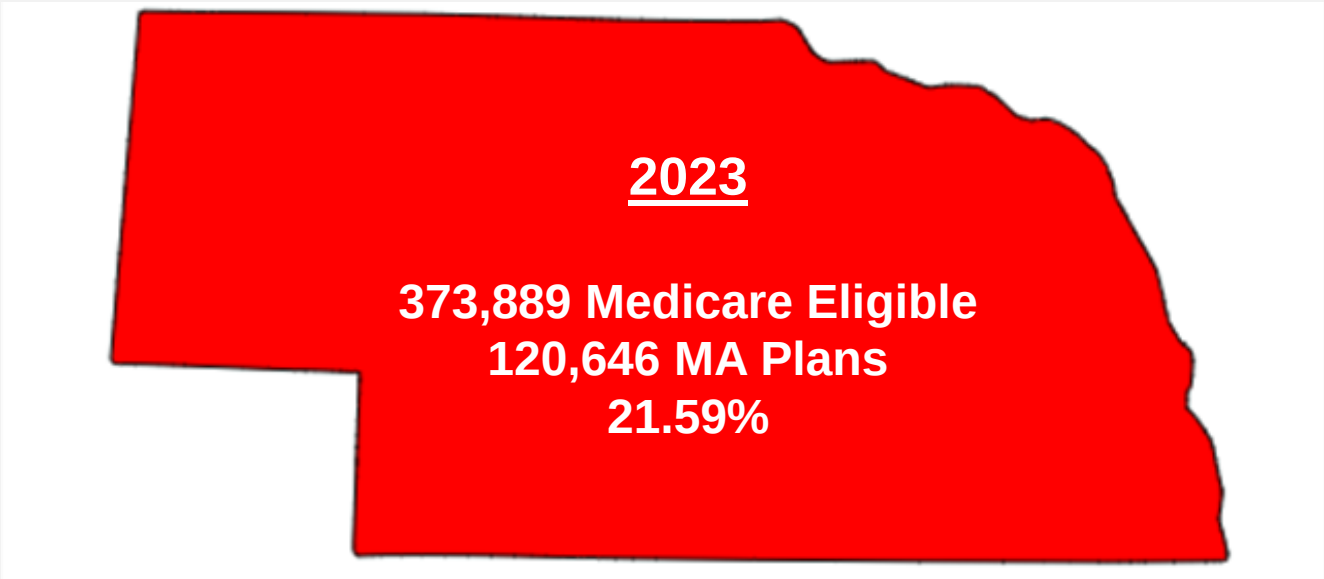
Agenda

- **About the Junk Drawer…**
  - Medicare Advantage Junk
  - Payor Junk
  - Random Junk Drawer Treasures


Medicare Advantage Junk

2023 Medicare Advantage Nebraska



Informational Links:

- 2024 Nebraska Medicare Advantage & Cost Plans by County
- CMS Medicare Advantage State/County Penetration

Medicare Advantage 2024 Final Rule

- Increases oversight of MA Plans
- Seeks to better align MA coverage with traditional Medicare

MA 2024 Final Rule-Prior Authorization & Medical Necessity Determinations

1. Cannot limit or deny coverage for a Medicare covered service based on their internal or proprietary criteria if traditional Medicare restrictions don’t exist
   - If no coverage criteria under traditional Medicare, MA plans can adopt criteria based on widely used treatment guidelines or clinical literature

2. Must follow “Two-Midnight-Rule” for inpatient admissions
   - Cannot deny coverage or require a lower level of care
   - Only exception would be if patient clearly does not meet level of care criteria per traditional Medicare guidelines

3. Cannot deny coverage later for lack of medical necessity unless there is evidence of fraud for services approved through prior authorization or pre-service determination

4. Site of service restrictions not found in traditional Medicare are limited

MA 2024 Final Rule-Prior Authorization & Medical Necessity Determinations

5. MA clinicians reviewing prior authorization requests must have the expertise in the relevant medical discipline for the service being requested

6. Prior authorizations must be valid for an entire course of approved treatment
    - Must be valid through a 90-day transition period if a patient undergoing treatment switches to a new MA plan

7. MA utilization management programs must be established to ensure oversight
    - Including an annual review of policies to ensure consistency with federal rules

MA Final Rule-Behavioral Health Access

1. Plans must have an adequate amount of clinical psychologists, licensed clinical social workers and prescribers of medication for opioid use disorder in their networks

2. Minimum access wait time standards must be met

3. Additional behavioral health services must be provided
   - Must have programs in place to ensure continuity of care

4. CMS clarified that an emergency medical condition can be physical or mental
   - Requires MA plans to ensure that patients receive medically necessary behavioral health services in a medical emergency, which would not be subject to prior authorization

MA 2024-Marketing Provisions

1. Prohibits advertisements for MA plans that do not mention a specific plan name, possibly misleading or confusing potential beneficiaries, such as trying to make it appear the information is from CMS
2. Bans sales presentations immediately following educational events
3. Restrict other sales interactions that involve pressure tactics while presenting only a subset of plan options
4. Requires sales agents to disclose:
   - Information about all the plans the agent sells
   - Describe information that can be obtained from Medicare.gov
   - Review a standardized list of questions/pre-enrollment checklist
5. Sales agents must explain the effects of a prospective beneficiary's enrollment choices on their coverage

AHA News Brief **Federal Registry-Medicare Advantage 2024 Final Rule**

FAQ-What Traditional Medicare Regulations Apply to MA:?

1. **Medicare Secondary Payor (MSP)-** NO
   - CMS MSP Manual-Chapter 3*: If the beneficiary is a member of an MA plan, hospitals are not required to ask the MSP questions or to collect, maintain, or report this information*

2. **Therapy Annual Thresholds** (Therapy Caps) - NO
   - Unless specified by contract

3. **Self-Administered Drug Requirements-** SOME
   - Grey Area for Some Payors
   - Organizational Adjustment policy

Switching back to Traditional Medicare from Medicare Advantage- The Catch!

Nebraska Is Not a Guaranteed Issue State Beyond The “Trial Rights”

Medicare Advantage Trial Rights:

1. Joined a Medicare Advantage plan when first eligible for Medicare, and within the first year of joining, switched to Original Medicare

- Under this trial right, a beneficiary can leave an MA plan and buy any Medigap policy sold in their state by any insurance company
- However, a beneficiary must apply for the Medigap policy as early as 60 days before the date their coverage will end and no later than 63 days after their coverage ends

2. Had Traditional Medicare and dropped a Medigap policy to join a Medicare Advantage plan for the first time. Within the first year, the beneficiary wants to switch back to Traditional Medicare and a Medigap policy

- If a beneficiary had a Medigap policy before joining MA, a beneficiary can purchase the same policy from the same insurance company, if it’s still offered
- If the same policy isn't available, a beneficiary can buy a Medigap Plan A, B, C*, D*, F*, G*, K or L that’s sold by any insurance company in their state

12 States have “state regulated” special enrollment periods for Medicare Supplement Plans-**Nebraska is not one of those 12 states**


Payor Junk

Payor Trends

- **Blue Cross Blue Shield**
  - Therapy multiple payment procedure reductions effective 12/1/2022
  - Radiology multiple payment procedure reductions effective Q1 2024
- **Aetna Medicare Advantage**
  - Hospital Services (Lab & Radiology) Paid on Fee Schedule
- **UHC Commercial**
  - Bundling Labs-CO-97
- **UHC Community Plan**
  - Reprocessing Medicare secondary claims where Medicare sequestration was included within the allowable
  - Period of claims affected: July 1, 2022 through November 2023
  - Estimated Completion Date: March 15th, 2024

Payor Trends

- **Worker’s Compensation**
  - Additional Worker’s Compensation PPO Discounts
  - Workers’ Compensation- Pay Timely or Pay 100%
- **Commercial**
  - Level of Care Adjustments
    - ER Facility Fee
      - Physician Level Alignment
      - Payor Algorithm
    - ER & Office Professional Fees
  - New Patient Visit Denials
    - Payor Load of Physician Taxonomy

Reimbursement Best Practices

Reimbursement Verification!

- Payment Variance Module within EMR or Analytics System
- Analysis of Paper/ Electronic EOBs
- Review Zero Balance Accounts for Adjustment in Full
- Conduct Regular Reimbursement Audits

Let’s Talk About Multiplan

- Possibly In-Network Without an Official Agreement
- Could Include PHCS
- Review Contract Terms & Reimbursement
- Extension to Worker Compensation and Liability Carriers

Random Junk Drawer Treasures

Pricing Transparency

January 1, 2024

- Good Faith Effort
- .txt file
- Footer Placement – “Price Transparency”

July 1, 2024

- Templates
- Affirmation
- Hospital Information
- General Element Changes

January 1, 2025

- Drug Unit of Measure
- More Standard Charge Information Additions

ENFORCEMENT!!

NSA – IDR Prices Set for 2024

Administrative Fee

- $115 per Party

Certified IDR Entity Fees

- Single - $200 - $480
- Batched - $268 - $1,173
- Batched Items in Excess of 25 - $75 - $250 per increment after 25
  - Exceeding 25 dispute line items, the Departments are finalizing the proposal that certified IDR entities may set a fixed fee within the range of $75-$250 for each increment of 25 dispute line items included in the batched dispute, beginning with the 26th line item

LB 227

Provisions of LB 227

- State of NE Medicaid will provide reimbursement at 115% of the statewide average nursing facility per diem if a patient no longer requires IP care but is unable to be transferred

- Requirements:
  - Enrolled in Medicaid
  - Admitted to IP
  - No longer requires IP care, but requires nursing facility level of care
  - Unable to be transferred to a nursing facility due to lack of available beds or in cases where the transfer requires a guardian, the patient is awaiting the appointment of a public guardian
  - Elgible facility

NE Medicaid actively working towards implementing

MPFS 2024 New Elgible Medicare Providers

New Medicare Allowable Behavioral Health Providers

Elgible as RHC Providers too!

- Marriage and Family Therapists (MFTs)
- Mental health counselors (MHCs)
- Addiction Counselors that meet all the requirements to be an MHC

MPFS 2024 New Services

New Services Included in Payment for G0511, RHC General Care Management

- Remote Physiologic Monitoring
- Remote Therapeutic Monitoring
- Community Health Integration
- Principal Illness Navigation

New Services-General

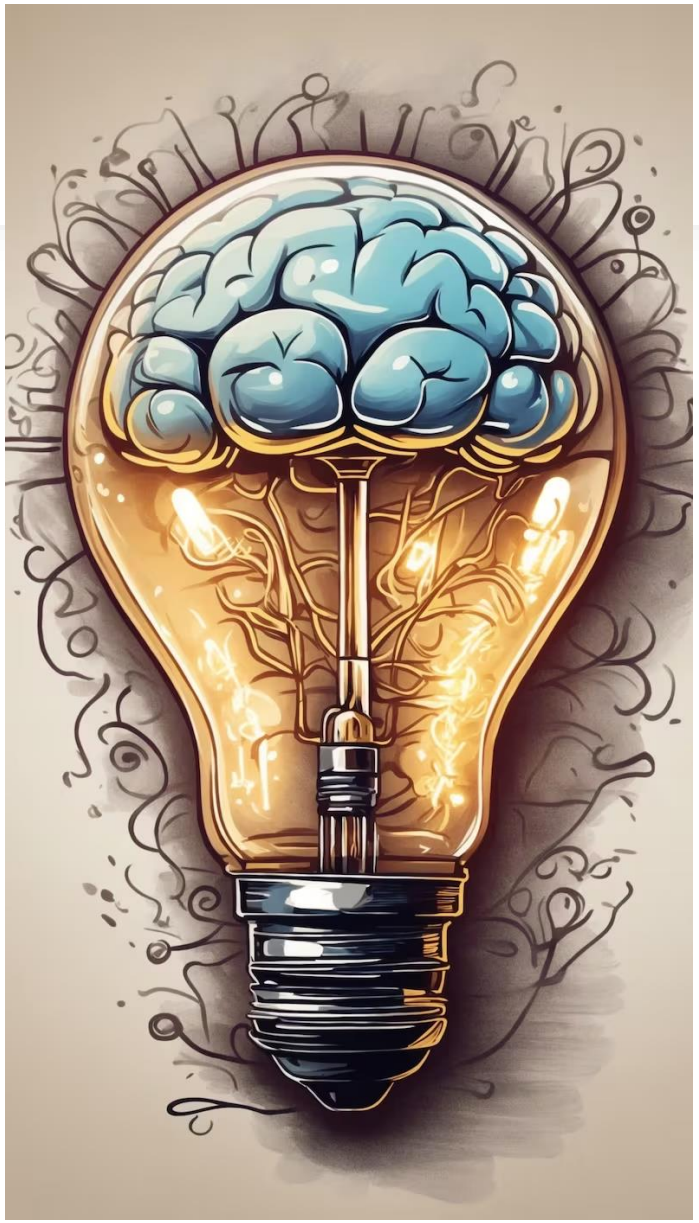
- Caregiver Training
- Community Health Integration
- Social Determinants of Health (SDOH) Risk Assessment
- Principal Illness Navigation

Prolonged Services

- Payment for add on code G2211
- *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition*

Bundling Supplies

- Trend Toward Bundling
- Increased Payor Policies
- Downstream Effects- Peer Comparisons



Medicare Prescription Drug Inflation Rebate Program

Part B provisions require drug companies to pay a rebate if they raise prices for certain drugs faster than the rate of inflation for some single source drugs & biologicals

- Each quarter CMS will specify whether a coinsurance adjustment applies to a rebatable drug
- Medicare will pay the difference between the allowed amount and the adjusted coinsurance

340 B Modifier Requirement

The inflation Reduction Act excludes units of drugs for which the manufacturer provides a discount under the 340B program from the units of drugs for which a manufacturer may otherwise have a Part B inflation rebate liability

CMS will remove separately payable units in claim lines that were billed with the “JG” or “TB” modifiers so those units can be subtracted from the Part B inflation rebate liability

CMS 340B Modifier Billing FAQ

Medicare Part B Drug Inflation Rebate-Revised Guidance-December 14th, 2023

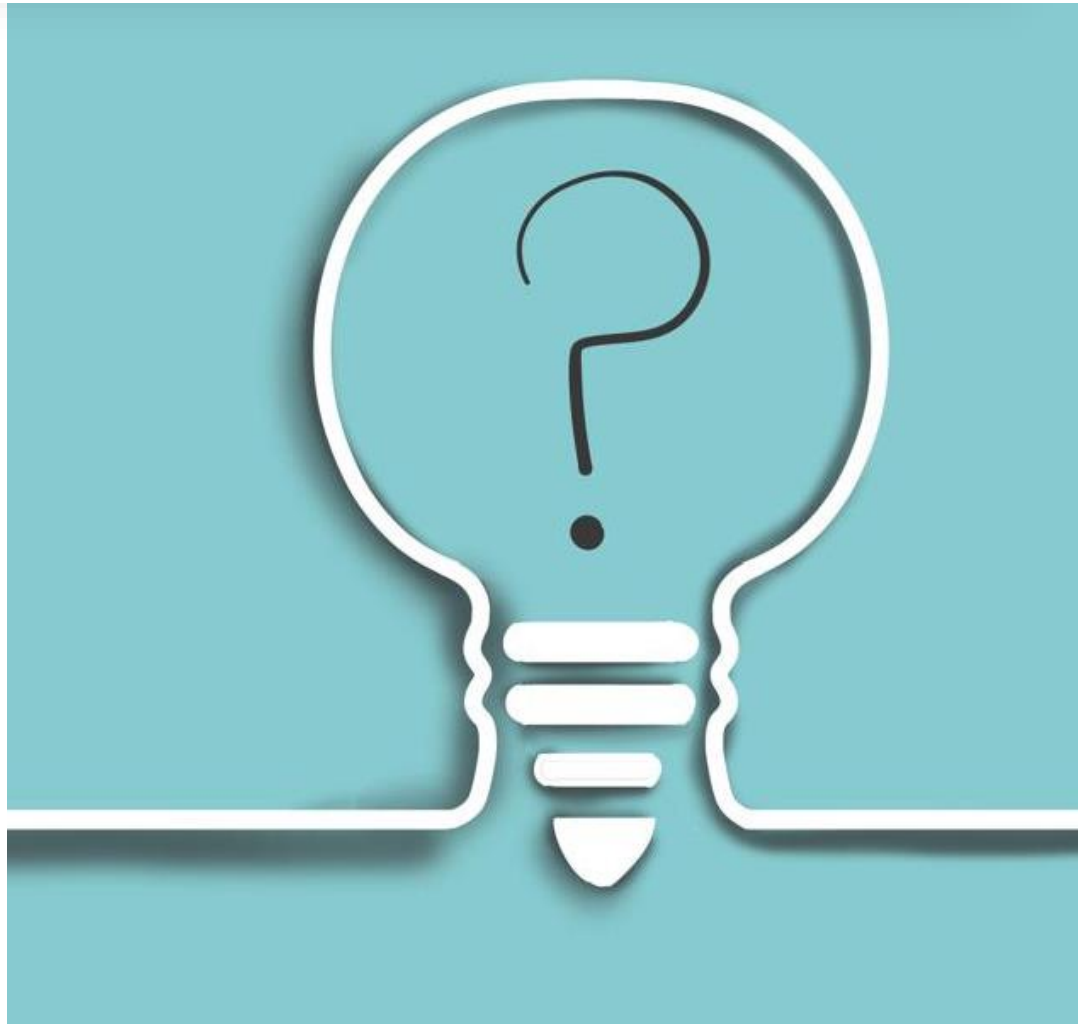
340 B Modifier Common Questions

How Are Other Facilities Implementing the Requirement?

Do RHCs have to report the modifier?

What if a drug has no HCPCS?

What about Generic Drugs?



Appointment Availability Standards

CMS guidelines released surrounding payor enforcement of appointment availability standards

Appointment Availability Standards

Commercial Payors

- **BCBS & Aetna**
- **Telephone Surveys to Begin in Q1 of 2024**
- **Corrective Action Taken for Non-Compliance**

Medicaid

- **Previously Established policy**
- **Examples:**
  - Non-urgent sick care must be available within 48 hours
  - Family planning services must be available within 7 days
  - High volume specialty care, routine appointments must be available no later than 30 days

Aetna Example

New appointment wait time standards ("access to care")	Primary care physicians (PCPs)	Behavioral health (BH) providers
Emergency and urgently needed services	Immediately (or referred to the emergency room, as appropriate)	Immediately (or referred to the emergency room, urgent care/crisis center, as appropriate)
Non-emergency/Non-urgent; but requires medical attention	Within 7 business days	Within 7 business days
Routine and preventive care	Within 30 business days	Within 10 business days
Follow-up care	As appropriate, if needed	• Non-prescribers of medication: within 3 weeks • Prescribers of medication: within 5 weeks
24/7 answering service	Must have reliable 24 hours per day, 7 days per week (24/7) answering service or machine with notification system for call backs. • PCPs must have appropriate backup for absences. • A recorded message or answering service that refers members to emergency rooms is not acceptable.	Must have a reliable live answering service or voicemail system in place 24 hours per day, 7 days per week (24/7). • Prescribing providers are required to have a designated provider backup and/or an answering service and/or a machine with a beeper/paging system in place 24/7. • Non-prescribing providers are required to have a voicemail greeting which provides contact information for a licensed BH provider who is available 24/7; and/or direction to go to the nearest emergency department; and/or direction to call 911/988 in a crisis.

Trends In Revenue Cycle KPIs

AR Days

Self-Pay

Denials


Wrap Up
Questions?

Appointment Availability Standards

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