
TRILOGY
REVENUE CYCLE

Optimize Managed Care Operations to Attack Revenue Leakage and Drive Payor Strategies

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Agenda

I. Organizing / Verifying Agreements
II. Accessibility
III. Managed Care Grids
IV. Denial Prevention & Resolution
V. Contracting / Negotiations Strategy

I. Organizing / Verifying Agreements

- Identify those not fully executed, missing effective dates
- Missing amendments
- Clarify which entities are associated with each contract document
- Clarify which products, by payor, by entity are contracted
- Include Medicare and Medicaid rate letters for CAH, RHC, FQHC

II. Accessibility

- Support Revenue Cycle
  - Business Office
  - Registration/Patient Access
  - Payment Verification
  - Price Transparency
  - Credentialing
- Share Drive, Contract Management System

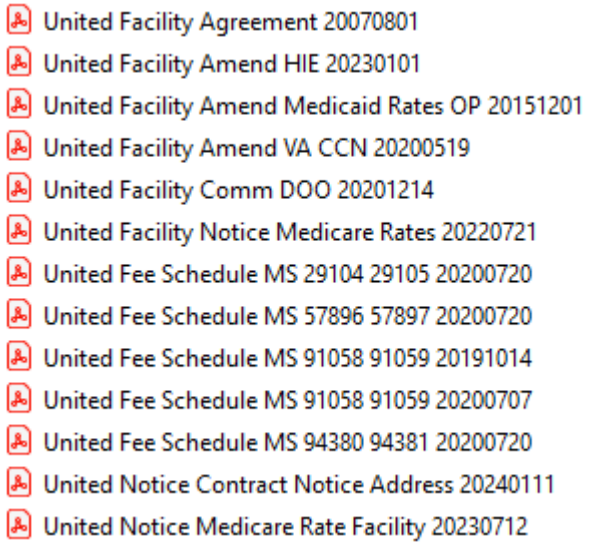
II. Accessibility

- Standardized Naming Convention

Managed Care Files Naming Convention						
Payor Name	Entity Type	Entity (mnemonic)	Document Type	Additional Descriptor such as Product, Clinic location, Amendment description, Other	Start Date	Termination Date
United	Facility		Agreement	Clinic mnemonic	YYYYMMDD	YYYYMMDD
BCBS	Professional		Amend	CHIP		
AHS	Global		Notice	Medicare		
Medicaid	Ancillary		Communication	Medicaid		
Medicare				Language		
				Rates		
Examples						
Aetna	Facility		Agreement		20100101	
Aetna	Facility		Amend	Rates	20110101	
Aetna	Facility		Notice	*description*	20180101	
Aetna	Professional		Agreement		20100101	
Aetna	Professional		Amend	Language	20120101	
Aetna	Professional		Notice	Rate Letter	20181001	

II. Accessibility

- Standardized Naming Convention



III. Managed Care Grids

- Contract Summary Grids
  - Contracts By Entity – Grid to know what agreements go with which entities and to identify inconsistencies
  - Contract Rate Summary
  - Contract Provision Summary – Contract terms that your Revenue Cycle staff need to know

III. Managed Care Grids
(Contracts By Entity)

		Name	Legal Name #1	Legal Name #2	Legal Name #3	Legal Name #4	Legal Name #5	STATUS	NOTES
		dba	Hospital #1	Ancillary #1	Hospital Based Physicians #1	Clinic #1	Clininc #2 (RHC)		
		TIN	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx		
Payor	**Contract ID**	**Description**							
Payor 1		Facility (Comm)						Termed	1/1/94 - 8/14/09
Payor 1		Facility (Comm, WC)	X	X	X			Active	8/15/09 - __/__/__
Payor 1		Prof (Comm, WC)			X	X	X	Active	4/1/10 - __/__/__
Payor 2		Facility (Comm, WC)		X	X	X	X	Active	1/1/12 - __/__/__
Payor 2		Facility (Medicare)	X	X	X			Active	4/1/10 - __/__/__
Payor 2		Prof (Comm, WC)				X	X	Active	11/15/12 - __/__/__
Payor 3		Facility (Comm, WC)	X	X	X			Active	11/15/12 - __/__/__
Payor 3		Facility (Medicare)	X	X	X			Active	11/15/12 - __/__/__
Payor 3		Facility (Medicaid)	X	X	X			Active	11/15/12 - __/__/__
Payor 3		Prof (Comm, WC)				X	X	Active	11/15/12 - __/__/__

III. Managed Care Grids
(Contract Rate Summary)

	Facilty Name															
	MEDICAL	SURGICAL	ICU	OB NORMAL DELIVERY	OB C-SECTION	SUB-ACUTE	HOPICE	REHAB	SNF	PSTCH - IP	OBSERVATION	OP SERVICES	OP SURGERY	DIAGNOSTIC RADIOLOGY	OP LAB / PATHOLOGY	PT/OT/ST
BlueCross BlueShield	**BCBS 1000**															
	$X,XXX PD					$XXX PD	$X,XXX PD		$XXX PD	$X,XXX PD	$XXX APC					
Cigna - Commercial	**CIG 1000**															
	$X,XXX PD					$XXX PD	$X,XXX PD				$X,XXX / Stay	XXX Charger	OP Surgery: Group X $XXX Group X $XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group XX $XXX	CT-$XXX MRI-$XXX PET-$X,XXX	XXX Charger	XXX Charger
Cigna - Worker's Compensation																
	State Fee Schedule															
Humana Military - Tricare	**MH 1000**															
	XXX Off Reasonable Cost Method							XXX Charger	XXX Off Reasonable Cost Method		XXX Off Reasonable Cost Method or XXX Off TMAC					
Department of Rehabilitation Services	**MDR 1000**															
	Prior to XX/XX/XX: $XXX.XX PD, Beginning XX/XX/XX: $XXX.XX PD										Billed Charges not to exceed three (X) days Per Diem					
Multiplan - Commercial	**MP 1000**															
	XXX Charger															
United Healthcare - Commercial	**UHC 1000**															
	$X,XXX PD		$X,XXX CR + $XXX PD Normal Newborn	$X,XXX CR + $XXX PD Normal Newborn	$XXX PD	$XXX PD	$XXX PD	$XXX PD			$X,XXX CR	XX.X% Charger	OP Surgery: Group X $XXX Group X $XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $X,XXX Group X $XX,XXX Group XX $XX,XXX Unlisted $X,XXX	CT-$XXX MRI-$X,XXX PET-$X	XXX% *Source Fee* in UHC Facility Lab Fee Schedule Exhibit	XX.X% Charger
United Healthcare - Medicaid	**UHC 1000**															
	Non-Contracted - Paid by MS Dept of Medicaid										XXX% of Medicaid					

III. Managed Care Grids
(Contract Provision Summary)

Payor	Timely Filling	Appeal Time Frame	Overpayment Offsets, Refunds & Recoupments	Billing Members	Clean Claim Payment	Medical Records	Eligibility Verification	COB/TPL	UM Requirements	Emergency	Medical Necessity	Plan Policy and Procedure	
Payor #1	(4.1.1) Primary payor - 180 days from DOS. Secondary payor - 180 days from Primary's EOB. Worker's Comp: (AWCA Addendum. VI) 90 days.	(4.1.1) 180 days	(4.1.2) 2 years after payment. 30 day notice w/ right of offset.	(4.3.1) Member must agree in writing to be liable for Non-covered service. Waived if member failed to identify themselves as a member of plan. (4.3.2) Member Held Harmless.				(see section 4.2)	(4.1.4) Provider shall abide by.	(1.14) Prudent Layperson	(1.23) Clinical but doesn't define UM Criteria. Allows for denials based on lowest cost setting.	(5.1) Dynamic and my change from time to time. Includes . Includes newsletters, e-mail and letter. 90 notice including newsletter or e-mail w/ 30 days to object.	se
Payor #2	(2.2.2.3) 180 days w/ best efforts in 30 days.		(2.2.7) Recovery allowed.	(2.2.3.1) Can't bill Members for services provided not in compliance with UM programs and policies. Member must agree in writing to be liable for Non-covered/Non-medically necessary service.	(4.3) Best efforts in 30 days.	(2.4.3) No charge.	(3.5) Not responsible for incorrect/retroactive information submitted by Group.	(2.2.5) See agreement.			(1.9) Clinical but doesn't define UM Criteria.	(2.2.2.2) agrees to comply. (3.6) BCBSNC will notify Provider of changes.	
Payor #2	(2.2.2.3) 180 days		(2.2.7) 30 day notice w/ right of offset.	(2.2.3) Member Held Harmless. Member must agree in writing to be liable for specific Non-covered/Non-medically necessary service.	(3.3) Reasonable efforts in 30 days.	(2.4.3) No charge.	(3.5) Not responsible for incorrect/retroactive information submitted by Group.	(2.2.5) see agreement for limits on reimbursement and billing of members.			(E1.1.9) Clinical but doesn't define UM Criteria.	(2.2.2.2 & 2.6.1) agrees to comply. (3.6) BCBSNC will notify Provider of changes w/ reasonable time to comply.	

III. Managed Care Grids
(Contract Provision Summary)

Revenue Cycle

Timely Filing

Appeal Time Frame

Overpayments, Offsets, Recoupments

Billing of Members

Clean Claim Payment

Medical Records

Eligibility Verification

UM Requirements

Emergency

Medical Necessity

+ 5 Others

Contract Administration

Amendments

Acquisitions

Assignment

Rate Negotiations/Increases

Termination w/o Cause

Renewal Date

Effective Date

Notice Requirements

Changes in Capacity/Services

New Service, TIN, NPI

Change in Insurance

Change in Licensure

Change in Charge Master

+ 4 Others

III. Managed Care Grids
(Contract Provision Summary)

- Timely Filing – How long do you have to file the first claim?

- Appeal Time Frame
  - How long to file an appeal
  - Is it time to file an appeal based off
    - Date of Service
    - Date of Discharge
    - Date of First Denial
    - Date of Last Denial
  - Timely Filing is not the same as Appeal Time Frame

III. Managed Care Grids
(Contract Provision Summary)

- Overpayments, Offsets, Recoupments
  - Is there a requirement of formal notice
  - Can the provider object to the recoupment
  - Does the payor have the right of offset

- Billing of Members for Non-Covered or Denied Services
  - Allowed
  - Prior notice of specific services

III. Managed Care Grids
(Contract Provision Summary)

- Clean Claims Payment
  - Is there a penalty
  - Start date
  - Interest rate
  - Loss of discount

- Eligibility Verification – Is the language worded to allow for
  - Is the plan responsible for providing accurate eligibility
  - What happens if eligibility is wrong or there is retro eligibility?
  - Is retroactive eligibility limited or is it open-ended?

III. Managed Care Grids
(Contract Provision Summary)

- ❑ UM Requirements
  - ❑ Notices
  - ❑ Pre-Certs
  - ❑ Authorizations
  - ❑ Time frames

- ❑ Emergency
  - ❑ Prudent Layperson
  - ❑ Notice Requirements
  - ❑ Definition of Emergency
    - ❑ Evaluate and Stabilize ONLY
    - ❑ Evaluate, Stabilize, and TREAT

III. Managed Care Grids
(Contract Provision Summary)

- Medical Necessity
  - Criteria
    - Medicare
    - MCG
    - InterQual
    - Clinical without definition
  - Exceptions

VI. Strategy Development

- Review Managed Care Grids
  - Contracts By Entity
    - Request any missing/incomplete documents from the plan
    - Are all entities contracted for all products?
  - Contract Rate Summary
    - Request any missing fee schedules
    - How do rates compare across entities and other payors?
  - Contract Provision Summary
    - How does language compare to other plans?
    - Is language being used to legitimize denials?
    - Language agreed to by competitors to address denials with increased pricing

VI. Strategy Development

- Edit or use existing language where possible instead of rewriting sections
- Ensure remedies are in the agreement to motivate payor to abide by the agreement
- Negotiate language first, then rates – Can't price agreement without first understanding operational, denial, and bad debt exposure. Leverage payor refusal to address language issues with increased pricing.

Organization leads to strategy transparency

Questions?

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TRILOGY

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