AR Systems, Inc
Training Library Presents

What is going on with the Payers?

Attacking Managed Care Denials –

And WHY I love the 2 MN rule

Day Egusquiza, Pres

AR Systems, Inc

What is the difference between inpt and obs?

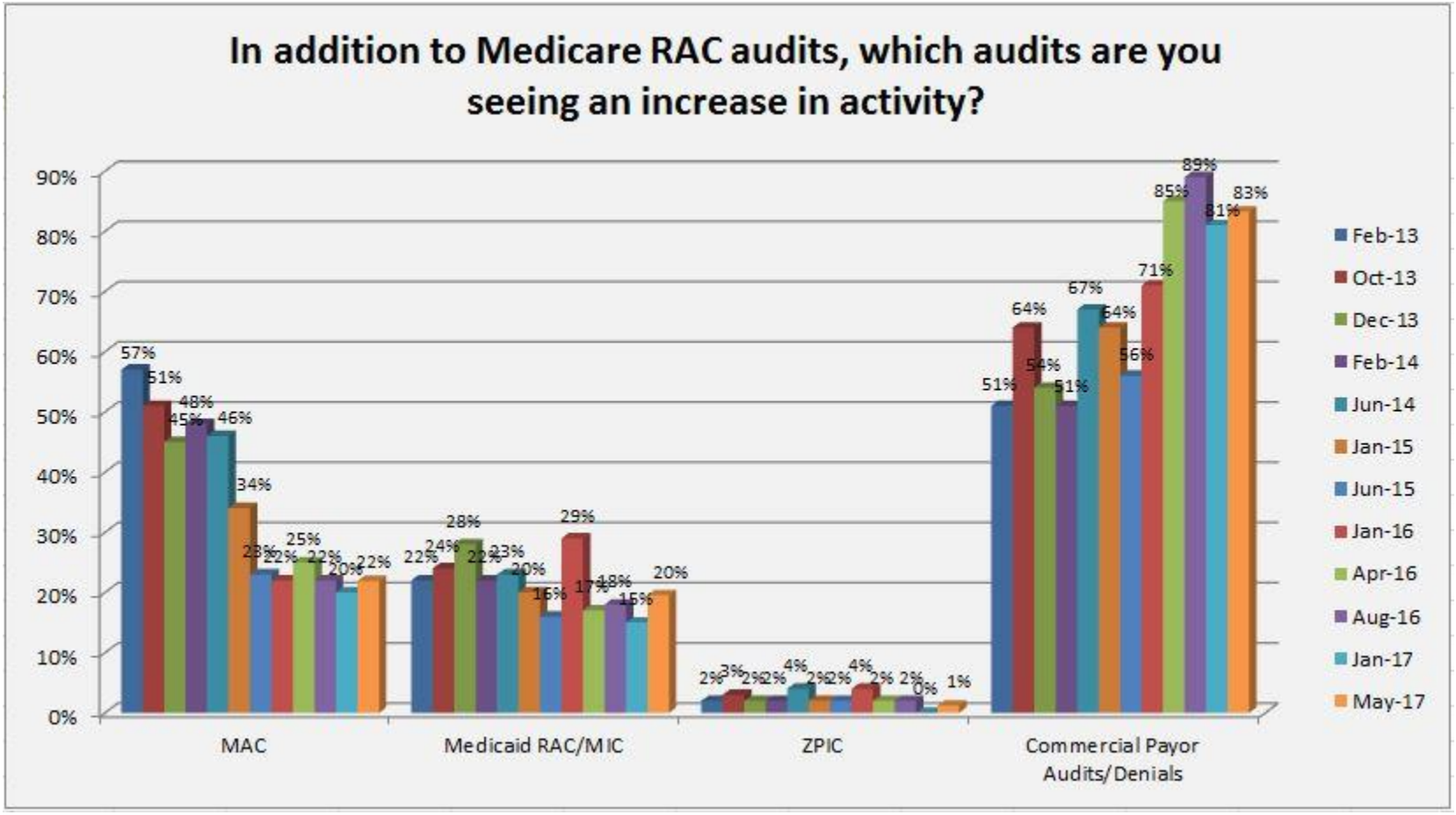
- Payer specific definitions
- Using Traditional Medicare, the two fold approach: Care that has to be provided in a hospital /severity and intensity AND the need for a 2 MN stay /with a plan.
- What is the difference for United? Humana?
- What is the difference for Medicare Mgd?
- What is the difference for Commercial?

Mgd Care Anguish- A Brave New World is Required- Attacking DRG Downgrades, Pt Status Disputes, Re-Admission Denials…

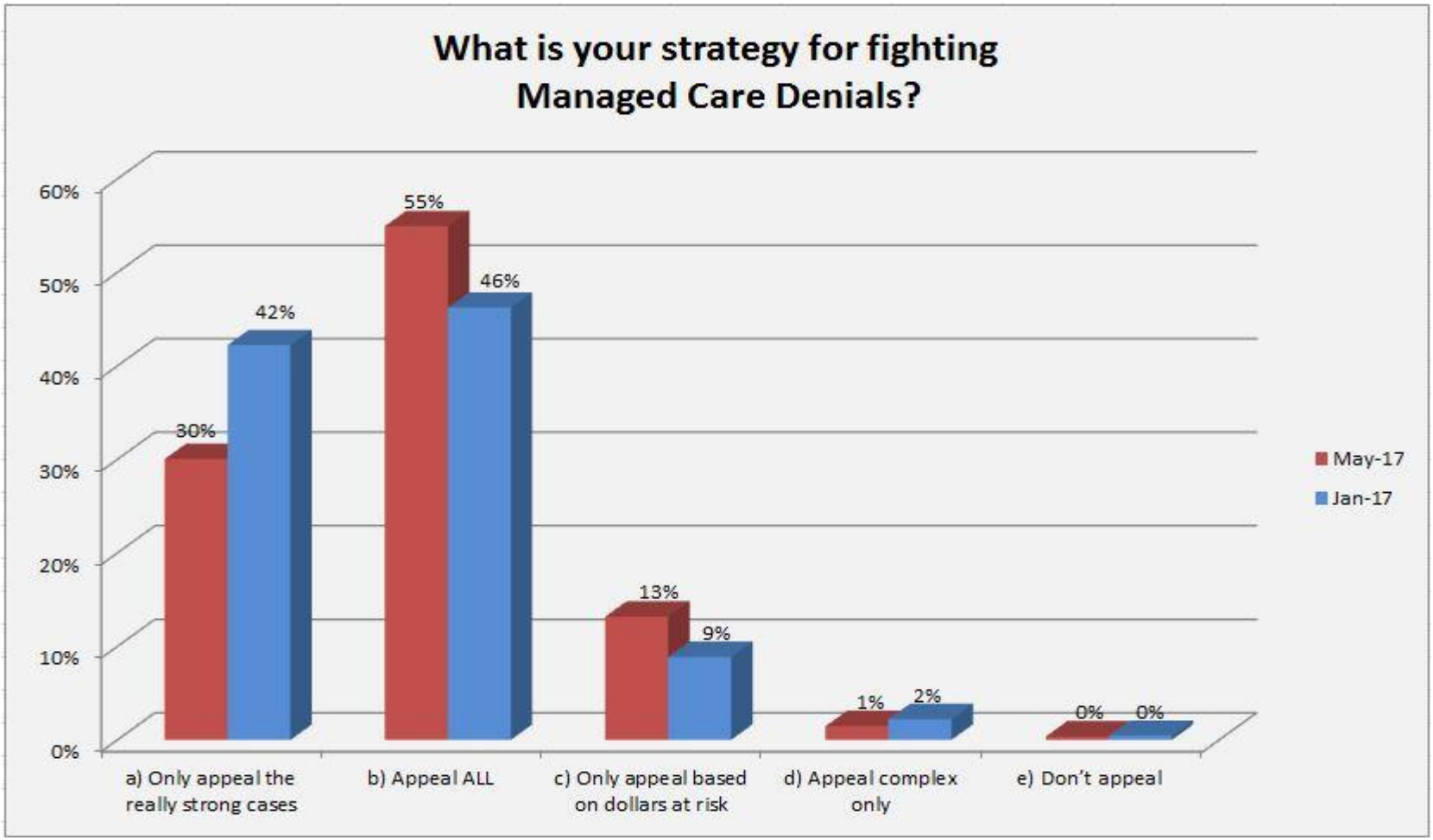
3 Legs of Anguish – Pt Status, DRG Downgrades, Re-Admissions

- Pt Status – what is their definition of an inpt?
- DRG Downgrades – what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- Readmissions - Related means? 30 days when CMS does not use this standard. Preventable means?
- Hint – all must be in the contract! Usually silent.

4 year trend – feedback from Compliance 360 Free Webinars



Feedback from Compliance 360 Free Webinars



Risk adjustment data validation

RADV

- The diagnoses that PacifiCare submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 55 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that PacifiCare submitted were valid. The risk scores for the remaining 45 beneficiaries were invalid because the diagnoses were not supported by the documentation that PacifiCare provided.
- As a result of these unsupported diagnoses, PacifiCare received $224,388 in overpayments from CMS. Based on our sample results, we estimated that PacifiCare was overpaid approximately $423,709,068 in CY 2007. (settled in 2017)

GAO Slams CMS on MA Audits

- GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments.
- CMS's goal of eventually conducting annual RADV audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments.
- CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act. GAO-16-76 Published: Apr 8, 2016

UPDATE: Medicare Failed to Recover Up to $125 M in Overpayments, records show. 1-6-17

"Under intense pressure from the health insurance industry, CMS quietly backed off their repayment demands and settled the audits in 2012 for just under $3.4 M – short changing taxpayers by up to $125M in possible overcharges just for 2007!" http://khn.org/news/Medciare-failed-to-recovery-up-to-125-million-in-overpayments-records-show/?utm_campaign

Whistleblower Tells Health Insurers Bilking Medicare 5-17

- “Former ‘well placed official’ at UnitedHealth Group asserts that big insurance companies have been systemically bilking Medicare Advantage for years, reaping Billions of taxpayer dollars from the program by gaming the system.”
- The sicker the pt- the more money paid.
- Scouring pt records and finding ways to ‘goose up’ the dx.

More on Justice Dept investigating

- Four other Medicare Advantage are being investigated by the Justice dept.
- Aetna, Humana, Health Net and Cigna's Bravo Health. **more potential whistleblowers
- Mgd Care Plans are paid a per member/per month to manage the pt's care.

https://mobile/nytimes.com/2017/05/15/business/dealbook/a-whistle-blower-tells-of-health-insurers-bilking-medicare.html/

What is the Regulation for Managed Medicare?

(Dr Ronald Hirsch/Accretive Health, 2016 PA & UR Boot camp**)

Medicare Advantage/Part C plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medicare Managed Care Manual, Ch 4

1-17 Privately run health plans have enrolled more than 17 M elderly and disabled people – about 1/3 of those eligible for Medicare –at a cost to tax payers of more than $150B a year. **Same article as slide 21 /added NOTE: Most hospitals have less then 1/3 of their business Managed Medicare – less in rural setting/shared risk too high.

What's your Case Manager's Reality?

- Demand patients stay observation for days on end
- 48-72-96 hrs to get approval for post-acute care
- Contracted home care agency has bad reputation
- DME supplier will not deliver supplies in a timely manner
- Bundling all readmissions within 30 days
- Did I mention – DRG challenges? Inpt is finally approved only to see a reduction in the DRG payment.
- TREAT MGD MEDICARE AS A COMMERCIAL PAYER

And UR/UM has the first point of contact challenge…

- Who is the primary payer?
- What are their rules for inpt?
- Is this payer contracted? What are the pt status contract terms? If not contracted, then what?
- What guidelines is the payer using to support /determine inpt? Milliman? Interqual? Neither?
- Who is the provider who will write the inpt order?
- What if the payer disputes the inpt request?
- What are the payer's rules for resolving a pt status dispute?
- Does UR know ANY of the contract terms? Why not..
- AND if pt status changes are contractually limited for after discharge, then what??

DRG Downgrades

- Lots of discussion regarding tying in the diagnosis outlined to the treatment. Simply listing dx is not sufficient to 'earn the higher DRG payment."
- Differing interpretations of 'co-morbid' conditions.
- Differing interpretations of 'primary and secondary ….reasons for admit.' Different DRG assigned.
- P2P calls..always!

Readmissions- CMS Policy

- When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital **and is readmitted to the same acute care PPS hospital on the same day for symptoms related t**o, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

30-Day Readmission CMS

Thanks, Denise Wilson, AppealMasters

CMS Hospital Readmissions Reduction Program (HRRP)

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing 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.**

Aetna Readmission Policy

- Effective July 1, 2015, we're changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we're also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays. **
- **ALERT:** All plans are using 'related' readmissions. Some are using 'preventable' readmissions. All denied for separate payment.

More readmission info- UNITED

- Per United Healthcare's "Hospital Readmissions", effective 10-1-16. Promoting Safe Hospital Discharges
- **Approx 19% of Medicare pts are readmitted within 30 days.**
- Only 37% are able to state the purpose of their meds
- Only 14% knew their medication's common side effects
- Only 42% are able to state their diagnosis
- 25% of discharged patients require additional outpt work-ups with greater than 1 of 3 work-ups not completed.
- As many as 41% of pts are discharged with test results still pending with 37% of the results actionable. Two of three docs are unaware of results.

Sources:* Mayo clinic proceedings: 2005 80 (8): 991-994 &

J Gen Internal Medicine: 2009 : 24(9): 1002-6

United Health Care Readmission

- 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. **

One RAC Relief User Issue

- Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.

- Suggested Response: Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **

National Contacts at CMS for Complaints: ++

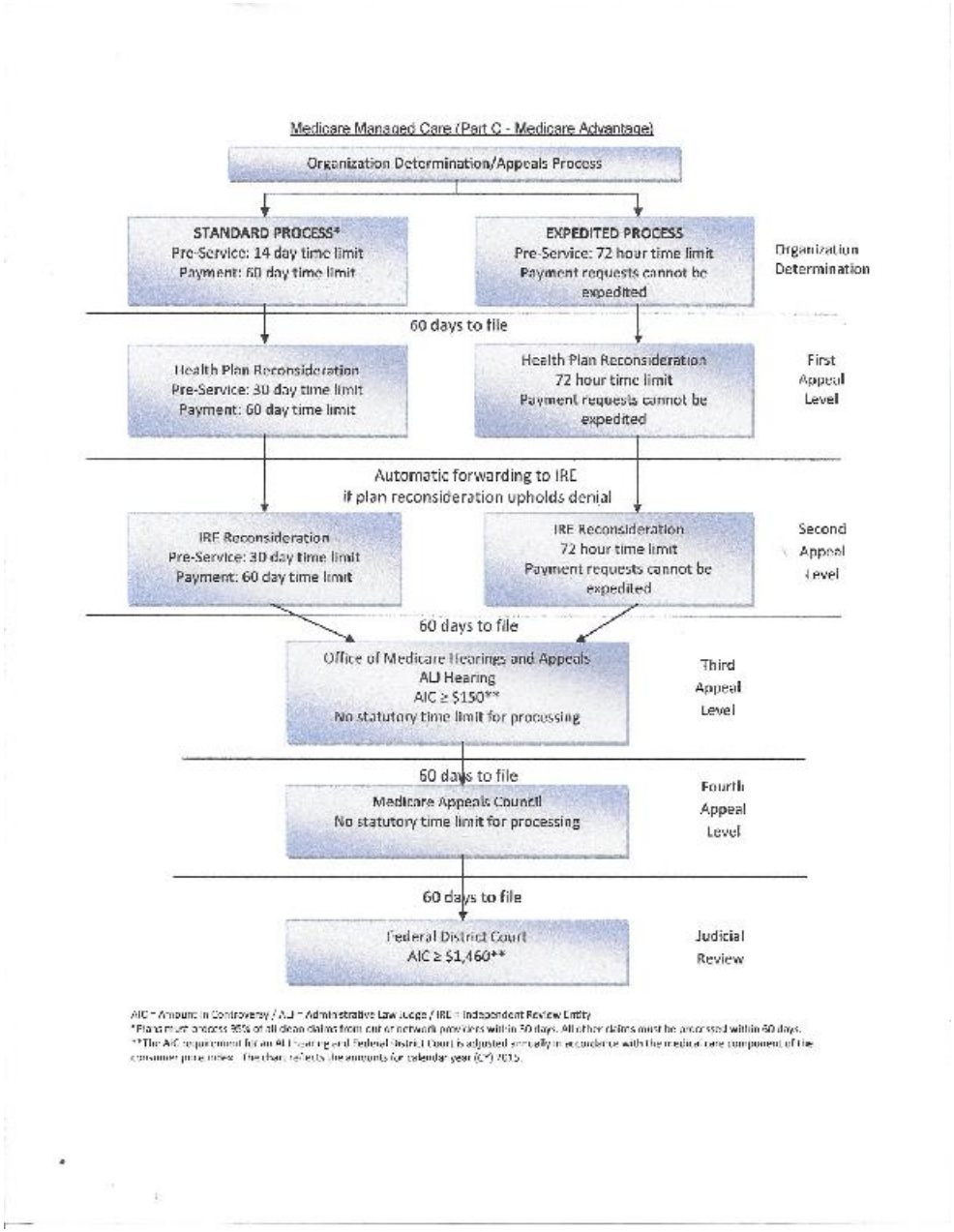
- Humana
  - Uvonda Meinholdt
    Health Insurance Specialist
    Kansas City Regional Office
    Phone: 816-426-6544
    FAX: 443-380-6020
    Uvonda.Meinholdt@cms.hhs.gov
- United
  - Nicole Edwards
  - Phone: 415-744-3672
  - Nicole.edwards@cms.hhs.gov
- Coventry Health / Aetna
  - Don Marek
  - Health Insurance Specialist
  - Denver Regional Office
  - Phone: 303-844-2646
  - Don.Marek@cms.hhs.gov
- BCBS Anthem
  - Anne McMillan
  - Health Insurance Specialist
  - Chicago Regional Office
  - Phone: 312-353-1668

General CMS Contact

Melanie Xiao, Health Insurance Specialist
CSM San Francisco Regional Office
415 744 3613
Melanie.Xiao@cms.hhs.gov

Part C/Medicare Appeals

- Unless the contract speaks directly to the levels of appeal, all Medicare patients should receive all five (5) levels of appeal.
- ALERT: Closely monitor the language within the contract to ensure it is not limiting.
- ALERT: If there is no contract with the Mgd Care Medicare/Part C/Medicare Advantage, then the Part A/Traditional levels of appeal apply.
- https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-pdf


Medicare Managed Care (Part C - Medicare Advantage)
Organization Determination/Appeals Process
STANDARD PROCESS*
Pre-Service: 14 day time limit
Payment: 60 day time limit
EXPEDITED PROCESS
Pre-Service: 72 hour time limit
Payment requests cannot be expedited
Organization Determination
60 days to file
Health Plan Reconsideration
Pre-Service: 30 day time limit
Payment: 60 day time limit
Health Plan Reconsideration
72 hour time limit
Payment requests cannot be expedited
First Appeal Level
Automatic forwarding to IRE
if plan reconsideration upholds denial
IRE Reconsideration
Pre-Service: 30 day time limit
Payment: 60 day time limit
IRE Reconsideration
72 hour time limit
Payment requests cannot be expedited
Second Appeal Level
60 days to file
Office of Medicare Hearings and Appeals
ALJ Hearing
AIC ≥ $150**
No statutory time limit for processing
Third Appeal Level
60 days to file
Medicare Appeals Council
No statutory time limit for processing
Fourth Appeal Level
60 days to file
Federal District Court
AIC ≥ $1,460**
Judicial Review
AIC = Amount in Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2015.

Last Tidbits

- Part A rules only apply if contracted.
  - "Can't change status after discharge." HUGE! Many disputed statuses are not resolved until after discharge. Ensure this is allowed in contract language.
  - Humana IS imposing no change of status after D/C. HUGE win for Humana as disputed status may involve P2P calls – which can take days to coordinate…pt is discharged with a disputed status… NO !
  - "Condition Code 44 has to be done" HUGE! Since Part C Medicare has to be contracted for status confirmation, it is not applicable unless contractually included.
  - Managed Part C plans 'quote' CC 44 for disputed status – inpt back to obs. Again, unless it clearly states that CC 44 is part of the contract – it is not used. HUGE win for the payer as disputes can take days to resolve – SO pt is an inpt until dispute is resolved. DO NOT Allow – 'we follow CMS guidelines' without additional clarity.

Complexity from all directions- Patients impacted

- Patients unaware they are 'seamlessly converted ' to the Mgd Medicare Plan when they had the same carrier as a Commercial plan. HOLY MOLY!
- See www.washingtonpost.com/national/health-science/senior-surprise-getting-switched-with-little-warning-into-Medicare-advantage/2016/07/26.
- Patients received letter /one of many as they approach 65. They MUST opt OUT of the plan or they are seamlessly being enrolled. "With Medicare's specific approval, a health insurance company can enroll a member of its marketplace or other commercial plan into its Medicare Advantage plan…which takes effect within 60 days unless the member opts out."
- Many pts without their doctor and more money out of pocket as didn't know they were part of a Mgd Plan!!!

BREAKING NEWS - HOLD

- Oct 24, 2016 CMS has temporarily stopped accepting new proposals from health insurance companies seeking to automatically enroll their commercial or Medicaid patients into their Medicare Advantage/Part C plans.
- CMS disclosed 29 Medicare Advantage companies – including Aetna, United, and several Blue Cross and Blue Shield insurers. Half of the companies received their approval this year.
- Members currently are AUTO enrolled unless they opt out.
- Dialogue want the pts to OPT IN..so they have choice. Doctor relationships are huge when the pt is AUTO enrolled.
- www.modernhealthcare.com/assets/pdf/CH1075661021.pdf
- www.modernhealthcare.com/article/20161004/news/161009981

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