Contracting – Priority in Payer Consistency

Day Egusquiza, President

AR Systems, Inc.

It’s all in the Contract

- What criteria are used?
- United Health Care Policy Number: H-006
- **Coverage Statement:** Hospital services (inpatient and outpatient) are covered <u>when Medicare criteria are met.</u>

- For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Update - United

- As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- UHC believes the best way to help UHC's members get access to the care they need is to relay on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- More specifically, United uses **Milliman Care Guidelines (MCG)** to determine medical necessity and the appropriate level of care.
- UHC will also provide a copy of MCG criteria upon request before, during, or after a reconsideration request.
- **Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."**
- Per UHC 2016 Provider Manual – pp 113-114 Criteria for Determining Medical Necessity.

Non-Participating update –United

Applies to Medicare Mgd/Advantage and Commercial

1. New Regional Director for SC- updated change in policy toward non-participating facilities and the loss of ability to interact with United.
2. **Non-Par will no longer have any cases concurrently reviewed.**
3. Peer to Peer discussions will no longer be available (no concurrent)
4. All cases will be retrospectively reviewed by Change Healthcare/EquiClaims and Cotiviti –who United contracts with to do their reviews.
5. Initial appeals will have to go to whichever contractor issued the denial and if the appeal is signed by a physician –then it will be reviewed by a Medical Director. Otherwise you will have to appeal up to 3 X to the contractor to eventually have it reviewed by the Medical Director after which you would have one chance to appeal to United but no guarantee of Medical Director involvement.
6. Non-par facilities still required to notify United of an admission but they will no longer be allowed to submit any clinical information since no concurrent review will be allowed.
7. Watch addresses on denial letters… could be wrong – miss deadline.

Thanks, Dr. Baker, Self Regional Healthcare 7-17

More United Anguish- Contracted

- Doing Peer to Peer calls with new dedicated MD. Contracted hospital.
- Often 'agrees' with our doctors that the pt 'belongs in the hospital' – and we are using Milliman/United's directive – and we are still denied.
- The letter says we can bill observation IF we have an obs order or code 44 – which we don't since we believe we have an inpt.
- Therefore, United says we can only bill for outpt services – **bill type 121/ancillary**
- We are 'begging' our contract people to let us be part of the negotiating or go Non-Par…
- Our denials have doubled this year between Aetna and UHC… and most of the increases are with Managed Medicare/MA.
- The payers believe we have no recourse…so it is time to file a formal complaint with CMS and look at No contract.
- Time to get a lawyer involved.

Thanks, Dr Casey, Western CT Health Network

And if no Part C/Medicare Advantage Contract?

- Do not be bullied or misled
- Part C is a commercial payer with the same commercial payer rules – just attached to a specific Medicare pt.
- If you don't have a contract with Part C – how can you be paid 'according to the contract?"
- Therefore, with no Part C contract, the provider is paid as though the pt has TRADITIONAL Medicare.
- Contact your MAC to determine the steps or for further clarity. **Everyone is new at this process**

UnitedHealth Adopts Bundle Payment Model for Orthopedic Care 12-16

- To reduce the high spend associated with hip, knee and spine surgeries, United Healthcare has adopted a bundled payment model.
- “Along with higher spends, members regularly show poorer health outcomes.”
- “For the most part, about 17% of company spend is in the orthopedic arena. Hip, knee, spine procedures constitute about 33% of that.”
- “By partnering with **high quality providers**, payers may also find their members experience better outcomes and decreased cost,” said Michelle Lobe, VP of Network Strategies & Innovations.

Proactive Strategies – Contracts
GOAL: It is a internal team sport

- Develop a template for terms for all payers – commercial and Medicare Part C/Advantage –beyond payment.
- <u>Areas to include:</u>
  - Timeline to submit clinicals – inpt vs obs
  - Timeline for determination from the payer- within 12 hrs
  - Immediate call/appeal including guarantee of a peer to peer call within 24 hrs with clear time assigned and kept.
  - Clearly outline criteria being used to determine inpt status. (Beyond 'medically necessary ' care.)
  - DRG – Correct coding guidelines being used. (Disallowing dx that are not being treated…lower the DRG payment.)
  - Re-admission guidelines. (Related? Like CMS?)
  - Appeal rights – post discharge. Ensure all 5 levels with Traditional Medicare are included for all Part C plans.
  - "Using Traditional Medicare/CMS" rules – but what happens when they don't?

And more updates- Part C

- Managed Medicare Plans/Part C = HUGE
- They do not have to adapt Traditional coverage rules.
- Treat them like a Commercial Payers – get pre-certs, determine if they are using '2 MN' rule methodology and/or clinical guidelines.
- Update contracts to CLEARLY outline the tools used to determine: what is an inpt.
- Always use: Physician order with rationale for why? (Sound familiar??)
- If not contracted –TRADITIONAL MEDICARE APPLIES!
- Big increase in denials…& disputes of status
- WHAT IS THE PAYER'S DEFINITON OF AN INPT!

Proactive Strategies - Payers

- Schedule monthly meetings with the primary contracted payers.
- Have examples of ‘abuse’ with inpt status and DRG and readmission. (3 hot spots)
- Involve contracting with all payer operational meetings/calls.
- Involve UM with all payer operational calls.
- Involve Coding leadership and/or CDI with meetings.