THE PHYSICIAN ADVISOR'S ROLE IN CONTRACTING DECISIONS

Absolutely Critical Component of any Contract Negotiation

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Denials Management is Key in Revenue Cycle

- What good is a small increase in the reimbursement rate when you lose much more on the back side through denials
- CRAP
- Managed Care Directors frequently are not knowledgeable about difficulties in obtaining payment from a given payer - looking to preserve market share
- The contract obligates you to follow whatever language is there and limits your ability to appeal any denial

Why the Physician Advisor Must be Familiar with the Contracts

- What is an inpatient?
- What are the requirements for certain diagnoses to begin care as observation?
- What is the appropriate length of time to cover as observation?
- What is a readmission and when is it not payable?
- How long can you cases be audited?
- How do you appeal a denial?

Key Requirements for Contract Review by the Physician Advisor

- Read the entire document and be sure you have access to all documents referenced in the contract since the detail used to deny care may be the Payer Policy Manual or Provider Manual
- Be wary of terms like “always or never” unless they refer to the payer, “make your best effort” which may sound innocuous but can be used against you in the denial
- Who and under what circumstances can make a change in the document

Key Asks In Contracting

- Any case concurrently reviewed and authorized cannot be denied for status unless fraudulent misrepresentation is proven
- MA Plan must follow CMS IPO List
- Peer to Peer Process – must allow system Physician Advisor to do these discussions and if lower level agreed to will be paid as if the original order was for that level of care
- DRG or Coding Validation Audits must follow ICD-10-CM definitions for terms, AHA Coding Clinic Guidelines, UHDDS definitions for additional coded diagnoses and limited to six months from the date the claim is filed
- Readmission denials can only be based on some action or inaction on the part of the facility that directly resulted in the readmission. Patient non-compliance is excluded and the plan must demonstrate that they followed up with the patient as well to prevent readmission

Key Asks Continued

- MA Plans should follow the Medicare Payment Integrity Manual (Chapter 6.5 is the 2 MN Rule)
- Do not give up the right to an appeal to an independent review entity and continued appeals after the plan denies
- Guidelines for approval of post-acute care with 24 hour turnover in decision making and if no bed available pay an administrative rate to the facility
- MA Plans required to report to CMS denied diagnoses to remove them from their RAF score
- Penalty for denials not based on terms of contract or denials overturned

Manage the Outcomes

- Once the contract is signed little chance to get any additional changes
- Physician Advisors are part of the revenue cycle team and are involved in payment decisions from the time a beneficiary enter the facility, through proper timely utilization of resources, correct coding with appropriate documentation, appropriate discharge planning and post acute care
- Understanding your payer contracts is vital in making sure you protect the revenue integrity for your facility

Bonus Information: CMS Dialogue on Non-contracted Facilities with MA Plans

- Previous work with CMS to address payment issues with the MA Plans resulted in specific people at CMS to hear complaints about individual plans – listed on next slide
- Resulted in contacts with the CMS Medicare Advantage Group and ongoing collaboration

CMS Contacts

- **Humana MED C Contact at Medicare:**
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- **Coventry Health Care Med C/Aetna Med C**
- Don Marek
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- **Blue Cross Blue Shield Anthem Med C:**
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- General CMS Contact:
- Melanie Xiao
- Health Insurance Specialist
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Bonus Information Continued

- CMS has taken the position that for non-contracted facilities the Medicare Advantage Plans must follow original Medicare regulations
- Two Midnight Rule for inpatient status no MCG or Interqual necessary
- No 30 day readmission denials as this is not CMS Readmission Reduction Policy
- All levels of appeal provided to original Medicare are available
- Not as clear yet is the question of whether or not a beneficiary can asses their SNF benefits with a qualifying 3 day inpatient stay as this may be a contract issue between the beneficiary and payer

Breaking News with CMS

- We have received in email confirmation as to the intent of CMS to hold the MA Plans to the non-contracted terms mentioned earlier with ongoing discussions to get this officially published by CMS
- Recent discussions with the CMS Medicare Advantage Group are moving toward rewriting the CMS policy on what MA Plans are required to have in their contracts to level the playing field for providers. (Two Midnight For All)
- Goal is to rewrite the CMS Medicare Advantage Manual by years end so that we are all playing the same game by the same rules

Latest Breaking News

- OIG announces in their new work plan they will investigate inappropriate denial of services and payment in Medicare Advantage
- Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services in an attempt to increase profits for managed care plans. We will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, we will determine the reasons for any inappropriate denials and the types of services involved.
- https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000299.asp