AR Systems, Inc
Training Library Presents

What is going on with the Payers?

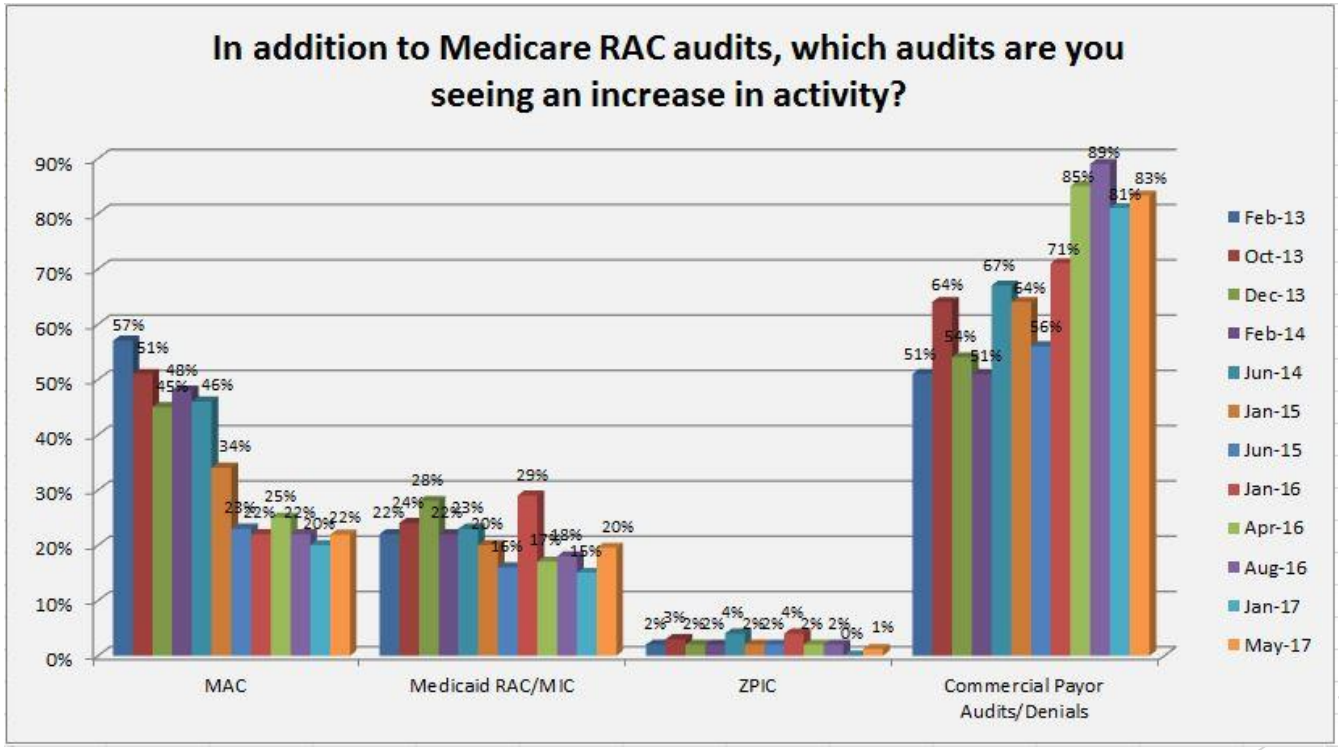
Attacking Managed Care Denials - The New Battleground

Instructor: Day Egusquiza, Pres

AR Systems, Inc

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

4 year trend – 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

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.
- Look to operational addendums.

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. **1-18 21M in MA /34% of 61M Medicare**

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.
- Peer 2 Peer/P2P calls..always!

Massive Requests for Records

- First: If contracted, what does the contract state regarding request? Volume? Frequency? Reason? ALWAYS validate with each request. (EX: NY health system)
- Second: If no contract, why send the records? If MA plan with no contract, what would 'traditional Medicare do' with the same issue? Threats to not pay or recoupment payment. IMMEDIATELY report to CMS /abuse.
- Third: Track and trend all requests. Why? What is the finding? Report to contract management ASAP.
- Fourth: HIPAA Standard Transaction and Privacy (2003ish) – only send 'minimally necessary information.' Never the full record. If prior authorized (all are) – then why do they need the record POST care?

One RAC Relief User Issue- Lost Medical Records??

- 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? **

Specifics – Disputes with payers Internal MD to Payer's MD

- **Do** more **Peer to Peer** calls- preferred Internal Physician
  - Get involved
  - Educate front line attending
  - Let them know what works
  - Let them know what is in question
  - Reward for great documentation
  - Share with all
  - Think internal Physician Advisor to effect change internally

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 when Medicare criteria are met. **DANGER ZONE***
- 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.

Medicare Advantage/MA plans 'using Traditional Medicare' to their advantage..

- 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.
  - EX) 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.

Update - United =25% market share

- 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.
- 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

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.

More challenges with Payers - United

HealthExecSnapshot

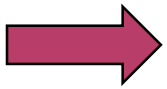
Tuesday, May 15, 2018

UnitedHealthcare's Value-Based Care Program for Knee, Hip and Spine Procedures

UnitedHealthcare reports their value-based care program for knee, hip and spine procedures helped reduce hospital readmissions by 22 percent and led to 17 percent fewer complications for joint replacement surgeries, as compared to nonparticipating facilities. For spine surgeries, hospital readmissions were reduced by 10 percent, and there were 3.4 percent fewer complications, as compared to nonparticipating facilities. They share that since the program's introduction, participating employers have realized an average savings of $18,000 per operation when compared with median costs in the same metropolitan area and eligible employees saved more than $3,000 in out-of-pocket costs.

SPONSOR

Payer Anguish



- United Healthcare
- Implementing bundle payments for 'high quality' providers for joints and spine procedures.
- Continues to buy companies that work directly with hospitals. Advisory Group, Optum
- Refuses to do concurrent reviews for inpt vs obs if not contracted.

- United Healthcare
- Effective 3-18, **ER Facility E&M** Coding Revision for commercial and Medicare Advantage plans.
- Polices focus on ED level 4/99284 and level 5/99285 – whether the provider is contracted or not.
- Using Optum ED Claim (EDC) Analyzer tool which uses presenting problems, dx services provided, and associated pt's co-morbidities.

Payer + Provider: 'Long road from Contention to Cooperation."

- 'Anthem/BC (Indianapolis-based) determines ER visits are not covered for 300 diagnosis. *Non-emergent*
- Impacts Kentucky, GA, Ohio, Indiana and Missouri. 40M+ BC members.
- Exceptions: under 14, on IV/new, no other care weekends, physician referrals to the ER, a lack of urgent care available.
- American College of ER Physicians:

"The changes do not address the underlying problem..pts have to decide if their symptoms are medical emergencies or not BEFORE they seek treatment. "

- If the diagnosis does not warrant 'emergent' under the payer-specific guidelines, there is on payment to the hospital and providers.
- EX) ***Pt in Frankfort, KY -after experiencing increasing pain on her right side of her stomach, thought appendix had ruptured. ER tested, diagnosed with ovarian cysts.***
- ***Patient owed full $12,000***
- Denials are based on FINAL diagnosis; not presenting diagnosis.
- Anthem believes 10% reviewed/4% denied

- **BC in TEXAS has started same non-covered ER 5-18**

Payer + Provider = New payment relationships

- AHA, AHIP and 4 other associations (AMA, BC/BS and MGMA) join to improve prior authorization processes.1-18
- Six healthcare groups agreed to take steps to make prior authorization processes more effective and efficient.
- Decrease the # of providers required to comply with prior authorization based on their 'performance, adherence to evidence-based medical practices or participation in a value-based agreement with the health insurance provider."

- Disney partners with 2 Florida health systems to offer HMO. 2-18
- Directly contracted with Orlando Health/6 acute hospitals and Florida hospital, Orlando/20 campuses to roll out two insurance plans for Disney employees.
- Goal: lower healthcare costs, higher outcomes
- Using Cigna/Allegiance to administer the program.
- NOTE: Remember employer-owned insurance is still looking for ways to reduce their costs..

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 to**, 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

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.**

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. **
- Aetna MD/CA case in court: did not do review of case/just read recommendation by clinical team. AG's investigating

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

Proactive Strategies – Contracts or Addendum to contract GOAL: It is a internal team sport

- Develop a template for terms for all payers – commercial and Medicare Part C/Advantage –beyond payment.
- Areas to include:
  - 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?
  - Build Addendums to contracts – outlining the operational aspects of the contract

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!

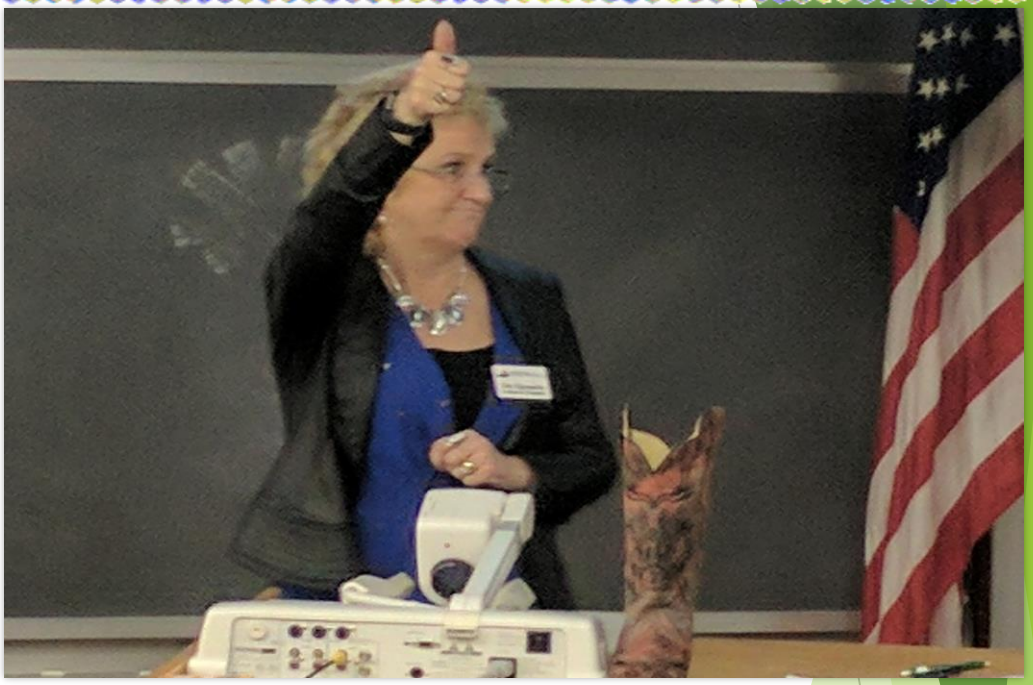
Complexity from all directions- Patients impacted

- 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

AR Systems' Contact Info



Day Egusquiza, President
AR Systems, Inc
Box 2521
Twin Falls, Id 83303
208 423 9036
daylee1@mindspring.com

Thanks for joining us!
Free info line available.

NEW EXPANDED WEBPAGE: http://arsystemsdayegusquiza.com