Key Revenue Cycle Elements

Do You Really Understand How the Contract Impacts Your revenue Cycle

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Medicare Advantage Plans Function as Commercial Insurance

- **HMO – Health Maintenance Organization**
  - Covers in network providers only, frequently require primary care assignment and referral to see specialist
  - Point-of-service (POS) option may allow some out of network coverage
- **PPO – Preferred Provider Organization**
  - Also maintains network of providers, but option to see out-of-network as well
  - Less restrictive, with generally no requirement for referral to specialist
  - Usually pay more to see out of network providers
- **PFFS – Private Fee-for-Service Plan**
  - Least restrictive, can see any Medicare participating provider that will accept the plan's payment terms. Some PFFS plans may still have networks of providers
- **SNP – Special Needs Plan**
  - Provides targeted care for institutionalized individuals, dual eligible, or those with severe or disabling chronic conditions

Commercial Continued:

- Prior authorization for surgery, certain drugs and diagnostic procedures
- Concurrent Review based on screening criteria
- Usually require notification of admissions and concurrent clinical information be forwarded at specified intervals
- You must understand how the plan defines an inpatient (MCG, Interqual, or proprietary references). Be sure to ask for the criteria used in making the decision as the Plan is required to furnish the information used in decision making

Medicare Advantage & the Code of Federal Regulations (CFR)

- Subpart C – Benefits and Beneficiary Protections
  - 42 CFR §422.100-136
  - Medicare Managed Care Manual, Chapter 4

- Subpart E – Relationships with Providers
  - 42 CFR §422.200-224
  - Medicare Managed Care Manual, Chapter 6

- Subpart M – Grievances, Organization Determinations and Appeals
  - 42 CFR §422.560-634
  - Medicare Managed Care Manual, formerly Chapter 13 (now unnamed chapter)

Benefits & Beneficiary Protections

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.318 (for entitlement that begins or ends during a hospital stay) and § 422.320 (with respect to hospice care), each MA organization must meet the following requirements:

(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) CMS's national coverage determinations;

(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions; and

(3) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan. If an MA plan covers geographic areas encompassing more than one local coverage policy area, the MA organization offering such an MA plan may elect to apply to plan enrollees in all areas uniformly the coverage policy that is the most beneficial to MA enrollees.

Beneficiary Protection Against Double Jeopardy

"If the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity."

– Medicare Managed Care Manual, Chapter 4, Section 10.16 – "*Medical Necessity*"

Funding for the MA Plans

- MA Plans receive a per member per month payment (benchmark Fee For Service risk adjusted)
- The methodology for risk adjusting the per member per month payment is to complicated for this discussion
- Bonus paid out each year based on “quality metrics” and Star Rating

It's All About the Contract

- You have to know what the contract says about status determination and how they define terms
- Your rights to appeal are generally outlined in the contract but frequently will be in documents referenced in the contract such as the provider manual. These documents must be reviewed prior to signing a contract. Most often standard contract only allows one level of appeal which is to the plan or to the auditor who did the review.
- CMS does not grant contracted providers any appeal rights
- Understand how the contract impacts denials and the additional work to get your facility paid. Historically MA Plans have significantly higher denial rates than any other payer.
- What constitutes a readmission and when are they not payable as a separate admission? Does the plan have language that excludes patient non-compliance or the denials only occur if the facility through some action or inaction directly affected the readmission?

Contract Continued

- How long can a patient receive necessary hospital care in observation?
- Does the plan have the unilateral right to make changes to the provider manual?
- How long does the plan have to audit a case after discharge?
- Does the plan follow the CMS Inpatient Only List?
- Who can do the Peer to Peer Discussions?
- What rules does the plan follow for DRG or Clinical Validation Audits?
  - Verify that the plan reports the removal of severity adjusting diagnoses to CMS so that their per member per month reimbursement from CMS is not incorrectly increased.
- Guidelines for use of post-acute care and what timeframe they have to give you a decision

Manage the Outcomes

- Once the contract is signed you have little chance to get any additional changes
- Physician Advisors are part of the revenue cycle team and should be involved in payment decisions from the time a beneficiary enters 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 to protect the revenue integrity for your facility

Trend and Track Your Data

- CRAP – claims requiring additional processing
- Amount of revenue involved in denials
  - Enough to affect contract performance?
- Administrative burden
  - Tracking denials
  - Writing appeals
  - Reprocessing claims and delays in payment
- Watch for zero dollar payments on readmission claims
- Impact of involving CMS

Peer to Peer Discussions and Building Relationships

- As a Physician Advisor you are much more aware of the regulations around status reviews and what it takes to be an inpatient
- The peer to peer discussion is not personal its business
- Do not undertake a discussion if you know the case does not meet as an inpatient so that you have credibility with the payer Medical Directors
- Get to know the people on the other end of the conversation
- Check the box person on the other end of the conversation
- Keep the discussion friendly
- Understand the immediate impact on revenue cycle
- Track you results
- Predetermination Discussion

Relationship Building

- Collect Contact information for each Medical Director and keep notes on how they interact with discussions
- Try to establish regular communication about issues you are having with the Plan
- Work with the Plan Regional Medical Directors when you are having issues to try to resolve those issues without formal appeals or reporting to CMS
- Schedule onsite visits or regular phone calls with the Medical Directors and Plan representatives

Additional Areas to Impact Revenue Cycle

- Probe Reviews, RAC, MAC, OIG, CERT, ZPIC, etc., if they audit I get involved
  - Stay ahead of the TPE and be sure to evaluate results and follow up
- Physician education in denials prevention
- Service Line data reporting
- Appeals writing
- Utilization Review Committee
- Compliance with Inpatient Only Procedures
- Surgery Precert Compliance
- Long Stay Accounts
- 0-1 Midnight Stay Reviews
- Medical Staff Education on Documentation and Coding and how these affect quality and yes payment
- Encourage Physician Compliance with Query Process
- Medical Staff Education on the Future of Healthcare Payment Models
- HCC Coding
- PSI Review

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