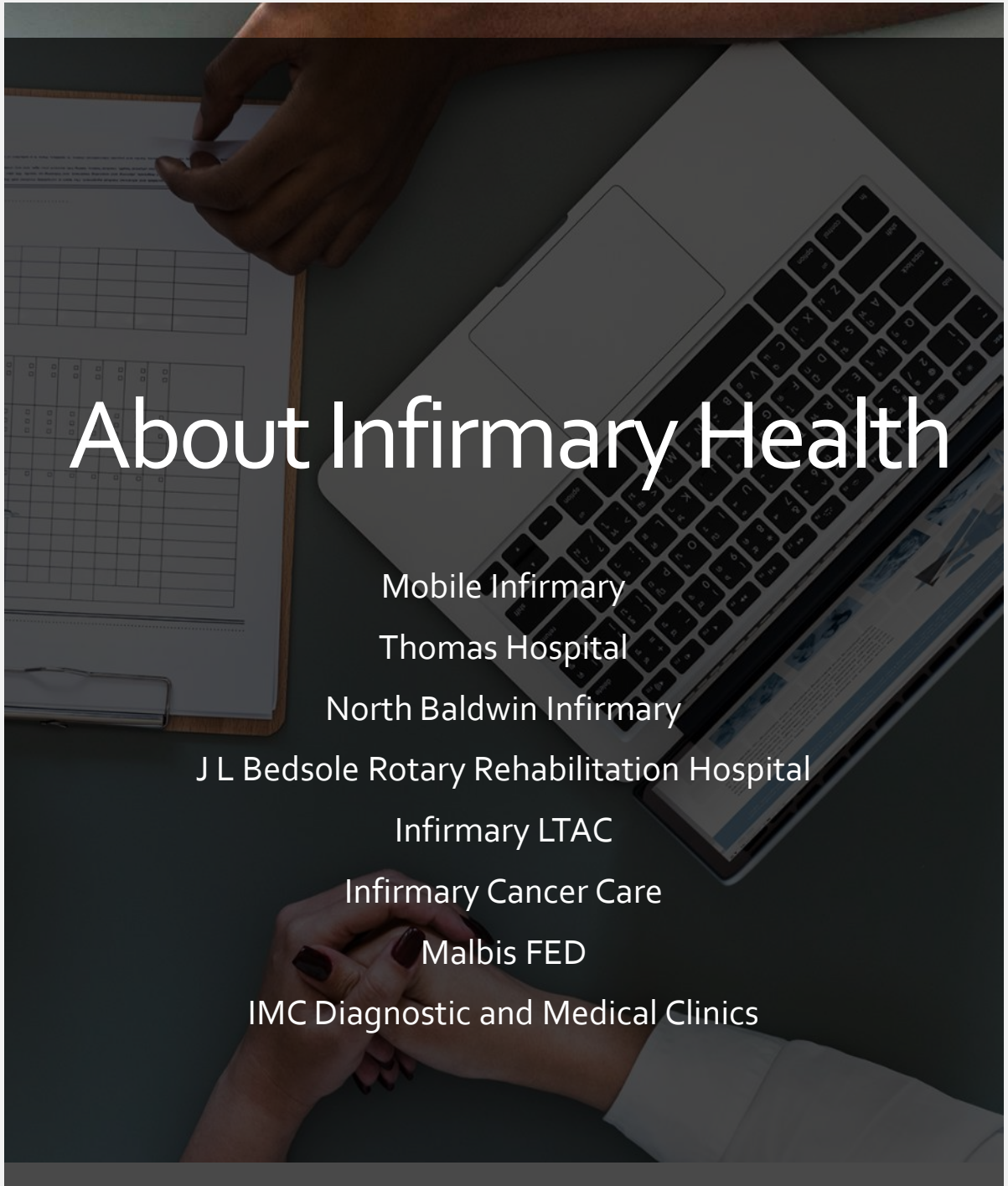
WELLNESS CHECK FOR THE MA PAYER/PROVIDER RELATIONSHIP

Insight and Best Practices Leading You To Success

Jennifer L. Bartlett

- Infirmary Health grew from a community-based campaign in 1896, and the original Mobile Infirmary opened in 1910
- The 669-bed Mobile Infirmary remains the flagship facility of Infirmary Health
- Infirmary Health is the largest non-governmental health care system in the state of Alabama.
- Serves an 11-county area of south Alabama and north Escambia County, Florida, with more than 700 active physicians on the medical staff and more than 5,700 employees.
- Composed of five acute care hospitals, three post-acute facilities, a physician clinic network with more than 60 locations, six diagnostic imaging centers, two full service breast centers and a freestanding emergency department, along with other affiliated entities.



About Infirmary Health

Mobile Infirmary

Thomas Hospital

North Baldwin Infirmary

J L Bedsole Rotary Rehabilitation Hospital

Infirmary LTAC

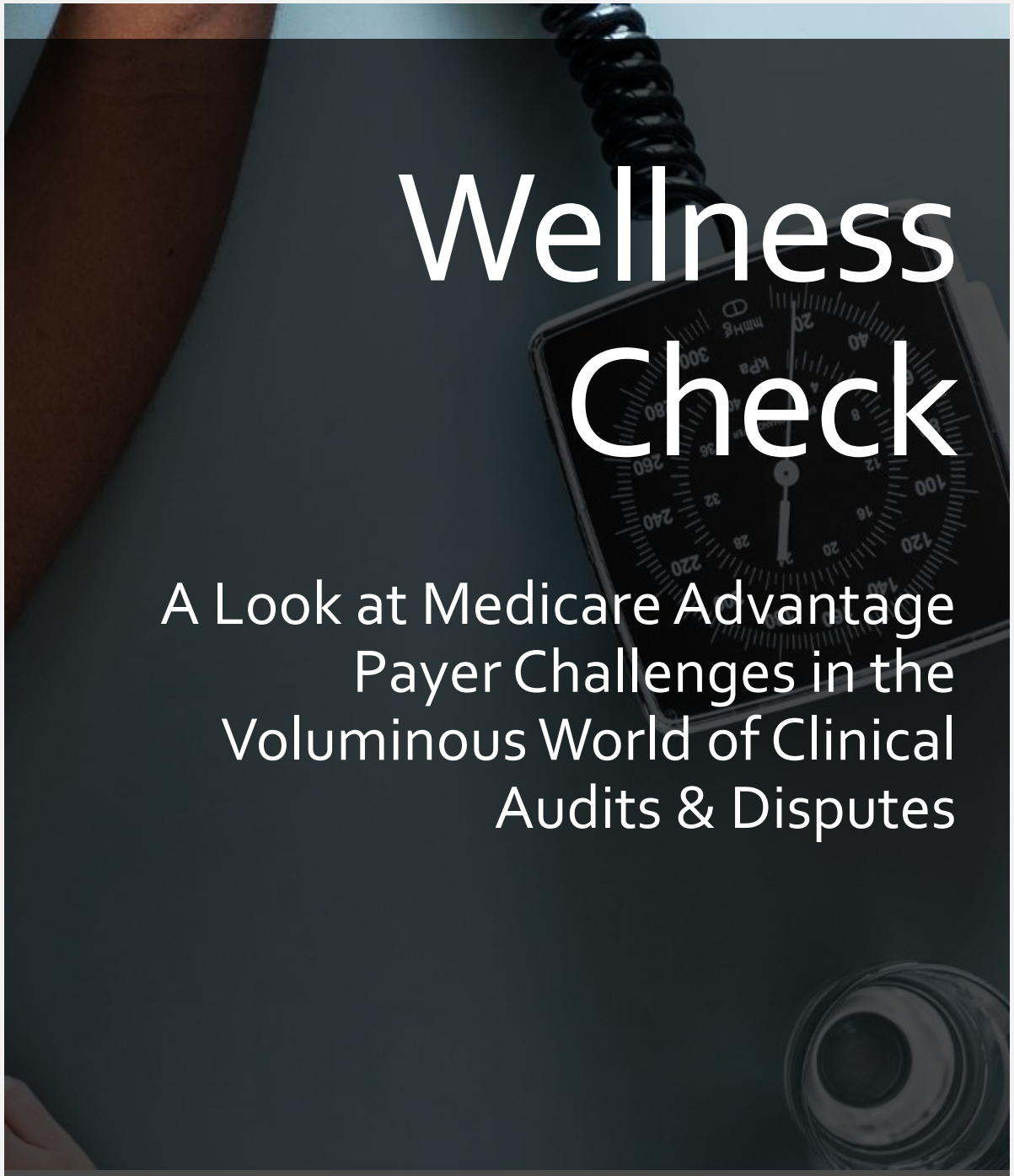
Infirmary Cancer Care

Malbis FED

IMC Diagnostic and Medical Clinics

DISCUSSION OBJECTIVES

- 3rd Party Auditors Are All the Rage-a Refresher
- Pre-pay audit challenges, solutions, tips and ideas
- Post pay audit challenges, solutions, tips and ideas
- Provider and Payer Audit Inventory Resolution
- Payer Portals, the State of the State
- Snail Mail—is that still a thing?



Medicare Advantage THIRD PARTY AUDITORS

A Third Party Audit Refresher

- Payers (large AND small) are utilizing third party audit vendors, even more so than the last time this group convened
- Provide your facility contact in facility contact matrix in spreadsheet form to every Payer and request that they communicate this information to all of their 3rd party vendors.

{{PAYER NAME}}-Third Party Audit
-CONTACT MATRIX BY TIN/NPI

LAST UPDATED 6/28/2019 BY JENNI

Facility	NPI	TIN	Preferred Email Delivery for all Additional Documentation Requests (ADR's)	Second preferred ADR delivery option	US MAIL Addresses for all Audit Related Correspondence	Preferred Email Delivery for all Audit Results/Findings	Preferred Delivery Method Refund Requests	Primary contact phone	Secondary contact phone
[redacted]	########	########	[redacted]	[redacted]	[redacted]	*See Preferred, Secondary and US Mail Options for ADR's*	*See Preferred, Secondary and US Mail Options for ADR's and Audit Results/Findings*	[redacted]	[redacted]

- Examples of 3rd party audit vendors include (but are not limited to): Equiclaim/ChangeHealthcare, Omniclaim, HMS (fka Health Data Insights/HDI), Cotiviti, CERiS (fka Corvell), SCIO, etc.
- Smaller local MA payers who were not using 3rd party audit at all are exploring this area of their operations
- These audit communications are coming out in the masses. You must be vigilant!

A Third Party Audit Refresher (continued)

- Can be complex (records requested) or automated (based on electronic scrub of the UB)
- Common 3rd party Audit Types may include (but are not limited to):
  - DRG Validation
  - *Medical Necessity of Inpatient Stay (*when they can and when they can't)
  - Clinical Validation
  - APC Coding
  - Itemized Bill Review (Charge Audits)
  - High Cost Drug Audits
  - Experimental and Investigational
  - RUG scores

Medicare Advantage PRE-PAY AUDITING

MA Plan Pre-Pay Audit

- Provider bills electronically, plan generates claim #, the plan issues an automatic request for your medical record.
- Payment for the claim is suspended until your facility submits the requested record
- Claim will adjudicate for technical denial and non-cover all charges if your facility fails to submit requested records
- If records are submitted, payer will then follow with one of these actions:
  - Claim will adjudicate and pay according to plan benefits (THIS IS WHAT WE WANT)
  - Claim will have findings letter issued with suggested changes in coding, DRG or with clinical validation findings
  - If findings issued, the claim will then adjudicate at the amount listed in the facility's findings letter, along with appeal instructions
  - The provider's A/R will most always show the denied amount, but some payers will adjudicate with everything listed as "covered", even though they took a reduction in processing

Medicare Advantage POST-PAY AUDITING

MA Plan Post-Pay Audit

- The claim has already processed and paid according to the plan benefits
- The plan submits an Additional Documentation Request (ADR) to your facility requesting a copy of the medical record for a particular type of audit
- **A technical denial will be issued by the plan if your facility fails to submit requested records.** If this is received, get the record submitted immediately. This will most often reverse the technical denial and the auditor will continue with the audit. If a refund request was issued, you can ask the plan to put the recovery on hold if you have proof that you have submitted the records.
- If records are submitted, payer will then follow with one of these actions:
  - A "No Findings" letter will be issued **(THIS IS WHAT WE WANT)**
  - Claim will have findings letter issued with suggested changes in coding, DRG or with clinical validation findings, along with appeal instructions
  - The provider's A/R will most always show the denied amount, but some payers will adjudicate with everything listed as "covered", even though they took a reduction in processing

Medicare Advantage Audits for Medical Necessity

(When They Can and When They Can't)

Post Pay Audit for Medical Necessity of Inpatient (DRG) Stay

When a Payer can and cannot perform post pay audit for medical necessity of inpatient stay:

Can't

- Patient is in an HMO-type product, provider is contracted and concurrent authorization issued by the payer
- Concurrent auth of the stay/determination was secured prior to discharge
- No denial of inpatient status was issued for the HMO-type product/patient

Can

- Patient is in a PFFS-type product (Payer should have specific policy regarding this product, which will state that they are subject to audit
- HMO product where the payer did not fully issue an auth in the concurrent process and they also did not issue a denial (payer will pay the claim and then submit it for post pay audit—typically these are 1-2 day stays occurring around a weekend DC
- Payer "auto approves" a patient during a weekend or holiday so that the claim will not reject but will be later post pay audited (i.e., Humana for Mid-South region)

The above are not exhaustive of all scenarios, but representative of our Mid-South region of the country and based on experiences with contracted Payers. Non-Contract payers must follow Medicare 2MN and provider has all Medicare appeal rights.

Medicare Advantage PROVIDER REQUESTS FOR AUDIT INVENTORY

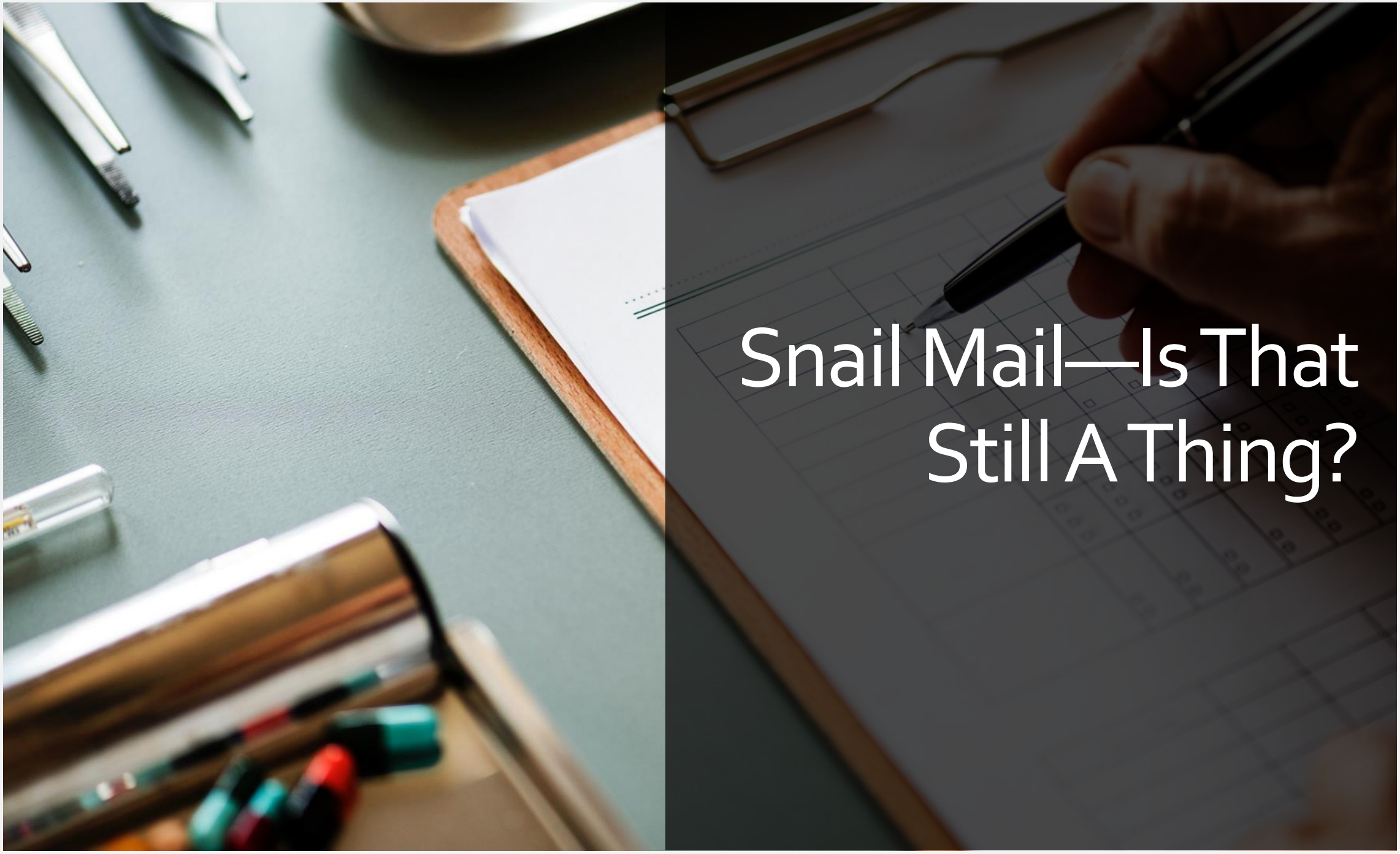
Payer-Provider Audit Inventory

- Make a request to the MA Plan's Provider Payment Integrity Department (PPI) for a monthly copy of their Audit Inventory of your accounts (if you are an organization, then ensure it's by TIN & NPI for all of your facilities
- In addition to the audit information they will provide for you, their inventory will need to include your Patient Control number from Form Locator 3A of the UB04 claim, as well as the patient name, DOB and the admission and discharge dates **(THIS WILL INCLUDE THE PRE-PAY VS. POST PAY AUDIT IDENTIFICATION!)**
- Data can be compared to your own inventory of accounts that you know are in their audit process (i.e., V-Lookup in Excel)
- If the payer uses multiple third party auditors, you can request that they include this data in the inventory. This will allow you to develop your own scorecards for their vendors and to ensure that they are abiding by the terms of your contract
- Have regular meetings with the PPI team for the payer to discuss the audit inventory. Hold them accountable for an answer Try to work in account batches when possible so that the payer can resolve like-issues for multiple accounts at one time
- If their vendor(s) are causing egregious issues within your organization, you must use this data in your meetings with the payer so that they can be made aware and can provide information on the remedial steps that will be taken to resolve the issue(s). **THIS CAN ACTUALLY LEAD TO A PAYER TERMINATING AN AUDITOR FROM AUDITING YOUR ACCOUNTS!**

Payer Portals, The State of the State

Payer Portals-- Best Practices

- Payer portals give you the ability to maintain a no-nonsense audit trail of your transactions + EFFICIENCY EFFICIENCY EFFICIENCY!
- Upload medical records to a portal vs. mailing or faxing
- Some appeal functions can now be performed within the payer portals, and more functionality is in the works
- Multi-payer platforms (i.e., Availity, Navinet) and what they mean to you
- Questions that you need to ask your Payers regarding the multi-payer platforms (if one payer has opted to turn on appeal functions on one of these platforms, then you need to rally your other payers to follow suit!)



Snail Mail—Is That Still A Thing?

Don’t Forget the Mail!

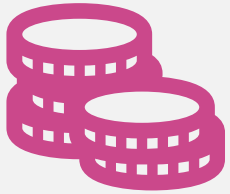
- Until mail is no longer used by Payers, it is worthy of discussion
- Be aware of your facility or organization’s mail procedures (who gets the mail and distributes it and are they giving it to you?)
- Audit Related mail can be even more time sensitive than Inpatient Status denial mail (due to the abundance of auditors)
- Be aware of the subtle changes that a payer might make from week to week, month to month, etc. Make sure that you are communicating these changes to those that can impact the process (you want to avoid technical denials!)

WELLNESS BENEFITS

GAINING TRACTION IN YOUR ORGANIZATIONAL FINANCIAL HEALTH

Unfavorable appeal results will trend downward when you are…

Getting it right up front or having substantive supporting documentation back end defense



Obtaining **AND** retaining reimbursement for the care provided because…

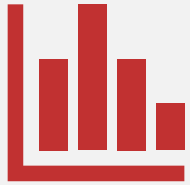
Payers will pay you, but they will take it back even faster.

Rebuilding of Provider-Payer relationships will occur when you…

Ask for data and then collaborate with payer with the data they have produced .

Your organization may be willing to deploy new or more robust technology…

When you can make a case for the disproportionate volume of payer denials/audit findings vs. FTE's



Meaningful data sharing between payers and providers…

Will allow providers to (when possible) work at the batch level vs. the account level

THANK YOU