

AR Systems, Inc Training Library Presents



Attacking Managed Care & Medicare Advantage Anguish - The New Battleground

Instructor:

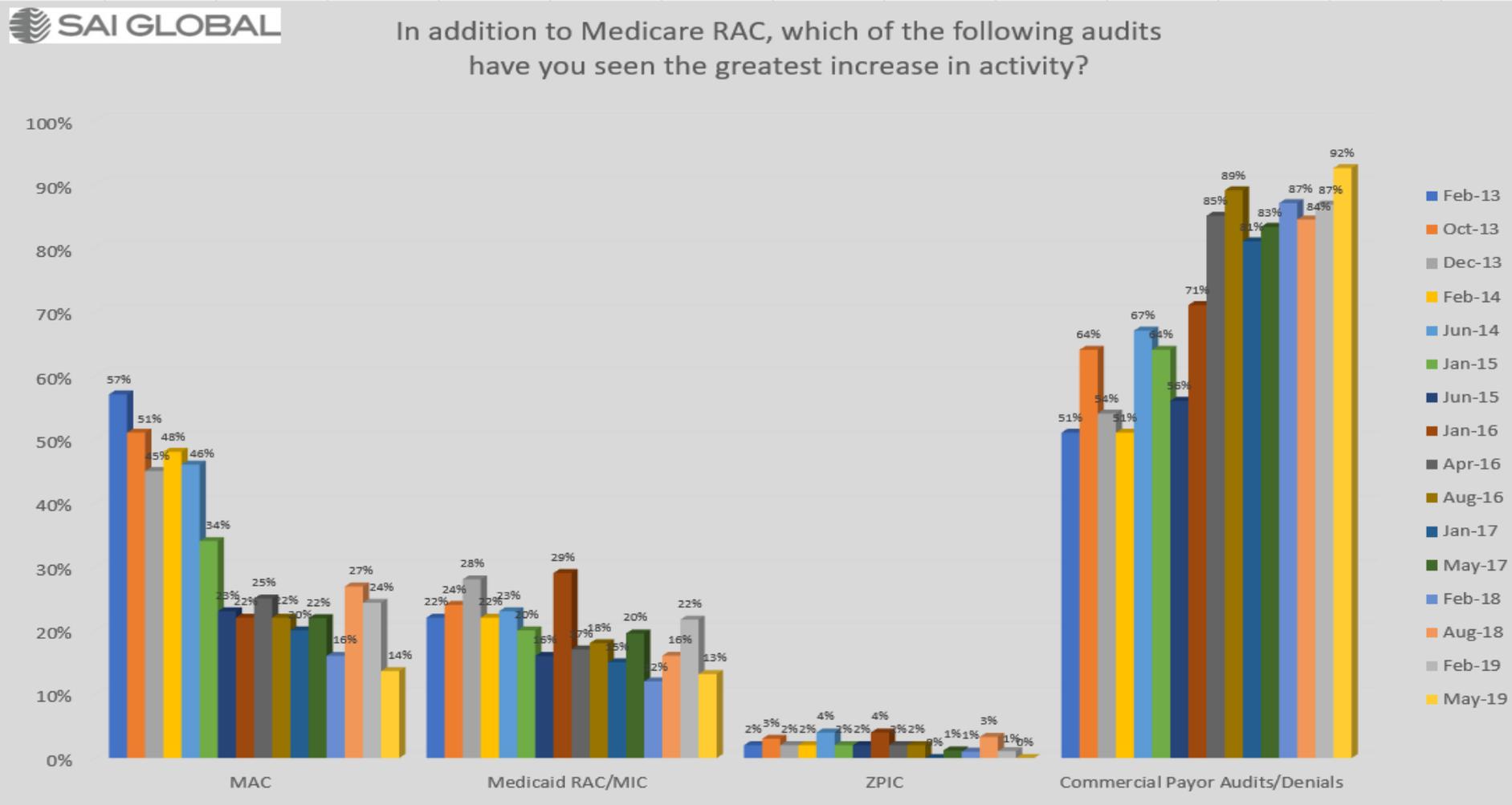
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AR Systems, Inc



Mgd Care Anguish-
A Brave New World Required-
Payer Policy Changes/Outside the Contract
Significant Growth of Medicare Advantage
Plans
= Financial Impact to Providers



6 year history from Free Webinars SAI GLOBAL 2013-current



Medicare Advantage/Part C/MA - increase enrollments

- ▶ By 2020, it is forecast that Medicare Advantage/MA will constitute 50% of the Medicare market.
- ▶ Significant changes were made to allow revision/expansion supplemental benefits -like hearing aides, health club memberships, in home visits, home delivered meals, glasses, and others ‘patient specific needs.’”
- ▶ 2019 - allow negotiation with pharmacy pricing
- ▶ Significant payments to plans for “Star Rating”(4&5) rated by pts.
- ▶ Limiting out of pocket yearly expense
- ▶ But not all plans are sold in all counties of the country.
- ▶ No ability to have a Medicare Supplemental - pt pays all out of pocket plus monthly premium.
- ▶ MA IS NOT TRADITIONAL MEDICARE. Medicare ‘s rules do not apply if the hospital signs a contract. IF NOT CONTRACT, Traditional Medicare rules apply.

Limited knowledge of lack of benefits - MA

- ▶ MA plans are 'county' specific within a state
- ▶ Only certain plans are sold in certain counties
- ▶ “Community coverage” with the MA plan
- ▶ Therefore, if the pt needs care that is not within their 'community' (Pt needs care outside their local community) - Out of network potential penalties. Exception - all Emergency care is covered. Just not after treatment care or ongoing care. (Snow birds-NO)
- ▶ Provider networks- MA plans cannot sell in your community unless they have a provider network.
- ▶ To contract or not to contract- what does the provider get for accepting less than billed charges? Win for payer, win /baby win for provider is??
- ▶ General enrollment - 1x yr; opt out thru March yearly.

Risk adjustment data validation

RADV-Medicare Advantage Plans

- 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

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



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? 'ALL" 30 day readmissions when CMS does not use this standard. Preventable means?
- ▶ **Hint - all must be in the contract! Usually silent.**
- ▶ **Look to operational addendums vs Payer -specific policies... UGLY**



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 secondaryreasons for admit.’ Different DRG assigned.
- ▶ Peer 2 Peer/P2P calls -limited ability to do as some payer’s are now stating - only P2P PRIOR to the claim denial. DRG disputes are usually not known until the downgrade on the Remittance.

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?

More ugly requests for records and illogical denials

- ▶ 2nd payer requests records. They are not paying primary so there is a minor amt due. Usually commercial payers who offered 'benefit' to the retiree. Why are records being sent? Challenge immediately. Contracted? Usually MA plans with retiree benefit - 2nd payer.
- ▶ Small outpt visits. The amount owing -usually as 2nd payer - is small. Many times less than \$100 pending from the 2nd payer. Contracted? Usually MA plans with retiree benefit - 2nd payer. NO and HECK NO!
- ▶ Payer approves first 2 days and then denies the next two days. Golden rule: One covered day of inpt stay = One DRG payment. So if the pt stays 4 days = same DRG payment. If the pt is approved for 2 days = same DRG payment. Someone obviously hasn't informed the company who is paid to deny days that the DRG doesn't change. Can we say a waste of precious resources!

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? ****



Medicare Advantage - Provider WINS - use regulations

- ▶ “If the plan approved the furnishing of a service thru an advantage determination of coverage, it MAY NOT deny coverage later on the basis of a lack of medical necessity.” Medicare Mgd Care Manual/Medical Necessity, Chpt 4.
- ▶ 2 MN required for MA plans. “Each MA organization must meet the following requirements: a) provide coverage by furnishing, arranging for or making payment for, all services that are covered by Part A and Part B of Medicare ..that are available to beneficiaries residing in the plan’s service areas. Services may be provided outside of the service area of the plan if the services are accessible..2) General coverage guidelines included in original Medicare manuals and instruction, unless superseded by regulations .. 42 CFR, subpart C, 422.101.” MA plans must comply with NCD and Guidelines.

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-documentation enhancements
 - ▶ Let them know what is in question
 - ▶ Share with all
 - ▶ Think internal Physician Advisor to effect change internally
 - ▶ **BIG: Healthplans (Humana) are including language about 'providers treating pt'**
 - ▶ **BIG: No longer do post-denial calls. Only concurrent. 9-18 (POLICIES)**



It's all in the Contract or is it Policy-outside the contract?



- ▶ 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 rely 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

Payer 'mis-information' for Medicare Advantage plans

- ▶ “Recently we received a denial for a status 3 years after the encounter. The pt was here for an OP Hemorrhoid procedure developing vomiting with distension of a colonic ileus. History of Olgilvie syndrome failed 48 hrs of outpt treatment. Inpt was approved thru payer contact prior to billing/3 years ago. Now the 3rd party vendor is stating he did not meet inpatient criteria.”
- ▶ Medicare Managed Care Manual, Cpt 4, Section 10.16. And Program Integrity, Cpt 6, Section 6.1.3 Medical necessity applies:
- ▶ **“If the plan approved the furnishing of a service thru an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity.” YAHOO!**
- ▶ Turn in abuse to CMS - as oversight for all MA Plans.

More payer anguish -Place of service Audits

- ▶ “One carrier has enlisted HDI to audit place of service. They sent us 10 cases, all Medicare Advantage, DOS vary from 2016-2018, only one case had a 1-day LOS and they all say the same thing: “The patient could have been safely and appropriately cared for in an outpt level of care.” Now that sounds like a medical necessity denial to me. The kicker? I have already been denied 4 of these cases (back in 2016 and 17) and one was overturned by peer to peer, the other three were overturned on written appeal. How can this be possible? “ Western Conn. 8-18
- ▶ SEE PG 18. It can’t! But think of the wasted administrative costs to continue to a) track, b) defend and c) repeat defend. Track and trend and turn all costs into Contracting.

More payer anguish - Outpt

- ▶ “For the last month or so, we have been getting letters from UHC wanting the medical records on all our outpt services and even if they are the 2nd payer and owe us under \$100, they want the records. They are asking for records for a simple CBC, strep test, drug screening, mammo, and colonoscopies. In many cases, it is costing us more to send them the medical record than what our actual reimbursement would be. I filed a complaint with our UHC Advocate and we have a phone call set up. They are calling it “pre-payment letters.’ In many cases we have a prior authorization and they are still wanting the complete medical records. Now other payers are starting to do the same thing.” Ill small hospital
- ▶ Most are commercial UHC and we are contracted..
- ▶ No idea why we would agree to this but under PROTOCOL, we have to respond.

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.**

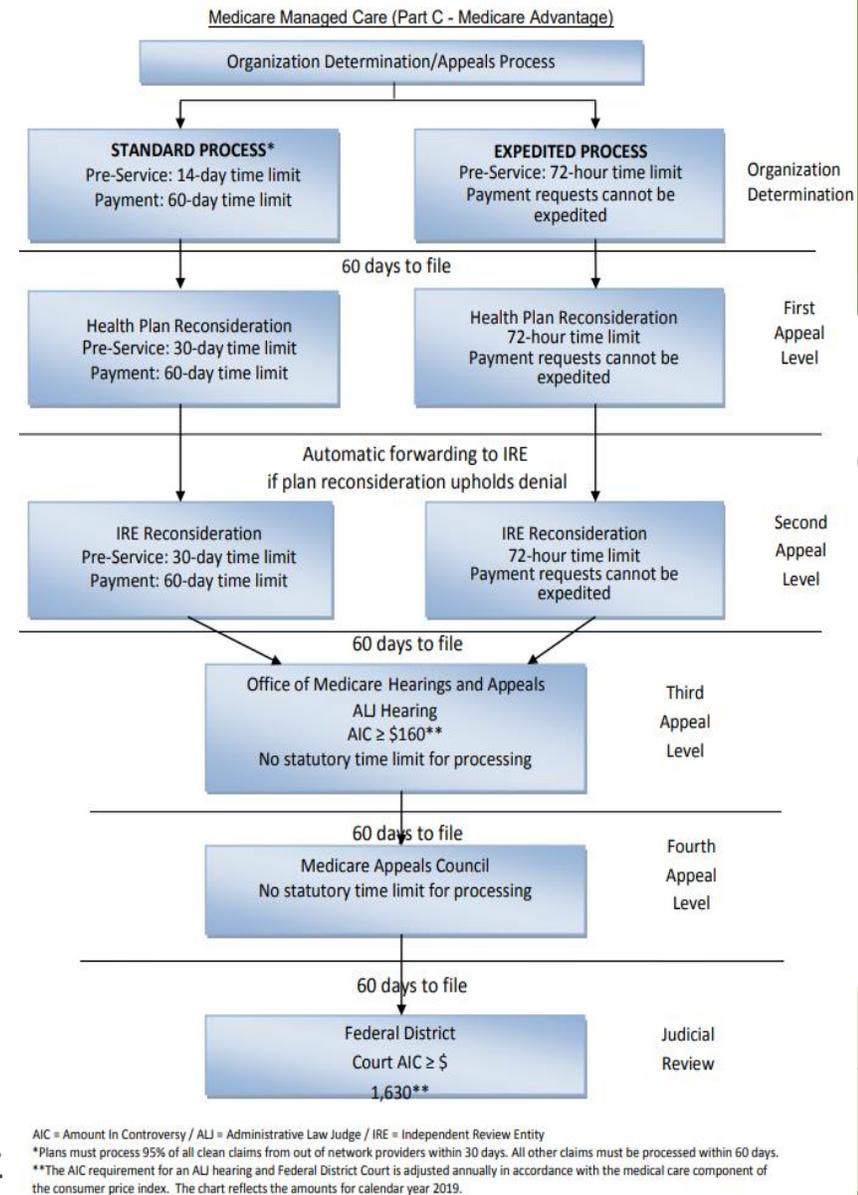
United Health Care Readmission



- ▶ 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**
- ▶ **FULL DENIALS of the 2nd admission by MA PLANS...and other COMMERCIAL PAYERS...**

MA Appeals Process

- ▶ Enrollee (beneficiary) appeal rights shown
- ▶ Non-contract providers may access standard payment appeal pathway if waiver of liability completed
- ▶ Anyone with formal representative authority can access full enrollee appeal rights without waiver of liability
- ▶ Note automatic forwarding to IRE if first level reconsideration upheld
- ▶ OIG report: 70% of MA plan's inpt denials have been overturned.



CMS Form 1696 - formal representative

- ▶ Must be accepted by all Medicare Advantage plans - cannot require a different form
- ▶ Sections 4 not applicable to Medicare Advantage because the Plan's Evidence of Coverage dictates any cost-sharing responsibility, unchanged by this form
- ▶ Providers cannot charge a fee for representing enrollee
- ▶ Valid for 1 year, and for life of an appeal

Form Approved OMB No. 0938-0950

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)	
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Section 1: Appointment of Representative
To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
 I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment
To be completed by the representative:
 I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.
 I am a / an _____
 (Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation
Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)
 I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date
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Section 4: Waiver of Payment for Items or Services at Issue
Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date
-----------	------

CMS Contacts for Specific Plans and General Contact

- ▶ **Humana MED C Contact at Medicare:**

- ▶ Uvonda Meinholdt
Health Insurance Specialist
Kansas City Regional Office
Phone: 816-426-6544
FAX: 443-380-6020
Uvonda.Meinholdt@cms.hhs.gov

- ▶ **UHC MED C Contact at Medicare:**

- ▶ Nicole Edwards
Phone: 415-744-3672
Nicole.edwards@cms.hhs.gov

- ▶ **Coventry Health Care Med C/Aetna Med C**

- ▶ Donald Marik
Health Insurance Specialist
Denver Regional Office
Phone: 303-844-2646
Donald.Marik@cms.hhs.gov

- ▶ **Blue Cross Blue Shield Anthem Med C:**

- ▶ Anne McMillan
Health Insurance Specialist
Chicago Regional Office
Phone: 312-353-1668
Anne.McMillan@cms.hhs.gov

- ▶ **General CMS Contact:**

- ▶ Melanie Xiao
Health Insurance Specialist
Medicare Advantage Branch
Division of Medicare Health Plans Operations
Centers for Medicare & Medicaid Services
CMS San Francisco Regional Office
90 7th Street, 5-300 (5W)
San Francisco, CA 94103-6708
Phone: 415-744-3613
FAX: 443-380-6371
melanie.xiao@cms.hhs.gov

Regulations 42 C.F.R. § 422.214

If non-contracting with a MA plan....

§ 422.214 Special rules for services furnished by noncontract providers.

- a) Services furnished by non-section 1861(u) providers.
 - 1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.
 - 2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.
- b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

Proactive Strategies - Contracts or Addendum to contract or Policy 'hits.'

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 & For REPLY w/in 12 hr
 - ▶ Timeline and allowance for P2P for any provider. Reply too.
 - ▶ 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

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



EXCITING! Save the date: 7th National PA & UR Boot Camp:

“Medicare Advantage: Building blocks of contracting, Provider sponsored MA plans and the Ongoing denial challenges.”

PLUS Pre-con: **“The Basics: Medicare 101, P2P 101, CDI 101, and Denials/Appeals 101”.**

WOW! July 29-31, 2019 Washington , DC

In person plus live web streaming...