Payer's (Still) Going W I L D!!

Bored yet?

Presented by:

AR Systems, Inc.

Day Egusquiza, President
AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.

Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.
Let me be the Patient Financial Navigator!

“Signs of Disruption in the Revenue Cycle”

- **<u>What are three C’s that keep CFO’s up at night?</u>**
- Compliance?
- Cash flow?
- Customer service?
- Cybersecurity?
- Complaints?
- Competition?

HINT: How about Cash flow, Customer service and CRAP… yep, just plain CRAP!!

- Or Claims Requiring Additional Processing/CRAP!
- Instead of ‘without margin there is no mission.’ How about re-thinking the new world of revenue cycle.
- PS Bet the Revenue Cycle Leaders have a few ‘keeping me up at night too!”

<u>SETTING TRENDS FOR SUCCESS</u> – Every payer issue is ALWAYS a patient issue. Patients pay the premiums and are ultimately responsible for the bill. How much do they know about their plan’s coverage? How to get what providers are in-network/No surprise bill? What will they owe?

Our “A Game” just got more complex…

- Mission Drives Margin. Why do patients pay? What is their perception of value for the healthcare they received?

Hospitals at risk – **300+ rural hospitals at immediate risk of closure** –have lost $ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23)

Stats from AHA	2023	
Total hospitals in all US	6129	
# of community hospitals	5157	84%
Of these, # of nongovt not-for-profit com hosp	2978	58%
# of owner investor-owned, for profit	1235	20%*
# of State & local govt community hospital	944	15%
Additional: # of Fed Govt hospitals	206	3%
# of nonfed psych hosp	659	11%
Other hospitals 2021	107	2%

By state - sample	# at risk of total # hosp
Kansas	29 Of 169 *34 private
Mississippi	25 of 128 *36 private
Oklahoma	24 of 165 *61 private
Alabama	19 of 133 *62 private
California	9 Of 570 *148 private
Iowa	7 Of 145 *5 private
Idaho	2 of 55 *13 private
Nevada	2 of 76 *37 private
As we carefully watch multiple small rural hospitals close , many are tied to Private for-profit investor owned.	Communities without a hospital – also means providers too.

AR Systems, Inc
Training Library Presents

Attacking Medicare Advantage Denials – Taking Your Power Back PLUS WELCOME TO THE 2 MN RULE!

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Instructor:

Day Egusquiza, President

David Johnson: Cracks in the Foundation (Part 6) – Overcoming inadequate leadership (hfm/9-22)

The American Hospital Association's (AHA) April 2022 *Cost of Caring* report pleads for more funding to offset double-digit increases in labor, supply and drug costs. Meanwhile, the latest West Health-Gallup Healthcare Value Index found that 95% of American adults find the perceived value of the healthcare they receive is "inconsistent" or "poor." Healthcare's leaders, including board leadership, should sit up and take notice.

A failure of healthcare leadership

- The economic principle is not complicated and applies to all industries. Demanding more money for overpriced services is no way to win consumers' hearts, minds and wallets. Warren Buffett famously observed, "**Price is what you pay. Value is what you get.**"

7 strategies for health systems to apply (Day's Hint: Be the patient!)

- Here are seven strategies that health systems can apply to create inspired leadership for advancing transformative change:

1. Have the courage to lead revolutionary transformation.
2. Streamline organizational governance.
3. Determine and articulate the "just cause" that will guide organizational strategy.
4. Undertake comprehensive culture change to educate and engage employees.
5. Tap the community for support and inspiration.
6. Remember that sacred cows make the best hamburger.
7. Start yesterday.

AND START WITH A LITTLE “PAYER FUN”

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U	usually
N	nine
I	in
T	ten
E	experience
D	denials…..

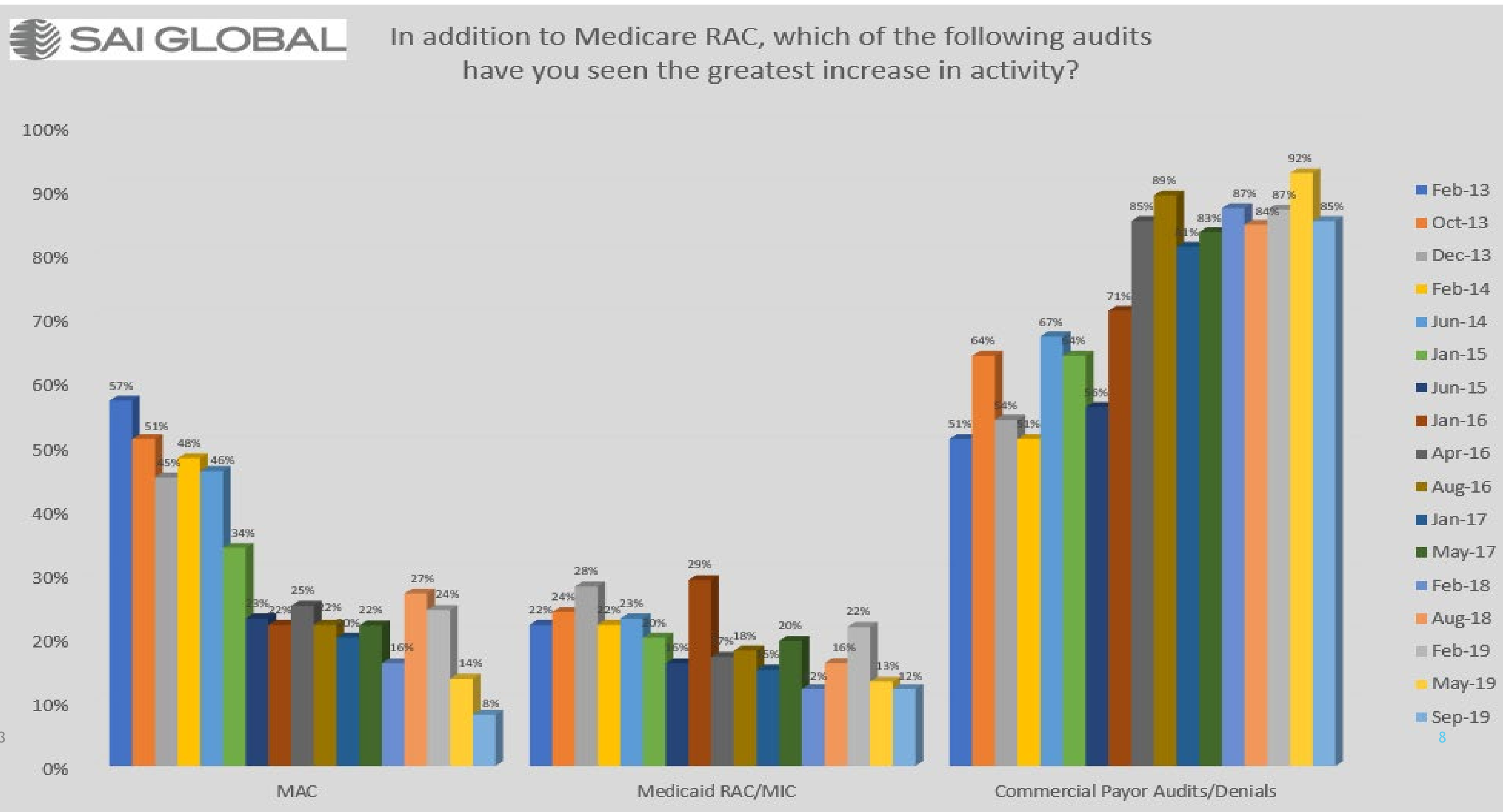
C	called
I	in
G	got
N	no
A	answer

++All time favorite: Singing the“Blues “

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

8 year history with Compliance 360/SAI

AHA survey: 78% of hospitals =payer relationships are getting worse. 84% said the cost of complying with payer policies is increasing; 95% saw increase in staff time spent trying to get prior authorization. 11-22 Win/Lose!



OIG Auditing MA plans PLUS AI payer concerns ++ MA enrollment has exploded by 337% from 2006-2022.

- OIG completes audit of specific dx codes that Excellus Health Plan, Inc submitted to CMS. 7-2023
- Under the MA program, CMS makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee.
- MA are paid more for enrollees with dx associated with more intensive use of health resources.
- OIG audited 210 unique enrollee high-risk dx submitted that did NOT comply with federal requirements.
- Specifically 202 of 210 sampled, the medical record did not support the dx codes, resulting in $479K overpayments.
- Estimated Excellus received approx. $5.4M in overpayments 2017-2018. Too early to make them pay back which recently changed.
- Excellus disagreed with all, but OIG confirmed

- Cigna sued following ProPublica report on unreviewed batches of denied claims. 7-23
- Two Cigna members have filed a class-action complaint against their insurer for allegedly denying large batches of member's claims without individual review- thereby denying them coverage for certain services.
- Many states require physicians to review pt files and coverage polices BEFORE denying claims for medical reasons.
- The suit alleges that Cigna has bypassed these steps by having an Algorithm called " PXDX" complete the review and then having physicians sign off on groups of denied claims.
- "Relying on the PXDX system, Cigna's doctors instantly reject claims on medical grounds (med necessity sound familiar?) without ever opening a pt file, leaving thousands of patients effectively without coverage and with unexpected bills. The scope of this problem is massive."
- Cigna denies.. For accelerating for low-cost screening…
- **HEY ELEVANCE HEALTH is seeing AI as a huge opportunity… quarterly earnings call… 7-23**

All Payers are auditing…

Watch for new 2024 MA and 2 MN rule

- Each payer has their own set of 'criteria' for coverage- Milliman/MCG, Interqual, medically necessary stay (?). (United, Blues, Part C Medicare, PEPPER/Traditional Medicare is targeting 1 day surgical, same day medical, and same day surgery, etc.)
- Each payer has their own standards for appeals
- Each payer determines if the documentation supports the service that was billed. Tell the patient story.
- But what is coming? EX) Amazon launching generative AI tool to power documentation software. The product, called AWS HealthScribe, is aimed at enabling software providers to build clinical applications that use speech recognition and generative AI. How will the payers address the 'automation of AI' with documentation? Is it worse than cut and paste? Copy forward?

Why we LOVE the 2 MN Rule for Traditional Medicare?

- What is the difference between inpt and obs for Traditional Medicare?
- 2 MN presumption: the provider declaring the estimated need for 2 MN PLUS a plan that will take the 2 MN.
- 2 MN benchmark: the provider declaring the need for a 2nd medically appropriate MN after the 1st MN as an outpt PLUS a plan that will take a 2nd MN.
- EASY ---LOVE IT! (Other payers – not so much!)

Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**
- "Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

Pg 50959

- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

Pg 50956

Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman/MCG criteria.
- ER, Observation, outpt surgery = all included in the 2 MN Benchmark.

- Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.

More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- Note: presumption = 2 midnights AFTER obs. 1 midnight after 1 midnight OBS = at risk for inpt **audit but still an inpt.**
- Pg 50946

- ..the judgment of the physician and the physician' s order for inpt admission should be based on the expectation of care surpassing the 2 midnights with **BOTH** the expectation of time and the underlying need for medical care supported by complex medical factors **such as history and comorbidities, the severity of signs and symptoms , current medical needs and the risk of an adverse event.** Pg 50944

STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- After the 1st MN as an outpt – anywhere – or the first MN in another facility and transferred in –

- "The decision to admit becomes easier as the time approaches the 2nd MN, and the beneficiaries in *necessary hospitalization* should NOT pass a 2nd MN prior to the admission order being written.' (IPPS Final rule, pg 50946)

- Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert or discharge. If clinical care is occurring, convert to inpt-no longer obs.
- As the 2nd MN approaches – is there a clinical reason to be in the hospital? Yes = convert. No= discharge.

"Meeting Criteria" – means Traditional Medicare ?

- It never has and never will mean – "meeting clinical guidelines" (Interqual or MCG/Milliman)
- It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet "Criteria"/Medical necessity not met – this means: Doctor cannot attest to a medically appropriate 2 midnight stay with a plan for 2 MN or additional 2nd MN after a 1st outpt MN– right?
- **11/1/2013 Section 3, E. Note: "It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate"**
- **Hint: 1st test: Can provider attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with PLAN – trumps criteria.**

More on clinical guideline clarifications/CMS

- FAQ: Does the beneficiaries' hospital stay need to meet inpt level utilization review screening criteria to be considered reasonable and necessary for Part A Payment?
- A: if the beneficiary requires medically necessary hospital care that is expected to span 2 or more MN, then inpt admission if generally appropriate.. While UR committees may continue to use commercial screening tools to help evaluate the inpt admission decision, the **tools are not binding on the hospital** or CMS. (update 3-12-14)
- If it not necessary for a beneficiary to meet an inpt 'level of care' as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpt LOC as may be defined by a commercial screening tool, does NOT make Part A payment appropriate in the absence of an expected LOS ..

Hot off the press- Auditing Traditional Medicare

- Livanta Claims Review Advisor Vol 1, Issue 18 7-23
- Does all short stay auditing for traditional Medicare nationwide.
- https://myemail.constantcontact.com/short-stay-review--The-inpatient-admission-decision.html?soid=1132747942080&aid=Wk7B_RLF2CM
- Plenty of case studies to use for teaching examples

- Medicare Program Integrity Manual Chapter 6- Medicare Guidelines which was revised 6-20.
- Includes key elements that need to be present to support inpt.
- Expectation of 2 MN in the record, inferred, transferring hospital, social, complex medical factors

Wow! Hot off the press – CMS Final rule with regard to Medicare Advantage Prior Authorization, Utilization Management, Traditional Medicare Coverage, etc.
Effective 1-2024 WELCOME TO THE 2 MN RULE, MA plans!!

- On April 5, 2023, CMS issued a final rule /2024 that revises the MA /Part C, Part D , Medicare Cost Plan and Programs of all-inclusive Care for the Elderly (PACE) regulations to implement changes related to:
  - Star Ratings
  - Marketing and Communication
  - Health Equity
  - Provider Dictionaries
  - Coverage Criteria **
  - Prior Authorization **
  - Network Adequacy
  - And other programmatic areas.

- Ensuring timely access to care: Utilization Mgt

This final rule clarifies clinical criteria guidelines to ensure people with MA receive access to the same medical necessary (subjective) care they would receive in Traditional Medicare/TM

CMS clarifies- MA plans must comply with national coverage determinations/NCD and LCD and general coverage and benefit coordination included in TM.

When applicable criteria are not fully established, a MA may create internal criteria based on current evidence in widely used treatment guidelines. Coverage not explicitly when MA use publicly accessible internal coverage criteria IN LIMITED circumstances is necessary to promote transparent, and evidence-based clinical decisions by MA plans that are consistent with TM. Must disclose what was used.

More Final Rule impacts – More UR And Prior Authorization

- Codify standards for coverage criteria to ensure *that basic benefit coverage for MA enrollees is NO MORE restrictive than Traditional Medicare*.
- Codify 422.101 (c)(1)(A) that MA organizations must make medically necessary determinations based on coverage and benefit criteria as specified at 422.101 (b) and (c) and may NOT DENY coverage for basic benefits based on coverage criteria that are not specified in 422.101 (b) or ©. **2 MN RULE is codified… Presumption Vs Benchmark**

This means that when an MA organization is making coverage decisions on a Medicare covered item or service with full established coverage criteria, the MA organization CANNOT deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in the TM coverage policies.

EX) Clinical criteria that restrict access to Medicare covered item or service UNLESS another service is done 1st, when not specifically required in the LCD or NCD, would be prohibited.

ex) 422.101 AND 412.3 (d) = using the 2 MN language to define an inpt. Benchmark. Rule prohibits MA from applying internal coverage criteria IN addition to TM statues.

- **Streamlines Prior Authorization Requirements** including adding continuity of care requirements and reducing disruptions for beneficiaries.
- Coordinated care/CC plan prior authorization policies MAY ONLY be used to confirm the presence of a dx or other medical criteria and/or ensure that an item or service is medically necessary. (Subjective)
- Requires CC Plans to provide a minimum 90-day transition period when an enrollee currently undergoing tx switches to a new MA Plan , during which the new MA plan may NOT require prior auth for active course of tx.
- CMS is requiring all MA plans to have UM committee.
- More clarity around 'course of treatment' – must be valid for as long as medically necessary to avoid disruptions in care.
- **Prohibit MA organizations from limiting or denying coverage when the item or service would be covered under TM.**

MAs must follow the 2-midnight rule, case-by-case exception and the inpt only list. YAHOO! BABY Steps!

- CMS explained under 422.101(b)(2),

"an MA plan must provide coverage, arranging for and paying for inpt admission when based on complex medical conditions in the record, the physician expects the pts care to cross two midnights (1+1/benchmark, 2 est at first touch /presumption) or admitting physician does not expect 2 MN but based on complex medical issues occurring that inpt is necessary (case-by-case exception) and when inpt is on the inpt only surgical list.'

DIFFERENT: Under presumption, 2 MN stay expected and billed 2 MN. Traditional Medicare = no routine auditing. Even if the pt only stays 1 MN, expectation and PLAN is present = TM pays inpt.

Now MA is expected to pay above example=1 & 2 MN.

BUT –MA plans can audit any 2 MN stays/presumptive of coverage for TM (use QIO, etc) Anything!!

EXPECT lots of debate of "medically necessary PLAN for 2 MN…with 1 MN…with a 2nd MN after the first outpt MN --why not obs?

- Effective Date

When it is effective? Rule references to a June 5, 2023 effective date with a Jan 1 2024 applicability date because CMS is codifying requirements rather than introducing new regulatory language. Gads.

- Payer situation

Spoke with a MA medical director. PA said this is a MA plan. Director – so? PA said 2 MN and she was very defensive. "Well we don't follow that.' Asked if she was aware of the new Fed guidelines on this. "Well we don't follow that and IF (she emphasized the IF) we decide to make any changes-it won't take effect until 1-2024 and that's all I am going to say about that." She then proceeded to uphold a denial for seizure with a 5 day stay that met MCG criteria.

She stated he was back to baseline mental status on Day2. PA pointed out that he was delirious an in role vest per documentation and got anti-psychotics on day2. She said-you can appeal."

NOW - 2 MN - how would this look? Doctor has a plan that would cover an estimated 2 MN stay. That plan is clearly outlined in the record/from the beginning. UM reads the plan. Now why denied? Much simpler but lots of documentation of PLAN that is full of medically necessary care. (Nursing adds to it too)

What's Going on with the MA payers in 2023?

- MA enrollment is up by 2.7M.
- Now totals 30.7 M of the 65 M Medicare beneficiaries.
- 46% -50% are now enrolled in MA plans
- Traditional Medicare is down by 4M since 2019.
- MA plans were to have a cut in payments in 2024. AHIP (Health Plan group) stated benefits would be impacted to the MA clients. In lieu of the cut,

  MA Rates WERE INCREASED 3.32% for 2024.
- ***In Feb, CMS finalized a rule to start recovering improper payments made to MA plans thru audits for the first time since 2007. Recovering is the key.***

- United Health Care Announces it will reduce its prior authorization by 20% and implement a Gold-Card program. 3-23 (Now prior for anything but screening colonoscopies.)
- Reductions will begin this summer for all Medicaid, MA plans and commercial plans.
- The national gold-card program will be implemented in early 2024.
- Qualifying providers will follow a simple notification process for most procedure codes rather than the prior authorization process.
- Both AHA and AMA are cautious to see if this really does remove unnecessary barriers to care and wasteful administrative burden on providers.
- Concern: How is this really done? Some states/Texas have had limited Gold Card activity and stated it was not what they had hoped for. More post payment audits?
- Concern: This is primarily for physician practices Not the hospital challenges with inpt vs obs.

And finally on 2024 Final Medicare Advantage and Part D (CMS-4201-F)

- Finally, MA organizations must comply with amended 422.566 (d) as in Section III.G of this Final Rule, which requires that a denial based on a medically necessity determination (subjective) must be reviewed by a physician or other appropriate health care professional with **expertise in the field of medicine or healthcare that is appropriate for the service at issue.**

- **If I was being pessimistic, I might worry about:**
  - **The Plan for 2 MNs or the 2nd MN after the first MN. The pt story must be very clear!**
  - **It is critical that the UR nurses STOP using Interqual or MCG as CMS has never required or endorsed them. It is all about the 2 MN rule since 2014.**
  - **Learn and use the 2 types of 2 MN – TM and now all MA.**
  - **A+ Game must be on for all UR, Case Mgrs, Denial team and contracting. Track and Trend violations but be the one who knows! Not the payers.**

- RELOOK AT EVERY LINE OF SERVICE When addressing the Medicare Advantage Patient.
- Assume all aspects of prior auth have been revised.
- Assume they can no longer deny a readmission within 30 days as TM only disallows a 2nd inpt payment for a) same day, b) same facility, c) similar dx. *Still discussing in new regs
- Assume they can no long request records to prior auth a covered TM service. Clarify w/contract.
- Assume they must abide by the Inpt Only list, the 2 MN rule without adding their own criteria on top.
- Immediately re-assess all contracts to ensure they include the correct new language.

More Federal “Concerns” with the MA plans

Medicare Advantage collected $12B in ‘excess payment’ – watchdog report says 3-22 **Directly tied to 2024 MA final rule.

- MA Plans received $12B in excess payments in 2020 according to the March 15th congressional report from the Medicare Payment Advisory Commission.
- **The report says that MA’s RISK SCORES were nearly 10% higher than similar fee-for-service (Traditional Medicare) enrollees in 2020 due to higher diagnosis coding intensity.**
- Though CMS does reduce MA risk scores to align closer with fee-for-service scores, they have never reduced lower than the minimum required by law. CMS reduced MA risk scores by 5.9% in 2020. The watchdog report says the scores “were about 3.6% HIGHER than they would have been IF MA patients had received fee-for-service care, leading to excess payments.
- Three previous risk adjustments recommendations from MedPAC:
  - Exclude diagnosis collected from health risk assessments. (IE. Tons of medical record requests from providers)
  - Use two years of dx data
  - Apply an adjustment to eliminate any residual impact of coding intensity.

The report says that chart reviews and health risk assessments are the MAIN factors causing coding differences between Medicare Advantage plans.

PROVIDER ALERT – where does it say, in your contract, that you have to send unlimited amt of records? What if you are not contracted with the MA plan? Traditional Medicare rules apply. No records?

MA Plans can offer more than Traditional Medicare, not less! ***2024 Final Rule is even more clear.

- 42 CFR 422.101 states:
- "…each MA organization must meet the following requirements:
- (a) Provide coverage of, by finishing, 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 area…
- (b) Comply with-
- (1) CMS's national coverage determinations
- (2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations…"

- This regulation essentially states that MAO's may not be more restrictive than Medicare FFS/Traditional Medicare.

- Questions: Inpt only list? 2 MN rule? Prior auth? CHECK THE CONTRACT!

Inspector General Office: Addressing concerns about improper denials in Medicare Advantage/MA. 5-11-22

(Did focused audit)

- **"A MA plan denied coverage for a walker a physician ordered for a 76-yr-old patient at risk of falling. The insurance company reported denying the walker because the pt received a cane in the past 5 years. A cane no longer provided the support the pt required to walk safely, and NO MEDICARE COVERAGE REQUIREMENT IMPOSES SUCH A FIVE-YEAR LIMIT.**
- **Another plan denied the MRI a physician ordered to assess why a 69-yr-old's pain and weakness continued five months after a fall. The insurance company's stated reason was that the patient did not first receive an X-ray. An X-ray could not detect the damage the physician suspected, and NO MEDICARE RULE MANDATES such an x-ray prior to MRI.**
- Recently, OIG reported that some MA organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. ***We found that 13% of denied prior authorization requests and 18% of denied payment requests were for care that ACTUALLY MET Medicare coverage rules***.
- Sometimes insurers said the request lacked necessary information, but all necessary documentation was present. Some give up. Some seek alternative care or pay out of pocket. Some resubmitted repeatedly. Obtaining medically appropriate are should not require such resolve.
- Our recent study builds on prior OIG work. In 2018, we reported that MA appeal outcomes and audit findings raise concerns about service and payment denials. The insurance companies running MA plans overturned 75% of their own prior authorization and payment denials upon appeal. Essentially, beneficiaries or providers who persist were mostly successful. BUT THESE INDIVIDUALS ONLY APPEALED ABOUT 1% OF DENIALS.
- Providers can advise pts that they shouldn't necessarily take an 'initial no' for a final answer and that they can consult appeal rights of MA beneficiaries on CMS' webpage." (Patients do this? Scary to them)

Department of Justice – continuing to investigate "RISK ADJUSTMENT FRAUD CASES with MA PLANS"

- DOJ announces multiple actions over Medicare Advantage Risk Adjustment Fraud Cases.
- Issue: Submitting incorrect dx to increase the risk adjustment payment. "Knowingly"
- 6 Whistle blower cases. (Ex. Kaiser)
- Buffalo, NY MA plan: Independent Health. Had a specified billing company: DXID who alleges was knowing submitting false dx. Both the owner of Indp Health, and DXID are listed in the legal action.
- More fraud focus from the OIG in 2022…
- OIG 09-20-21 **"Some MA companies leveraged chart reviews and health risk assessment to disproportionately drive payments."**
- **MUCH discussion about changing the way MA plans are paid – Risk adj $ for dx. as growth is now approx. 50% of the entire Medicare age pts. 7-23**

Creating a Payer-Specific Matrix
Great tool in the toolbox

Key elements in having the inpatient vs outpt observation discussion with non-Traditional Medicare payers. (HINT: Better practice ideas)

- Each payer has their definition of 'what is an inpt.'
- Each payer should have published what they are using in making that determination. (EX: Humana/MCG; United/MCG sort of/moving to IQ in May 2021; Indept BX plans/IQ- some moved to MCG)
- Each payer should have a way to request and complete a P2P challenge of patient status. (Contracted or within polices on webpage)
- Once this information is created as an internal matrix, now both the UR and the PA team know – what is this payer's unique definition of an inpt.
- **Oh, not so simple –you say.** YEP – as there is unlikely anything tied directly to a contact payment or penalty if they don't follow their own guidelines. BUT –it is the beginning step of a) requesting an inpt based on their own published clinical guidelines, b) UR's efforts to confirm the inpt and c) talking points if a P2P call must occur.

PAYOR	HEALTH PLAN	PLAN TYPE	CONTRACT IN PLACE	UM CRITERIA	DRG	SURGICAL LIST REFERENCE	IP NOTIFICATION/ AUTHORIZATION	INTAKE-IP NOTIFICATION CONTACT
Who is the primary Insurance Payor?	What is the name of the Health Plan? UM should look at & start to think about what Payer and Plan Type does this patient have?	What type of plan is this? Knowing the type of plan can assist UM to think - Medicare regulation vs State Regulation vs Commercial contractual obligations vs. Corpoarte policy adherance in the absence of a contract	Is there a Contract with this payer/plan? A Yes vs No can prompt UM to think Contract specific rules at play vs. having to adhere to Plan's Corporate Policies	What UM Screening Tool does the Payer/Plan Use? Interqual, Millimen, CMS 2 MN Rule? Any other guidelines - IE: Medicare C list, Plan Specific Surgical Lists? Etc.	What DRG System is used - APR, MS, AP, Per Diem?	For Surgical Preadmissions - what does the plan reference for surgical bookings. EI: Medicare C-List, Medicaid IP Only list, Interqual, etc.	Who is responsible for the initial Notification of an IP Admission & Authorization Set-up? Financial Counseling, Patient Accounts, Business Office, Social Work, UM? *This information is important when retrospective denials occur for the technicality of "No Authorization Secured"; helps to get the visit back to the responsible party to attempt to rectify/update	If UM is responsible for any Inpatient Admission Notifications & Initial Auth Requests then who is the contact & how do they reach them?
MVP	MVP Gold MVP Medicare	Medicare	YES	Interqual	MS-DRG	Medicare C-List	**Financial Counseling** - responsible for Notification of all ED Inpatient Amissions. **UM** - responsible for Notification of all Obs to IP upgrades occuring on Floor Units	For Obs to IP upgrade occuring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679

"Payers Gone Wild" –understanding the contract, website posted policy updates, appeal language and when to just say 'heck no" ****Look to 2024 Final regs

1) "All stays under 48 hrs are observation." Where does it say that in the contract? If not contracted, Traditional Medicare rules apply. What to do if continues to deny all inpt until more than 48 hrs has occurred?
2) "The patient can be treated in a lower level of care without endangering their health.or How long do you think they will need to be in the hospital?" Wow – that is tough as which UR nurse would say that the care is different in OBS vs inpt. But that is not the reason for inpt: The patient's condition met their clinical guidelines. Not LOS; met clinical guideline +++
3) "If changes to pt status are made after d/c, the facility cannot bill anything. Provider liability and absorb. Just like traditional Medicare." Nope!
4) "We only speak to the attending physician for P2P calls. CMS Form 1696
5) "We don't do P2P. Just file an appeal." Contracting.
6) "Let's just access pertinent parts of your EHR so you don't have to send us records." *(Hint: When is the payer making the decision? ER to inpt = decision. The longer they 'see', the pt can recover and then obs.)*

Hospital shall comply fully with the rules, policies and procedures that the Company has or will establish, including, but not limited to, those regarding utilization management including, but not limited to precertification of elective admissions and procedures, etc"

- "Hospital agrees to use best efforts to participate in, as required, and to abide by Company's utilization review and decisions with respect to all members"
- "Hospital agrees to provide, when and to the extent possible, pre admission telephone notice to company of all members for whom admission through hospitals emergency room is contemplated."
- "Hospital agrees to use best efforts to provide clinical data and information to company as is necessary to permit company to conduct utilization review."
- "Hospital agrees to use best efforts to provide upon company's request, and in accordance with hospital policy and State Law, complete copies of Member's medical records."

HUGE at risk 'hidden' in the language of the Payer Contracts. HUGE need to look beyond rates and at UR impact and other high cost issues –all records. Who is doing this? **(Thanks, Stephani Daniels, PhoenixMed, retired)**

Payer Uglies – In Contract. Watch and ensure there is an understanding prior to signing. HUGE! (NY 10-22)

- **Humana - Claims Payment Policy**
- Subject: Inpt to outpt Rebilling
- Published: 9-2016 Policy # CP2015018
- Claim for inpt services when an inpt admission was not medically necessary. ***(PS Based on their decision and guidelines. Do you know it?)***
- ***Humana's Medicare Advantage plans follow the CMS guidelines for inpatient Part B rebilling. (PS- they do not use the 2MN rule, they require records sent for prior auth, delays in replying)***
- When an acute care hospital determines **BEFORE discharge t**hat the pt should not have been admitted as an inpt, Humana will ONLY accept services submitted on an appropriate outpt bill type (131) or 85X and will allow the provider to submit all codes for a normal outpt situation and required Condition code 44. (Again, not following TM rules but applying CC here. Even with this ruling, delays in ruling and time to get CC 44 done, which means pt notified, UR committee done, attending doc/notified and order changed – then can bill obs. UG!)
- When an acute care hospital or Humana determines **AFTER discharge** that the pt should not have been an inpt, Humana will only accept inpt bill type 121. This billing should reflect the reasonable and necessary Part B services and provide CPT codes where appropriate. Report condition code W2 to indicate this is a Part B claim and include "A/B Rebilling" in the treatment authorization field.
- For pre-admission services in the 3-day payment window, the hospital may separately bill for services prior to an inpt admission and should report "A/B Rebilling" in the treatment authorization field of the appropriate outpt TOB 131 or 851.

WOW and DOUBLE WOW! Additional Thoughts:

Did contracting know of this clause? Why allowed?

How long is it taking to get initial decision? 3-5 days?

CONTRACT 1-2 DAYS. What are the chances of getting the P2P scheduled, done and decided PRIOR to the pt leaving?

Order says inpt? How did the provider bill?

Action items to get ready for the Medicare Advantage Plans to begin to use the 2 MN rule –with auditing! Tons of contracting and non-contracting work!

- Prior to 1-24, meet with the MA plans to discuss how you are going to tell them the PLAN FOR a) expected 2 MN presumption plan including signs & symptoms, acute LOC, complications, co-morbid conditions and b) 2 MN benchmark- 1 outpt MN including transfers in and 1 more in-hospital medically appropriate care = 1 MN = inpt. **New form after clarifying prior auth process.**
- What will PRIOR AUTHORIZATION Look like? Present your form you will submit that outlines the above plan –in accordance with Fed regs.
- Clarify the 2 MN rollout -like Traditional Medicare. Outline that once an inpt is approved, the DRG is paid and there is no reason for concurrent review.
- As MA plans have to coordinate post discharge care thru one of their contracted care provider, and SNFs do not require a qualifying stay, coordinate how you will advise of pending d/c. Then work with them but ultimately MA's responsibility. Since there is no motivation to complete transfer, ensure the NEW LANGUAGE includes pre-diem payment for any delays.
- Ensure P2P communication is included as required in all contracting. New guidance is to have the same specialty at the payer as relative to type of case.
- Ensure CAH's are made whole… if not contracted, the Traditional Medicare rules apply-but what about the cost report at year end? Do the MA plans have to do them? …..and if contracted, same question as accepting TM rates is deadly as there is no cost report with the MA plans. **Must have a higher rate to offset the loss from the lack of the cost report.**
- Analysis of current LOS in obs with each MA plan. Track and trend changes with movement to 2 MN. Report abuses with CMS rep designated for your region.
- UR team, denial team and all interacting with the payers and providers: Do not use 'does not meet criteria. This patient's plan for an estimated 2MN is not clear. Query and clarify. Look to add order set questions: Admit to inpt. Plan for 2 MN: Free text. Plan for 2nd MN after 1 MN: Free text

More Denial Reasons & Action Items – Ex Humana

Normal course of Inpt Request with payer. (Let's use Humana for teaching ex)

*****Look to 2024 final rule – all using same inpt definition – 2 MN rule*****

- Inpt denied as 'not medically necessary' for inpt level of care. SURPRISE
- UR and internal PA review the case. Decide to go to P2P to fight for inpt.
- Inpt continued to be denied. SURPRISE
- Now the hospital decided on one of the accounts to accept obs.
- They tell the payer they are going to downgrade to obs and bill
- Payer says: "You can't as you don't have an obs order" and the pt has gone home. (See previous note about no CC 44 with MA plans. Don't get it both ways)
- IDEA: Begin using a template for the medical record. It is telling the payer:
- ***" Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes." Signed by MD or Internal Physician Advisor.   Order is now in the chart for obs.***

Patterns from payer determination letters: Aetna (ex) **No longer allowed with final rule 2024!!*

Aetna: MA account. Using clinical guidelines.

'We use national recognized clinical guidelines such as MCG, as well as ***clinical policy bulletins to support these coverage decisions***. Coverage has been denied for the following reasons:

- We used inpt and surgical care MCG guidelines. The requirements for coverage are: (1) active bleeding w or w/o high-risk endoscopic features; (2) hemodynamic instability; (3)severe anemia causing heart failure, cardiopulmonary symptoms and /or cognitive impairment; (4) severe liver disease or abnormal coagulation; (5) treatment intensity or monitoring that requires inpatient treatment; (6) severe thrombocytopenia; (7) inability to tolerate oral hydration; (8) previous aortic graft placement or known aortic aneurysm; or (9) documentation of significant active comorbid conditions requiring hospitalization. The member did not meet any of these requirements.

- PLUS: Peer to peer: 'It you are a treating practitioner and you disagree with a coverage denial, you may request a peer to peer with the Medical Director who made the decision. Follow fax: Scheduled P2P call within 14 days to speak to Med Director. (**DOS: 5-18 Rec Ltr: 5-24. 6 days)**

***Change of internal request for inpt. Develop a payer matrix to know exactly what every payer is using. MA plans – use CMS form to create a representative for each MA pt/ internal PAs.

And more crazies…Non-traditional Medicare/Other payer surgical inpts

**Look at 2024 Final regs..

Inpt approved. DRG payer. Payer granted two days; a 3rd one was requested. Payer denied. Hospital bills as inpt with 3 days. Payer refuses to pay any charges. WHY? "Days' does not equate DRG payment. (What if the hospital just bills with 2 days? Same DRG payment. Why anguish?)Never should have been allowed!

*Inpt approved. DRG payer. Procedure ordered was submitted. During the case, another procedure was conducted. Payer requires to be told of the additional procedure. If not, denied inpt. WHY? Inpt was already approved. *2024 – was this on the inpt only list? Now auto covered as inpt, ordered as inpt, no LOS requirement.

*Inpt requested. Inpt was denied. Hospital tries P2P call. Told can't bill outpt as inpt was denied. WHY? Absolutely a medically appropriate procedure. Pt status – inpt vs outpt – was in dispute. Hospital can a) accept the downgrade to outpt surgery and bill type 131/outpt or b) use a physician to appeal. Must always know what the payer is using to determine 'inpt surgery' – what clinical guidelines? **MA plans must use TM inpt only*

*Inpt denied. But did approve 72 hrs of obs. What is the contract for payment for obs hrs and other related services? Does it equal an inpt surgery? Do not accept. **Violation as doing less than traditional Medicare. Also on the inpt only list?

The Anguish continues - Medicare Advantage is NOT Traditional Medicare

To Contract or not to Contract. What is the "win' for the provider to contract? To not contract? Out of network penalties to the beneficiary…but what if you didn't contract – where would the patient get their provider network?

The MA plan cannot sell without a provider network in your community.

Regulations 42 C.F.R. § 422.214

If non-contracting with a Medicare Advantage/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.)

Medicare Advantage – Provider WINS – no post d/c

Use Regulations.   Have legal letter ready to send to the payer if post-request for records/MA

If the plan approved the furnishing of a service thru an advance determination of coverage, <u>it MAY NOT deny</u> coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. Section 10.16.

- Approved for inpt. 10-18-18. Resulted in 1 day stay. Hired company to audit – denied and told to downgrade to obs. Not medically necessary for inpt. 9-19. Nope.
- Approved for obs 8-8-19.   Did P2Pcall. Overturned and approved for inpt. 8-12-19.   Indept firm (paid to deny) audited and stated downgrade to obs –could be treated in a lower level of care. 2-1-20. Nope.
- Of course, payer says you understood that this prior authorization was not a 'guarantee of payment' thru the contract language. Same language with commercial prior authorizations. But Medicare Mgd Care Manual adds more strength to the provider.

Medicare Advantage – Provider WINS –

Use Regulations. Have legal letter ready to send to the payer if post-request for records/MA

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." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. Section 10.16.

- **New process:** With each request for records from the MA plans, leadership reviews: was this already prior approved? Yes. Send attorney letter telling the MA plan/or their representative they are in violation of the above section. Discontinue requesting and any subsequent denials or recoupments or a formal complaint will be filed with CMS. Track and trend by payer. DO NOT SEND RECORDS - send letter instead.

- Idea: Create attorney template letter to send with each MA request when a prior authorization was received..and due to the delay, payment made.
- Upon receipt of record request, do not send. Instead send the template letter/attorney signature.
- Track to ensure no recoupment occurs. Send formal compliant if needed.

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. 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!**
- **Update: Some comments from CMS after filing complaint center around: What does your contract say about ability to look back for any period of time and audit with auto take back? Huge issue to look for asap. 8-23**

CMS FORM 1696
Appointment of Representative (AOR)

- 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
- **Use when a payer says – we will only speak to the ATTENDING! NOPE!**
- **USE THE FORM TO BE PRO-ACTIVE**

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

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

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

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

Readmission Denials- 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 t**o, 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. Chpt 3 Sec 40 2.5

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. 1 Single payment with same day readmission WOW ***2024 codified this for all MA plans too.

30-Day Readmission Traditional CMS

Yearly penalties, not each case as MA Plans are doing

CMS Hospital Readmissions Reduction Program (HRRP)

The Social Security Act establishes 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.**

READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES.

83% OF 3080 HOSPITALS /2499 ANNOUNCED FINED (10-21) COULD CUT UP TO 3% FROM EACH MEDICARE CASE DURING FISCAL YEAR 2021. PROGRAM IS 10 YEARS OLD

Sample Re-admission Denial – COVID involvement – 2 admissions within 30 day window. Denied$ on 2nd. CT hospital 3-22

- Pt admitted in Jan and Feb 2020. (Vaccines??)
- The first admission: obese male with 2 weeks of SOB who was COVID positive and admitted for 5 days in late Jan.
- He was treated with PO steroids, remdesivir and discharged on high flow 02.
- The Discharge DRG was 177, Respiratory infection and inflammation w/MCC.
- Records requested.

- The 2nd admit was 22 days after the first admission's discharge day.
- He was admitted with post COVID-19 hypoxemia despite being on 3 L of 02 at home.
- A Chest Xray revealed bilateral infiltrates and the patient was treated for 8 days for possible aspiration PNA.
- He was discharged on a higher 02 to home.There was no clear dx of PNA.
- The coding was to DRG 189, Pulmonary edema and respiratory failure.

- **WHY DID IT DENY?**
- **Related? Which dx were the same on the 2 claims and what did it edit for?**
- **Grossly unfair with a totally new pandemic infectious agent with no clinical information.**

Proactive Ideas for all non-Traditional Medicare/TM Contracting

Usually in Operational Addendum & Appeals

"Payers will do whatever you allow them to do." Dr Hirsch, RAC RELIEF 7-23

Outline key elements prior to signing the contract. Re-visit throughout the contract year if concerns arise. Rates are not included in this list.

1. **Timeline for submission of clinicals**. Week days, weekends, obs conversion request to inpt.
2. **Clinical guidelines the payer is using making the inpt decision** along with required REASON for not approving inpt with decision.
3. **Timelines for reply of request**. Weekends same as weekdays. 4-8 hrs maximum
4. **Once inpt has been approved, no additional record requests** unless pt is a candidate to move to a post-acute level of care. Contract language must be known – i.e. qualifying stay. (DRG)
5. **If granting access to the provider's electronic medical record**, critical to have a very limited review (ER if from the ER/labs/imaging/notes) with a firm timeline for decision. 4- 8 hrs maximum. Continued delay yields risk of the pt 'recovering in a lower level of care/obs." If in obs, grant access when the pt's condition needs reassessed. 8 hrs maximum.
6. **DRG hot spots**: Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
7. **MA plans**: Ensure there is understanding that a disputed status may not resolved while the pt is in-house. TM rules do not apply. Status can be changed post discharge will full billing as inpt or outpt/131 bill type.
8. **P2P:** Any provider may discuss the account on the patient's behalf. All contracts allow both concurrent and post-discharge P2P. Once the request is made, a time is agreed to /recommended. Identify timeline with penalties if not adhered to. Agree to the qualifications of the payer MD. Outline the scope of the Payer MD can use –beyond meeting the clinical guidelines. No minimum LOS to be an inpt. (EX: all accts under 48 hrs are obs.)
9. **Re-admission deni**als. Outline exactly what is a 'related' case within 30 days. "Same as Medicare' = same day, same facility, same dx. Chronic dx are excluded. Identify which dx must be the same and in which 'spot' of the up to 10 dx.

CMS Contacts for Regions 1-10 (7-21)

File complaints – squeak – with excellent examples of abuse
Will require the provider try to work it out with the payer first. Then file.. *Cannot be regarding rates*

Region 1	Robosora@cms.hhs.gov	CT, ME, MA, NH, RI, VT
Region 2	Ronycora@cms.hhs.gov	NJ, NY, Puerto Rico, Vir Islands
Region 3	Rophiora@cms.hhs.gov	DE, Dis of CO, MD, PA, VA, WV
Region 4	Roatlora@cms.hhs.gov	AL, FL, GA, KY, MS, NC, SC, TN
Region 5	Rochiora@cms.hhs.gov	Ill, IN, MI, MN, OH, WI
Region 6	Rodalora@cms.hhs.gov	Ark, LA, NM, OK, TX
Region 7	Rokcmora@cms.hhs.gov	IA, KS, MO, NE
Region 8	Roreaora@cms.hhs.gov	CO, MT, ND, SD, UT, WY
Region 9	Rosfoora@cms.hhs.gov	AZ, CA, HI, NV, Pacific Territories
Region 10	Rosea_ora2@cms.hhs.gov	AK, ID, OR, WA

Payer's (Still) Going WILD--

Line item/Forensic Audits

Presented by:

AR Systems, Inc.

Day Egusquiza, President
AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.

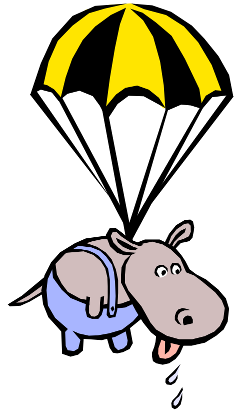
Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.
Let me be the Patient Financial Navigator!

Hospitals at risk – **300+ rural hospitals at immediate risk of closure** –have lost $ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23)

Stats from AHA	2023	
Total hospitals in all US	6129	
# of community hospitals	5157	84%
Of these, # of nongovt not-for-profit com hosp	2978	58%
# of owner investor-owned, for profit	1235	20%*
# of State & local govt community hospital	944	15%
Additional: # of Fed Govt hospitals	206	3%
# of nonfed psych hosp	659	11%
Other hospitals 2021	107	2%

By state - sample	# at risk of total # hosp
Kansas	29 Of 169 *34 private
Mississippi	25 of 128 *36 private
Oklahoma	24 of 165 *61 private
Alabama	19 of 133 *62 private
California	9 Of 570 *148 private
Iowa	7 Of 145 *5 private
Idaho	2 of 55 *13 private
Nevada	2 of 76 *37 private
As we carefully watch multiple small rural hospitals close , many are tied to Private for-profit investor owned.	Communities without a hospital – also means providers too.



Payers have found a new way to deny services. Dreaded new phrase: **Provider is unbundling separate items that are included in the primary service provided.**

Commercial and MA are the largest ones current doing this.

Where does it say in their CONTRACT that this is defined?

How can commercial, WC, & Medicaid contracted payers use Traditional Medicare language when these are not Traditional Medicare patients?

There is no Rule for your Rule – to the payers from the providers…

Post –discharge, outlier payment, **line item audits.** Commercial, MA, Medicaid Mgt Care. Each payer has their own list, their own justification, internal.

- If paid by DRG and an outlier payment is expected, here come the line item audits. If paid a % of billed charges, here come the audits.
- Absolutely a contract issue. Join other providers. Strategize. Charge the payer for sending records, make decision to severe contract, etc. What to expect? CMS: R&B covers routine nursing. Defined?

Unbundling: Disallowing any separate nursing charges. R&B covers all nursing inpt uniquely ordered services. Separately ordered, separate CPT coded during obs or inpt not covered. NO venipuncture, in-room pt specific ordered treatments/blood transfusion, ICU/ ventilator daily, drug adm, Conscious sedation, assisting provider with procedures/any setting, CPR, suctioning.

Routine: Surgeries. Disallowing many unique supplies to the patient, unique to the unique to surgery charges. All covered in the per procedure/per time charge

Challenging the payer's arbitrary decision to disallow a separate charge as unbundling from the primary charge.

- Key – Must challenge the 'routine/not separately billable ' item. The payers are stating that the item is part of the service/a routine part and not separately billable. It is not a medically necessary denial; it is an unbundling denial. How is that defined, payer specific?
- HOW CAN WE APPEAL:
  - Does sending records help?
  - **Golden rule: The item is separately billable as it was NON-ROUTINE. 3 step**
    - If there a unique service/item that was ordered for this unique patient? (1)
    - If there an order from the physician for the service? (2)
    - If there documentation that it was done? (3)
    - Who did the service? NOTE: RT doing ventilator care was disallowed.
    - What if nursing does the service plus an OBS hr, an inpt day, an ER level visit, and OR procedure charge? Must clearly outline what its ROUTINE that is included with the above items and why is unique to the pt- meeting the 3 elements above!

ROUTINE VS NON-ROUTINE SUPPLIES & ROUTINE NURSING

The Medicare Reimbursement Manual defines Routine Services in 2202.6 on page 22-7:

"Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

"In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. " (See § 2203.1 for further discussion of routine services in an SNF.)

What are some examples and challenges- NW

- **Critical Access Hospital**:
  - Did not request records
  - Identified by Revenue Code and as an outpt, CPT code/UB-04 only.
  - Auto denied as 'unbundled.'
  - EX) Surgery charged for unique supplies and implantable. Had to have an xay due to the provider's need to ensure it was placed correctly.
  - Payer auto denied all supplies and the xray as considered 'bundled' –included in the charge for the procedure or the pre min charge.
  - Traditional Medicare pays CAHs a % of charges/allowables for outpt. Many commercial & MA plans also do%. High risk for audits.

- **DRG hospital:**
  - Did not request records
  - Identified by Revenue code only as inpt ICU claim. No CPTs.
  - Requested itemized statement
  - (EX) Used Rev Code/RT and itemized statement to disallow all ventilator management charges. Only left the ICU R&B rate.
  - (EX) Bedside procedures that are unique to the pt are routinely disallowed as 'bundled.'
  - Focus – Charge outliers, high charge pts
  - Focus- Any outlier in the contract (Neonate, high costs/transplants, cancer treatment.) High risk for audits.

Super Big Challenge –Charges for unique care

- Bundling 'assumes' that all services are similar for all patients.
- Hospitals assign unique charges to align COST TO CHARGE.
- Separately billable services require an order, documentation to support separate unique to the pt item/service and charges to cover costs.
- IF the hospital simply states: we will no longer bill ____ separately, then ALL patients receive the SAME amount for the denied Surgery or the Ventilator for the ICU patient or any other 'identified bundling' that the payer is using…based on their own definition. (Think ER too)
- EX) ICU R&B rate. Historically $1500 per day with add on for unique services the pt needs. Now R&B rate is $2000 per day regardless of what unique services the individual pt needs. VERY WRONG! No cost to charge alignment.
- More: Depts loose productivity stats/RT for ventilator, others

What to do with line item audits? Get prepared!

- Some payers are strictly using the itemized statement to disallow. *They have to request them as they are not submitted with 837/claims.
- **How pt friendly are the descriptors**?
- OR levels – have you developed an outline of what is covered in each level? Procedure level vs time – what is included, reducing price of multiple procedures. (Set up, clean up, routine supplies, all staff in attendance, sterilization, preference card items, 02)
- Nursing services – have you developed what is covered in R&B rate? ICU will be different than medical/surgical. (Medical: 8 hrs direct pt care, CN A, usage/equipment in the room, IV items, cleaning, adm meds.)
- NON ROUTINE: Separately ordered for the pt, specific to the patient, usually CPT, documented.
- Assume the payer 's team does not know what is included in ANY CPT code or how it is used.
- What is the payer's definition of routine, unbundling, etc? Need their policy ahead of time to review

- If requesting a full medical record,validate prior to sending. If records are sent, charge fee and get payment prior to sending. $150 ea
- OR OR OR – require all line- item audits be done onsite. Have a trained nurse /revenue cycle internal staff sit with the payer. Every line item is discussed, with the internal staff noting all variances.
- This internal control will ensure a) variances are known immediately, b) challenges are ready to be sent and c) anything need clarified?
- The departments need a way to relieve items, count for productivity = all done thru charging. Some routine items roll, but others are chargeable.
- **Be ready to discontinue contract. Where does it say this is allowed? Join with others.**

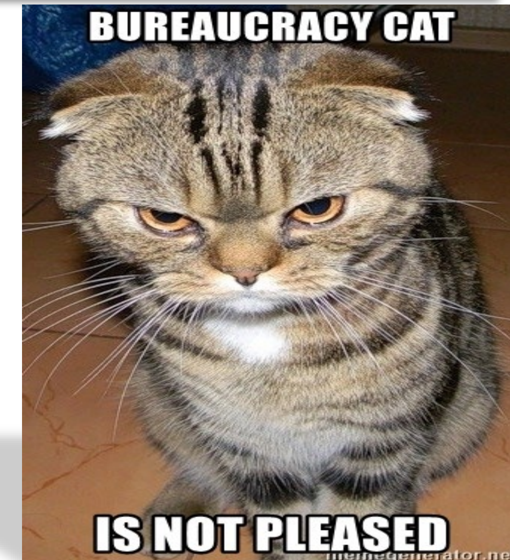
Payer Challenges: It's All About the Money!

Health Insurance Companies are reporting record profits at the expense of providers.

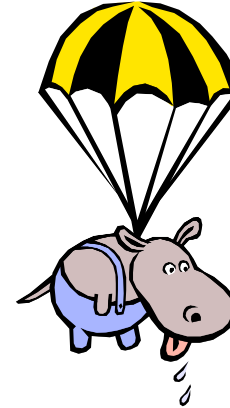
Insurance	2017 revenue	2018 revenue	2019 revenue	2020 revenue	Revenue increase from 2017 to 2020	% Revenue Increase (2017 to 2020)	2017 net income	2018 net income	2019 net income	2020 net income	Net Income increase from 2017 to 2020	% Net Income Increase (2017 to 2020)
United Healthcare	$201.16 billion	$226.25 billion	$242.16 billion	$257.14 billion	$55.98 billion	27.83%	$10.56 billion	$11.99 billion	$13.84 billion	$15.40 billion	$4.84 billion	45.83%
Cigna	$41.81 billion	$48.65 billion	$153.57 billion	$160.40 billion	$118.59 billion	283.64%	$2.27 billion	$2.64 billion	$5.10 billion	$8.46 billion	$6.19 billion	272.69%
Anthem	$90.04 billion	$92.10 billion	$104.21 billion	$121.87 billion	$31.83 billion	35.35%	$3.84 billion	$3.75 billion	$4.81 billion	$4.57 billion	$0.73 billion	19.01%
Humana	$53.77 billion	$56.91 billion	$64.89 billion	$77.16 billion	$23.39 billion	43.50%	$2.45 billion	$1.68 billion	$2.71 billion	$3.37 billion	$920 million	37.55%
Centene	$48.38 billion	$60.12 billion	$74.64 billion	$111.12 billion	$62.74 billion	129.68%	$828 million	$900 million	$1.32 billion	$1.81 billion	$982 million	118.60%
Molina	$19.88 billion	$18.89 billion	$16.83 billion	$19.42 billion	$-0.46 billion	-2.31%	$-512 million (loss)	$707 million	$737 million	$673 million	$1.19 billion	231.45%

Average Claim Denial Rate for Large Hospitals

Geographic Region	Denial Rate
Northern Plains	10.58%
South Central	8.88%
Midwest	7.89%
Southern Plains	7.72%
Pacific	7.58%
Northeast	7.21%
Mountain	7.18%
Southeast	7.14%



Thanks, Chris Loftin, MS HFMA



Payers continue to do what providers let them do. Dr Ron Hirsch, RAC Relief 7-23

WHAT CAN A PROVIDER DO WITH THIS BROAD RANGING DENIAL RULING – UNBUNDLING?

BATTLEFIELD

REVENUE CYCLE

Strategies and Tactics to combat Forensic Audits

Chris Loftin

System Director – Regional Business Office
Baptist Memorial Health Care Corporation
THANKS A TON, CHRIS FOR ALLOWING THE USE OF YOUR COOL SLIDES

Mr. Loftin is the System Director of the Regional Business Office for Baptist Memorial Health Care Corporation, which consists of 14 Acute Care Hospitals, 1 Long-Term Acute Care (LTAC) Hospital and 4 Critical Access Hospitals located in Arkansas, Mississippi and Tennessee. He currently directs all hospital billing and follow-up activities for all third party payers within the revenue cycle.

Mr. Loftin is a seasoned health care executive with over 27 years of experience in both segments (payer and provider) of the health care industry. His specialties include academic (physician and hospital) revenue cycle management, non-profit/faith-based revenue cycle management, critical access hospital revenue cycle management, central billing office leadership, government liaison, call center development and management, project management, lean healthcare champion, and government and commercial claims adjudication.

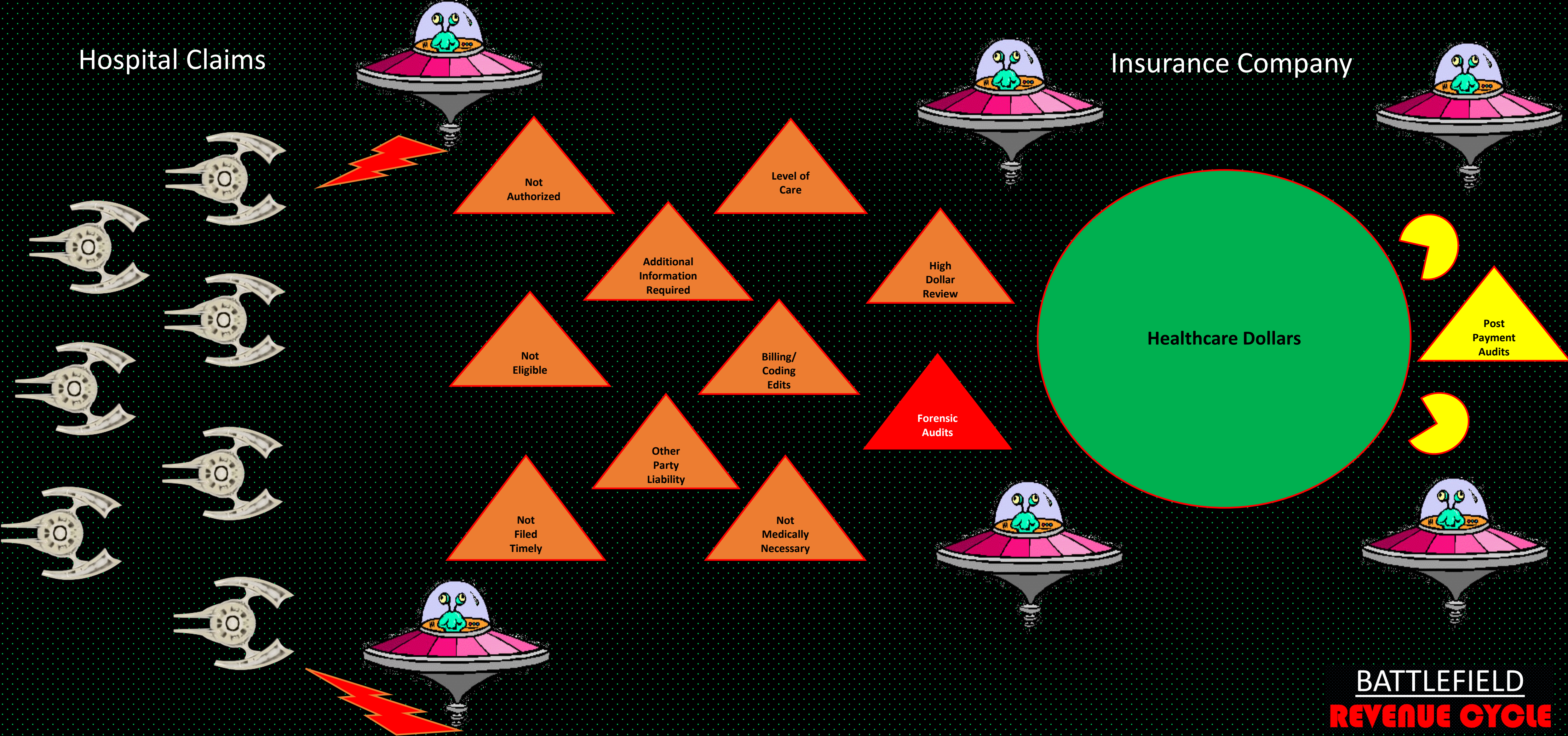
Mr. Loftin received his Bachelor of Science in Business Administration degree at The University of Southern Mississippi in 1995. He is also trained in Advanced Performance Management, Project Management and received his Healthcare Lean Certificate from the Mississippi State University CAVS Extension (equivalent to a Six Sigma Black Belt) in 2015. Mr. Loftin has also been a guest presenter at conferences held by the Centers for Medicare and Medicaid Services (CMS), Healthcare Financial Management Association (HFMA) Region 9, Mississippi HFMA, Mississippi Hospital Association (MHA), Mississippi Health Information Management Association (MSHIMA), Georgia HFMA and Arkansas HFMA. Mr. Loftin is the Co-Founder and Co-Chair of the MHA Revenue Cycle Roundtable, is a member of the MHA President’s Council and is on the Mississippi HFMA Board of Directors.

Latest News: It's All About the Money!

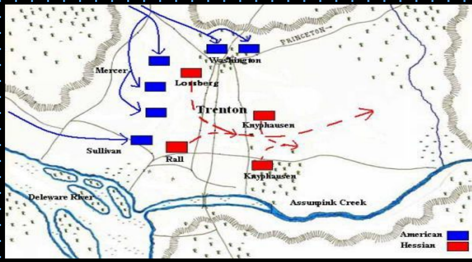
Insurance	2017 revenue	2018 revenue	2019 revenue	2020 revenue	2021 revenue	2022 revenue	Revenue increase from 2017 to 2022	% Revenue Increase (2017 to 2022)
United Healthcare	$201.16 billion	$226.25 billion	$242.16 billion	$257.14 billion	$287.60 billion	$324.16 billion	$123 billion	61.15%
Elevance (formerly Anthem)	$90.04 billion	$92.10 billion	$104.21 billion	$121.87 billion	$138.64 billion	$156.6 billion	$66.56 billion	73.92%
Humana	$53.77 billion	$56.91 billion	$64.89 billion	$77.16 billion	$83.06 billion	$92.87 billion	$39.1 billion	72.72%
Centene	$48.38 billion	$60.12 billion	$74.64 billion	$111.12 billion	$125.98 billion	$144.55 billion	$96.17 billion	198.78%
Cigna	$41.81 billion	$48.65 billion	$153.57 billion	$160.40 billion	$174.08 billion	$180.52 billion	$138.71 billion	331.76%
Molina	$19.88 billion	$18.89 billion	$16.83 billion	$19.42 billion	$27.77 billion	$31.97 billion	$12.09 billion	60.81%
TOTALS	**$455.04 billion**	**$502.92 billion**	**$656.30 billion**	**$747.11 billion**	**$837.13 billion**	**$930.67 billion**	**$475.63 billion**	**104.52%**

Insurance	2017 net income	2018 net income	2019 net income	2020 net income	2021 net income	2022 net income	Net Income increase from 2017 to 2022	% Net Income Increase (2017 to 2022)
United Healthcare	$10.56 billion	$11.99 billion	$13.84 billion	$15.40 billion	$17.29 billion	$20.12 billion	$9.56 billion	90.53%
Elevance (formerly Anthem)	$3.84 billion	$3.75 billion	$4.81 billion	$4.57 billion	$6.10 billion	$6.03 billion	$2.19 billion	57.03%
Humana	$2.45 billion	$1.68 billion	$2.71 billion	$3.37 billion	$2.93 billion	$2.81 billion	$360 million	14.69%
Cigna	$2.27 billion	$2.64 billion	$5.10 billion	$8.46 billion	$5.37 billion	$6.67 billion	$4.4 billion	193.83%
Centene	$828 million	$900 million	$1.32 billion	$1.81 billion	$1.35 billion	$1.2 billion	$382 million	44.93%
Molina	$-512 million (loss)	$707 million	$737 million	$673 million	$659 million	$792 million	$1.3 billion	254.69%
TOTALS	**$19.44 billion**	**$21.67 billion**	**$28.52 billion**	**$34.28 billion**	**$33.7 billion**	**$37.62 billion**	**$18.19 billion**	**93.52%**

The Revenue Cycle Battlefield

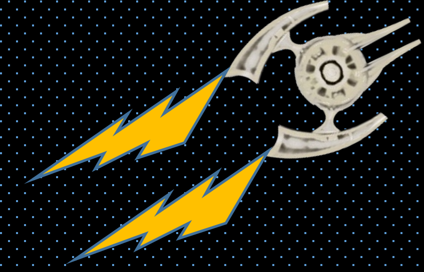


BATTLEFIELD
REVENUE CYCLE



Battlefield Analysis

Forensic Audits



Background

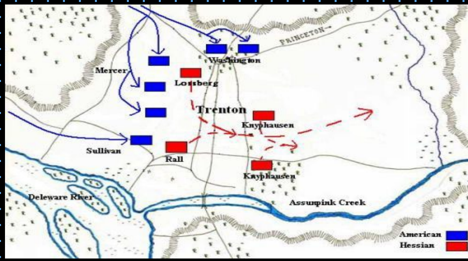
Insurance companies are using cost containment vendors to perform forensic audits (aka itemized bill reviews or line-item audits) prior to fully adjudicating claims for the sole purpose of reducing the hospital's outlier payment. In some cases the insurance company pays nothing up front while in other cases they pay the inlier payment but hold up on considering the outlier payment until the audit is finalized. We first encountered forensic audits over 5 years ago and they only involved Medicare Advantage Plans. Since that time we have seen most of the large commercial insurance companies, Medicare Advantage Plans, and Medicaid Managed Care plans adopting this cost containment tactic.

Charge-Based Cost Outlier Contracts versus Day Outlier Contracts

If your hospital or health system has charge-based cost outlier contracts, these type of audits should already be impacting your organization. If your hospital or health system has day outlier contracts, your organization should not see these type of audits.

Common Cost Containment Vendors

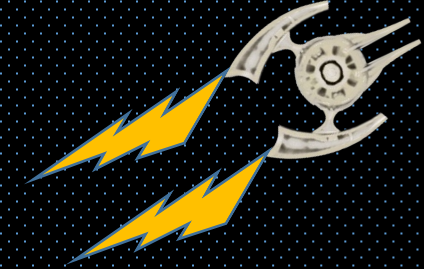
- CERiS
- Equian (owned by Optum/UHC)
- MedReview
- Humana has an internal team and does not outsource these audits
- Zelis



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification



Unbundling

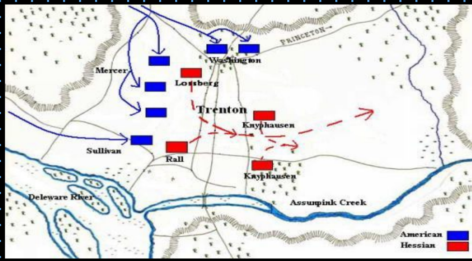
The Forensic Review evaluated this claim to determine whether it contained charges for supplies or services that appear to be either "routine," and/or are integral and necessary components of underlying daily service or procedure charges.

Section 2202.6 of the CMS Provider Reimbursement Manual ("PRM") directs facilities to include routine supplies and services within underlying daily room or procedure charges and specifies that such routine charges include "the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

PRM Section 2202.8 limits a facility's ability to separately charge for ancillary services and defines separately billable ancillary services as including "laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational)."

PRM Section 2203 requires that each facility create and maintain "an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services." Accordingly, this provision instructs that all facility bills shall comply with the above PRM provisions and that a facility's charges need to "reasonably and consistently" relate to the facility's underlying cost.

Resolution of Unbundling Questions – If you disagree with any of the Forensic Review Report's unbundling findings, please submit the explanations and/or documentation necessary to show that these charges are separately payable.



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification

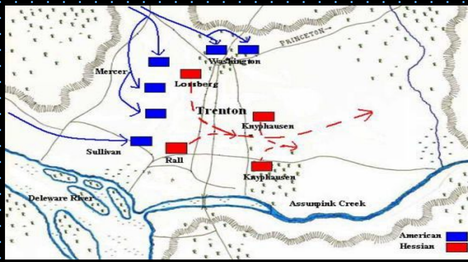
The cost containment vendors attempt to use the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) language to justify their tactics.

- ✓ The cost containment vendors claim that this section directs hospitals to include routine supplies and services within the underlying daily room or procedure charge. The language in this section simply states that a room and board or procedure charge is intended to encompass a variety of services but does not mandate anything.

> 2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

- ✓ The cost containment vendors claim that this section limits a hospital's ability to separately charge. The language in this section simply defines Ancillary Services and limits nothing. The part that the cost containment vendor chooses to exclude reads, "Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge."

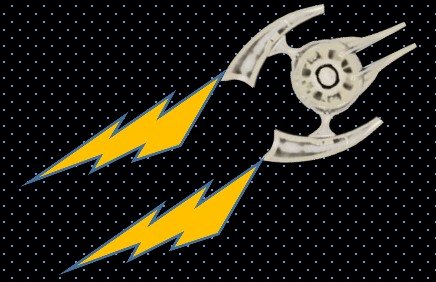
> 2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification



2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

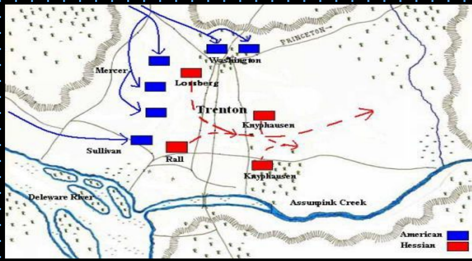
To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges described in §2314.B.

In determining reimbursement for the costs of routine services, providers do not use charges but use patient days for apportionment purposes in a skilled nursing facility (to the extent certified) or in a hospital (with separate computation for each separate care unit). Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.

The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in §2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement. A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge. Where there is no

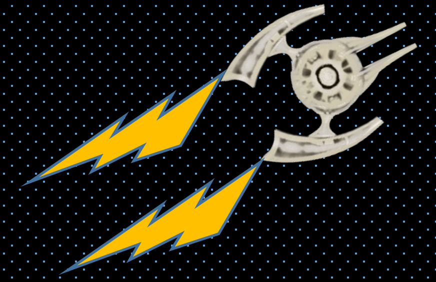
common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program. Ancillary charges for items or services furnished Medicare beneficiaries, including those enumerated in §2202.8, are not recognized by the program if separate charges are not also recorded by the provider for all non-Medicare patients receiving these same items or services directly from the provider.

- ✓ First, your charge to cost ratio is not changing. Services were rendered and your cost has not changed. If you remove charges, the charge to cost ratio is going to go up and the payer will end up paying you more anyway.
- ✓ Second, Section 2203 simply states that providers need to have a charge structure that accurately allows for the determination of cost to the program and that Medicare is entitled to contest certain charges if they determine that they inflate costs to the program.
- ✓ Third, Section 2203 gives providers the latitude on creating and maintaining a charge structure as long as that charge structure is charged consistently to all patients. Bottom line, section 2203 does not give the Insurance Company or their cost containment vendor the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- ✓ Finally, Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The regulations governing for operating costs under the Inpatient Prospective Payment System (IPPS) are located at 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86. CMS publishes the outlier threshold in the annual IPPS Final Rule.



Battlefield Strategy

Forensic Audits – Strategy 1



Consider working with the Insurance Company to modify your contract.

Some Insurance Companies are willing to work with you because they are good business partners and prefer not to lose valuable in-network hospitals or health systems. If this scenario applies, you may want to consider doing the following:

Tactic 1

Require the Insurance Company to add language to the contract that eliminates internal and external forensic audits

or

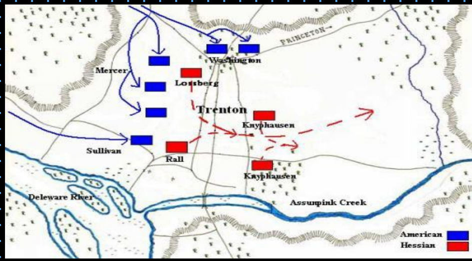
Tactic 2

Require the Insurance Company to add language to the contract that limits the number of forensic audits

or

Tactic 3

Require the Insurance Company to reimburse your hospital/health system up-front to offset the potential financial impact of forensic audits



Battlefield Strategy

Forensic Audits – Strategy 2
"The Nuclear Option"

Consider terminating your contract with the Insurance Company.

Terminating your contract "The Nuclear Option" is a strategy to consider if forensic audits in conjunction with other audits is a significant financial issue for your hospital/health system. Some Insurance Companies may be willing to work with your hospital or health system if you even mention this option.

Special Note

If the Insurance Company is a Medicare Advantage plan, you may want to consider this option because out-of-network plans are required to reimburse your hospital/health system for Part A and Part B services provided to Medicare beneficiaries with an amount that is no less than the amount that would be paid under original Medicare. Non-contract providers are required to accept as payment, in full, the amount that the provider could collect if the beneficiary were enrolled in original Medicare.

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https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/providerpaymentdisputeresolution
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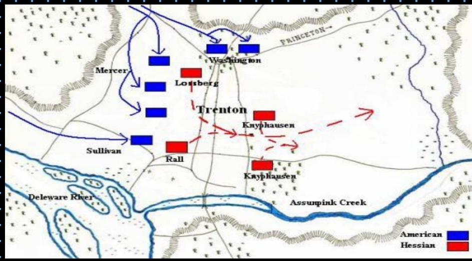
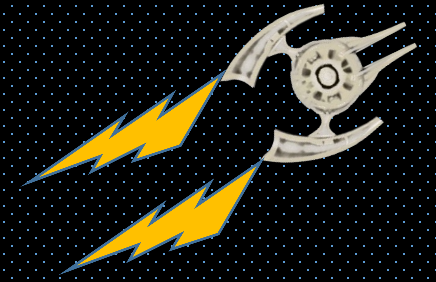


Battlefield Strategy

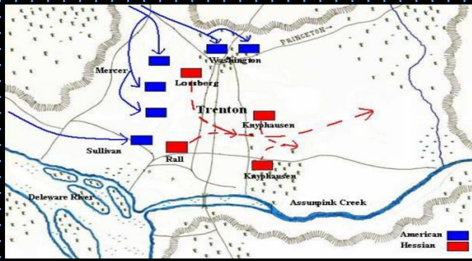
Forensic Audits – Strategy 3



Consider implementing proactive processes to prevent the audits.

Implementing proactive processes will require utilizing internal resources with expertise in determining how best to combine the applicable charges. For example: You may be currently billing saline under revenue code 258 and the auditor is indicating that you can not bill it separately. You may want to consider working with the Pharmacy in your facility to include the saline cost as part of the drug cost when the charge is routed to your financial management system.

- ✓ Identify the Insurance Companies conducting forensic audits;
- ✓ Pinpoint the charges they are routinely including in their audit findings; and
- ✓ Develop internal processes to combine the auditable charges.



Battlefield Strategy

Forensic Audits – Strategy 4

Consider developing letter templates and tactics to dispute the forensic audits –LOW SUCCESS RATE. Same people who denied it originally/insurance plan.

Although it is admirable to consider fighting forensic audits, you will most likely end up losing your disputes. After all, your fighting judgements already made by the same company. If you decide to fight, listed below are things to consider.

- ✓ Use language from your hospital's Provider Participation Agreement
- ✓ Use language from Medicare Law
  - ➢ Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs.
  - ➢ The Centers for Medicaid and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) gives providers the latitude on creating and maintaining a charge structure as long as the charge structure is charged consistently to all patients. The PRM does not mandate or give the MA Plan the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- ✓ Use language from the Medicare Managed Care Manual (if a Part C plan)
  - ➢ MA organizations are required to pay "Clean Claims" within 30 days of receipt;
  - ➢ Otherwise, the MA organization must pay interest on claims that are not paid in a timely manner.

BATTLEFIELD
REVENUE CYCLE

Thank You for Joining Us in this Educational Journey

DAY EGUSQUIZA
President, & Founder
AR Systems, Inc. &
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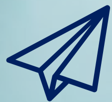

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