



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

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!

“Hi everybody. Love being with you in our new virtual world. Mask on, smiling underneath, staying safe while we all stay connected. Perfect!”



Make up on, hair done, business.

Vs.

no make up, workout sweats...LOL

New definition of 'business casual'



Most common phrases from 2020:

“Can you hear me?”

and the favorite, as we talk up a storm:

“You are still on mute.”

“Signs of Disruption in the Revenue Cycle”

▶ What are three C’s that keep CFO’s up at night?

- ▶ 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!’

LET'S CATCH UP ON THE BIG PICTURE ISSUES FIRST



The Inflation Reduction Act: Congress passes bill extending ACA subsidies, adding Traditional Medicare's ability to negotiate for pharmacy/Part D pricing and provide a new cap. YAHOO-FINALLY! But the Senate GOP did block a measure to bill a cap for insulin at \$35 for Americans and private medical insurance. Medicare pts will have the potential benefit. Bill extends the Marketplace subsidies thru 2025. Approx 14.5M enrollees were lured with help with premiums. Lowest uninsured at 8%.

CMS is seeking feedback on how to improve Medicare Advantage/due by 8-31-22. Request for Info gets you started: <https://www.federalregister.gov/public-inspection/2022-16463/request-for-information-Medicare-program>.

Improving Senior's Access to Care Act of 2022- Working thru the process of tweaking the version of last year's Medicare Advantage prior authorization reform. Lots of attention!

Rural emergency hospitals may not furnish acute care inpatient services. What they can provide, however, are emergency department services, observation care and certain outpatient services as permitted by scope. When the category becomes **effective in 2023, rural emergency hospital services will be reimbursed at 105% of the Medicare Hospital Outpatient Prospective Payment System amount for covered outpatient services.** In addition, rural emergency hospitals will also receive a monthly facility payment amount that increases annually by the hospital market basket percentage

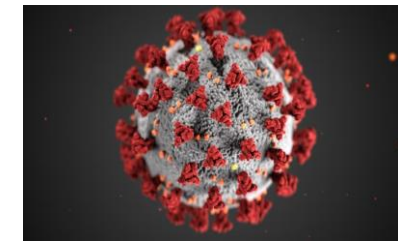


IDAHO'S RURAL COMMUNITY HOSPITALS

ONLY 8 OF 27 HOSPITALS ARE FINANCIALLY VIABLE, PER IHA, 2018

OUTCOME: LEGISLATURE SAID NO TO FUNDING EXPANDED MEDICAID. VOTE OF THE PEOPLE SAID YES WITH 67% IN FAVOR.

COVID-19 QUICK HIGHLIGHTS



Public health emergency /PHE extended .Waivers as outlined by CMS are still in effect. (Thru 10-22/renew every 90 days). Administration said they would give 60 day notice if it was going to change.

- NOTE: During PHE, Medicaid recipients were not removed from the active roles. No screening or loss of insurance during PHE.
- Many waivers have been in effect since 1st PHE – 2 + years. Plenty to unwind. Including will telehealth to continue in any setting?? BIG!

CARES ACT = no charge for the vaccine or administration. Insurance billed/they pay. If no insurance/HRSA. But no 'cost share' to the pt for administration of the vaccine. Add-on Booster approved. \$40 for adm cost payment.

Cost of testing for COVID: ranges from \$240/ARK with many averaging around \$145. If the pt goes to the ER or urgent care center, there will likely also be a facility fee. Billed to insurance/pt. *Most payers waived, some no longer are. Some providers waived OOP.

20% add on to DRG for confirmed test in record. Lots of challenges with transfers, indept labs, locations, EMR, etc. FOR MEDICARE Patients. (ID: ave age 72; now 58. Different payers)

US Death toll:

As of Aug 13, 2022: 1,033,556 Daily ave: 189

Daily new cases: 46,480 12% positivity rate-- W/O counting self tests.

Long COVID means symptoms beyond initial positive case

1 in 5; 25% found in research study/NJ. Some can have symptoms up to 2 yrs later. Biden calls for an –all-hands-on-deck effort to study Long COVID/HHS. These symptoms can include fatigue, cognitive dysfunction, chronic pain, neurological issues, organ damage and many others. 4 M are unable to work. (Time, 8-3-22; 3 min read/Healing American Healthcare Coalition.)

1. People can get COVID More than once. (Auto Immune daughter – 3x; different variants each time. Fully vaccinated but just can't fight it off.)
2. Long COVID is different for different people. If there is a pre-existing condition, the virus attaches itself to that 'risk area' and symptoms vary.
3. Women appear to suffer more persistent symptoms than men.
4. The study found even mild COVID cases resulted in chronic, long-term issues.

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 “



Payer: Traditional Medicare

- ▶ RAC audits are back
- ▶ Prior authorization rules
 - ▶ additional procedures & mandatory new electronic rules/govt payers/PAUSE
- ▶ Office visit E&M new criteria, effective 1-21
- ▶ ER non-emergent issues
- ▶ **Loss of ALL inpt only procedures/CANCELLED.** Aggressively moving outpt approved procedures to ASC/ 11 in 2021. 1-22 new list of removals from inpt only CPTs published.
- ▶ No Surprise bills- Final interim, effective 1-22* Payer, provider & patient impact.
- ▶ Transparency- 1st 'warning' by CMS/with fines& **PAUSE**/publish of non-compliant hospitals, 2021 -updated penalties *larger facilities, higher penalties/proposed. 95% hospitals non-compliant/ Washington Post 7-22. Payers now impacted 7-22. CMS begins issuing fines. 8-22
- ▶ **Readmission penalties**



Payer: Traditional Medicare

RACS Are Back! Audits are Back!

“CMS expects to discontinue exercising enforcement of medical review audits regardless of the status of the PHE.” - 8/2020¹

- ▶ RAC Examples: total hip and total knee: Medical necessity and documentation requirements. Duplex scans of extracranial arteries: Medical necessity & documentation requirements. Implantable auto defibrillator -inpt. (Same) All A/B MACS. (More listed) 20% are still doing all joints as inpt per PEPPER report/end of 2020.
- ▶ SMRC/supplemental medical review contractors has current projects and closed projects. Closed: Spinal fusion 25% error rate; Emergency ambulance 98% error rate; non-emergency ambulance 79% error rate. (Hint: Spinal fusion has now moved to prior-authorization 2021)
- ▶ MAC Examples: targeted probe and educate/TPE. Pre-claim reviews: prior authorization for 5 identified outpt procedures. (TPE - common issues on CMS webpage.)
- ▶ Livanta- national contract for high weighted DRG and short stay audits for the country. 4-21

¹(www.cms.gov/research-statistics-data-and-systems/monitoring-program/medicare-ffs-compliance-programs/recovery-audit-program/approved-RAC-items)

Financial Impacts of Change- Traditional Medicare - TKA

Critical Access Hospitals are paid differently

Facility Payment

Inpt DRG: 470

Avg: \$10,630 (JJ-GA, AL, TN/34,777 cases J to J 2017)

Avg: \$12,010

DRG is wage adjusted + teaching +++ upward of \$15,000-\$30,000

APC Payment for CPT 27447/APC 5115

Avg: \$10,122 *

APC is wage adjusted:

Higher = higher payment;

less than "1" wage factor = lower than base payment

Patient Responsibility

Inpt every 60 -day deductible:
\$1408/2020 \$1484/2021

APC frozen amt per CPT:
\$2024/20% of APC\$ -but cannot exceed inpt deductible. CMS pays the difference to the site.

Max amount due from pt:
Inpt Deductible -whether inpt or outpt.

PS: Physician is paid the same -inpt or outpt

PRIOR AUTHORIZATION HAS COME TO TRADITIONAL MEDICARE – CERTAIN OUTPT PROCEDURES 7-1-20

Hospital outpt impacted only. No surgery centers, no in-office procedures.

Five groups: Blepharoplasty, Botulinum Toxin Injection, Panniculectomy, Rhinoplasty, Vein Ablation.

Submit required information to A/B MAC. No required form. Mailed, faxed or electronic

Initial or resubmission review. Decision within 10 Bus days.

Unique tracking #. Claims must have the UTN. ??FL 1-18 but check with MAC.

Provisional valid for 120 days from decision.

If no UTN, denied. If not prior approved, denied.

2021 Discontinue all inpt only Surgeries within 3 years. All fall to 2 MN rules or outpt. Or new prior authorization? 2021 - move 300 musculoskeletal off. Increase OPPS \$ by 2.6% in 2021. Also allow ASC to perform 11 more procedures - including hip arthroplasty - making 28 new procedures being allowed in ASC/ambulatory surgery centers. WOW!

1-2022. List of CPTs no longer on the inpt-only list are published/active. However, the original rule to eliminate all inpt only CPTs is not going into effect. Per usual yearly updates. 8-22 Report says \$48B paid incorrectly for cosmetic-type procedures/MACs/CMS need to do more oversight



Payer: All payers – new CPT guidance

Physician office E&M new guidelines, only

- ▶ Biggest change to E&M since 1995/97
- ▶ **Only impacts office E&M visits**
- ▶ Audit risk: Carefully monitor bell curve.
- ▶ Medical decision-making vs time for entire day/all providers. Which is most accurate for each visit? Who is making the decision? What new /revised documentation was created?
- ▶ Patients over paperwork. Saves 2 min per visit/forecast.
- ▶ Suspended 2% payment adjustment (sequestration). Ex Order to delay implementation of the sequestration thru 2021. Increased cuts in 2030 to pay for the delay. 4-14-21



- ▶ G2211/ADD ON CODE IS NOW BUNDLED UNTIL JAN 2024 . G2212/PROLONGED (NEW)
- ▶ **BEWARE BUDGET NEUTRAL!** Winners and losers: proceduralist lost payment to allow for office visit providers to have gains. Relative value weights went up for office visit practices. Conversion factor down 10% from 2020 but thru end -of-year legislation, only 7% reduction for 1 yr. What about the other payers and their provider contracts? How are they paid?
- ▶ New CV & RVU = significant potential increases in \$ for primary care w/0 increase in volume. Impact to employed /contracted providers.
- ▶ Post visit audits: Both compliance and revenue options. (1995 vs new time vs new MDM)

Anguish of Prior Authorization - High Value vs Low Value with many payer approvals. *Fed Legislation*

- ▶ Delays in medically necessary, physician ordered, patient specific care
- ▶ 21% of 182 M authorization transactions were full electronic in 2020.
- ▶ Provider authorization processes:
 - ▶ Eligibility verification check - 12 min
 - ▶ Determine if an authorization request was already filed.- 3 mins
 - ▶ Inquire if an authorization request was already filed. - 2 mins
 - ▶ Submit authorization request - 11 min
 - ▶ Process payer's clinical questions and requests for additional information - 15 mins
 - ▶ Inquire concerning authorization request status - 2 mins = 45 mins. (CAGH index 2020)
- ▶ “AHA urges CMS to address Prior authorization issues affecting Medicare Advantage patients.”
- ▶ New, input request to the Biden Adm on the need for mandatory electronic submission and timelines for replying. (Question: Who sets the rules for what services need prior auth? What are they and how can the providers know the rationale behind)
- ▶ Value based care = focusing on high value procedures, not excessive output volume. (Problem - many payers requires low acuity procedures, ex xrays, prior to approving a higher acuity procedure, ex. MRI. Overutilization? And patient pays due to high deductibles. How does that drive down the cost of healthcare -to the system and the pt?) High value determined by ea payer.
- ▶ **Denials steadily rising, up to 10.8% 2ndQ 2020 - ½ of claim denials are caused by front end RCM such as prior authorization.** (Change healthcare 2016-2020)
- ▶ AMA research - 14 hrs weekly spent trying to get prior authorization. Impact to pt care.

And what if the initial request is denied? Now alternatives? Patient notified? Provider tried to appeal? Cost and impact to pts' health.

What about the hospital UR, Cancer, Imaging, etc. other departments? Is this cost even tracked?

CMS guidance on Prior Authorization- NEW LEGISLATION

2-18-21: Biden Adm “pause” rollout to assess

- ▶ **Final rule is out! Most provisions go into effect 1-1-23.** Payers slam as ‘half baked’. Rushed as the sweeping rule revamping electronic prior authorization was finalized a scant 30 days from when it was proposed/Dec 10,2020. Codified just 5 days before the Biden administration.
- ▶ The rule requires all Medicaid, CHIPS and those plans operating on federal exchanges which are commercial insurance plans to use standardized application programming to give providers and patients electronic access to prior authorization data, including pending decisions. Payers also have to give faster decisions. In 2024, Maximum of 72 hrs for urgent and 7 days for standard requests.
- ▶ **BIG concern!!!** Medicare advantage plans aren’t included in the final rule, but CMS is considering further rulemaking to make them similar. That omission was a major hang-up for hospital groups which argues excluding the private plans -which cover about a 1/3 of the Medicare beneficiaries - could result in more variation in prior authorization processes in the U.S. and reduce incentives for providers to adopt the new standard methodology, per AHA.
- ▶ *Per a 2019 AMA survey of physicians - 14 hrs of each week is dedicated to trying to get prior authorization for care the physician believes is necessary for the patient’s care...including ongoing drug therapy. Didn’t even ask the hospitals about their costs with prior authorizations!*
- ▶ **Faxing vs creating secure portal to ‘place’ all medical records for payers. Control what is seen but also allow for rapid review and decisions.**

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 –

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 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. Section 10.6.

- ▶ 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

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 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. Section 10.6.**

- ▶ **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.
- ▶ 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.

“Payers Gone Wild”: Understanding the contract, website posted policy updates, appeal language **and when to just say ‘heck no’!**

- 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.)

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	
-----------	------	--

Specifics – Disputes with payers.

Internal MD/Physician Advisor with the Payer’s MD

- **What is a Peer to Peer call? Trained internal physician advisor speaking to the payer’s physician. Goal: Resolve dispute from initial request for inpt. All done prior to claim submission.**
- **Re-evaluate the initial ‘submission’ to the payer for prior authorization. *1st touch* Submit cover letter with initial submission – WHY an inpt!**
- **Payer’s use some type of clinical guideline to determine first decision: Inpt or Obs**
- **EX) Aetna denial letter/NC. ‘We reviewed information against MCG guidelines for inpt and surgical care. The requirements are ... The member doesn’t meet any of these requirements.’**
- **Important to a) Know what the individual payer is using. B) Present the case as it appears from the ER/Acute level including the ‘meet’ and other co-morbid conditions, risk factors as not all cases ‘fit’ into MCG or IQ.**
- **CDI work usually happens AFTER the records have been sent in the initial ask. How does this information get updated to the payer? Absolutely use in the P2P call. “New information!” Powerful.**



DRG = 1 payment for the entire stay

- ▶ Traditional Medicare for larger facilities = DRG. Each DRG has a mean LOS that the payment is based on. The diagnosis and inpt procedures are grouped into a single DRG payment. Some DRGs have higher payments based on co-morbid conditions. There is a small variation for each site but: 1 stay = 1 \$.
- ▶ Medicare Advantage pays= same DRG methodology -with coding rules controlled by the HIPAA Standard Transactions 2003. 1 stay = 1 pre-determined payment for the dx and procedures done.
- ▶ Re-evaluate - why battling for additional 'days' when the inpt has already been confirmed? Exception - need for SNF and Outlier \$/additional \$ based on very long LOS/outside the norm for the dx.
- ▶ EX: Aetna approved 2 days. Hospital is pd DRG. They requested 3rd day. Denied. Aetna denied and reduced payment by \$1200. WHAT?



And more crazies...



Non-traditional Medicare/Other payer surgical inpts

- | 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?)
- | Inpt approved. DRG payer. Procedure ordered was submitted. During the case, another procedure was done. Payer requires to be told of the additional procedure. If not, denied inpt. **WHY?** Inpt was already approved.
- | 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?
- | 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.

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.
- ▶ **DENIAL PREVENTION:** 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? PS Some payers = “Pt signed document allowing us to request full record.” **Ask to see it.** PHI

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

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 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. 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.

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.

United Health Care Readmission- 30 days for any related reasons *common language. Paid for only 1 of the 2 admissions.



- ▶ 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...**
- ▶ **Exclude ALL CHRONIC CONDITIONS from readmission penalties.**
- ▶ **Finalize which of the up to 10 dx/order of have to be 'same/similar' for rejection.**

Proactive Ideas for all non-Traditional Medicare/TM Contracting Usually in Operational Addendum & Appeals

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 denials.** 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.

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.’ *Traditional Medicare is the only one using 2 Midnight rule; not IQ or MCG.*
- ▶ 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. Corporate policy adherence 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 occurring on Floor Units	For Obs to IP upgrade occurring on a floor - UM to contact Lisa at MVP. Phone 518-234-5678 Fax 518-234-5679

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	Roatloral@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: United Health Care

- ▶ Optum is owned by UHC. Optum has purchased many companies that work directly with healthcare providers.
- ▶ Optum purchasing Change healthcare. (McKesson was part of CHC which owns Interqual.) 2-21 Dept of Justice is investigating \$13B purchase by UHC/Optum. 4-21. AHA supports. Still pending legal.
- ▶ UHC announces moving to Interqual effective 5-1-21. (No longer using MCG)
- ▶ READMISSIONS 'RELATED' PLUS 'PREVENTABLE'.
- ▶ Site of service- limit outpt services in hospitals. Move to ASC and imaging centers. Saves 60% on average.
- ▶ UHC's unique lab coding system & Imaging - **delayed until 1-22./now 'until further notice'**
- ▶ **UHC Delays ER policy until end of PHE/6-21.** Retro review of ER visits for 'emergent dx/reason.' Expected 1 in 10 denied.
- Significant request for records: "CMS requires UHC to submit complete dx data for MA members". Clarify, always!
- "A federal appeals court has ruled against UHC, the biggest private payer in the US, and REVERSED a 2018 decision overturning Medicare's overpayment rule requiring REFUNDING reimbursement to CMS within 60 days if they learn a dx lacks medical record support." MA plans pd by CMS per-member-per month then adjusts payments based on acuity or severity³² of their member's health status as supported by dx codes. (Healthcare Dive 8-21) YAHOO

More ‘hot off the press- CDI’ (Clinical documentation integrity)



- ▶ Integra filed a False Claims Act lawsuit Aug 10, 2019 in the US District Court of Central CA against Providence Health & Services. The lawsuit allege Providence routinely used **unwarranted major complications and comorbidity secondary codes on Medicare claims to inflate reimbursement.**
- ▶ According to the 100-pg lawsuit, Integra discovered the unwarranted secondary codes during an analysis of Medicare claims dated back to 2011.
- ▶ Integra said an investigation of the business practices of Providence and its consultant, clinical documentation improvement company, JA Thomas & Associates, confirmed that Providence’s false Medicare claims were not only intentional but were part of a systematic effort to boost its Medicare revenue.
- ▶ Pushed doctors to make unwarranted dx and used leading queries.
- ▶ UPDATE: Court will not reopen the whistle blower case. 5-21 Appeal?

Short Term Health Insurance - 4 things to know (Becker Hospital Review 8-18)

- ▶ Trump Administration released FINAL rule for short term health insurance plans/STP. Open ended with coverage.
- ▶ “State Relief & Empowerment Waiver/1332” - state can offer less 10-18 (Judge upheld selling 7-19)
- ▶ Previously could only offer 3 months, now can last up to 3 yrs.
- ▶ 1) STP do not have to abide by the rules by the ACA requiring coverage of essential health benefits and pre-existing protection. Nor do they have to abide by insurance plans imposing limits on how much care is covered or the requirement that at least 80% of premium money go toward care.
- ▶ 2) Not abide by ACA, STP do not cover as much as more comprehensive plans. They tend to not cover: maternity, prenatal care, mental health, drug treatment and prescription drugs. May not cover sports injuries and other specific services like cataract treatment, immunizations, and chronic fatigue or pain treatment.
- ▶ 3) Some do not cover \$250,000 - \$2M. Others only covered inpt on weekdays, others with waiting periods.
- ▶ 4) Generally they are cheaper than the ACA plans. Kaiser study found ex) 40 yr old single man in Atlanta was \$371/AC compared with \$47 for STP.
- ▶ **BUYER BEWARE!** Less coverage = more out of pocket if healthcare is used. (Biden Adm. assessing/allowing. 6-21)
- ▶ 1/3 of all small employers state that health insurance and healthcare costs are their major concern. 3-21 (Healthcare Dive)



A day in a life of 'junk insurance' and coronavirus/COVID-19

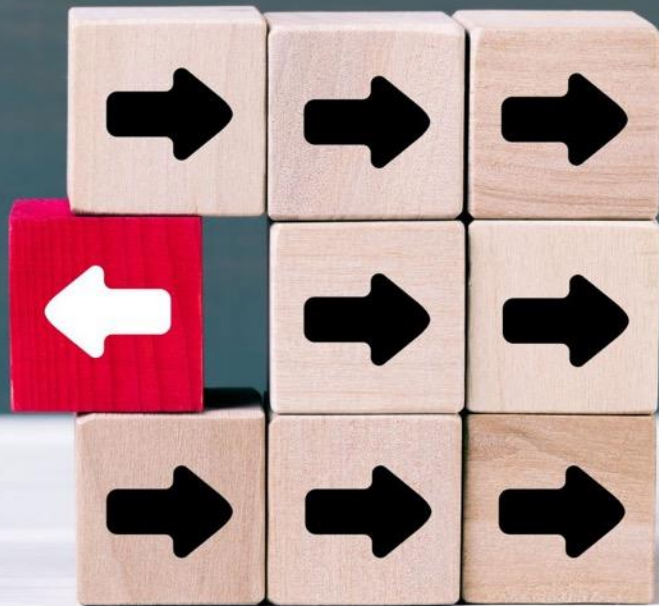
FL patient, 3-20

- ▶ Been to China recently. Had flu-like symptoms. He followed advise of public health experts and went to the hospital for testing.
- ▶ He tested positive. Staff said needed to have a CT scan too.
- ▶ He received a bill for \$3270. Insured but with 'junk insurance' which offered limited benefits and DID NOT COVER PRE-EXISTING.
- ▶ Based on his ins, he has to pay \$1400. BUT to get the claim paid, at all, he had to send THREE YEARS of medical records to prove that this 'flu' was not related to a pre-existing condition.
- ▶ He pays \$180 a month in premiums.



More Payer Challenges- Anthem and Imaging

Anthem is the largest for-profit organization of BCBS



- ▶ Anthem BC - Discontinuing coverage of outpt imaging at hospital. **“IMAGING CLINICAL SITE OF CARE.”**
- ▶ Directing patients to Free Standing Imaging Center for CT and MRI.
- ▶ 2017- KY, IN, MO, WI. Added CO, GA, NV, NY, OH, CA. March 2018- added CT, Maine and VA. 13 states impacted & more
- ▶ Pt steerage, limiting patient choice and labor cost to do prior authorization for CT and MRI. Some exceptions - Rural, tied to pre-op services.
- ▶ Quality of care, availability of the reports, interoperability limitations, Rad provider interpreting = all listed as concerns.
- ▶ **CONCERN:** Service is authorized but not at the hospital requested/ Insurance picks cheapest site of service.
- ▶ **HUGE THREAT TO REVENUE THROUGH OUTPT SERVICES.** “Front Door” is being impacted by payers and new competitors /non-traditional.
- ▶ With Site of Service referrals - what is the WIN for the providers in return for giving reduction from billed charges? **CONTRACT, CONTRACT, etc.**

Change of payer/provider/patient relationships

Convergence

Walmart Moving BIG into healthcare

Put more focus on its wellness business 7-18 (Sean Slovenski)

- ▶ Joining with Anthem's MA plans to pay for over-the-counter items - braces, etc.
- ▶ "Walmart to launch Medicare Insurance agency" 7-20 Explore narrow network 3-20
- ▶ "Walmart's launch of a Medicare Advantage plan will likely impact provider service volumes."
Cloverhealth. 7-20 HFMA
- ▶ **Walmart moves deeper into primary care market- New clinic called **WALMART HEALTH** is in Dallas, GA. Appts start in 9-19. Will offer primary care including lab, x-rays, dental, counseling, etc. Low cost primary services - next to Walmart.**

Rise of "Convergence" in healthcare. Means?

- ▶ Cigna Corp agrees to buy Express Scripts, the nation's largest pharmacy benefit manager.
- ▶ Apple does own clinics for employees.
- ▶ Humana to open 100+ Medicare centers by 2023 thru its partners in primary care unit within Humana. Located in underserved areas/srs.
- ▶ **Convergence: Where a company merges its capabilities with another organization in an adjacent industry. Only works if the industry's solutions are not comprehensive, compelling or able to satisfy customer needs.**
- ▶ **Amazon buys One Medical/Huge primary care. What now? 8-22**

New competition- New patient outreach

Impacting the 'front door' of the revenue cycle for outpt services. **STEERING AWAY!!!**
Think RIPPLE revenue with lab, x-ray, other ancillary services. Competition at the front door of the revenue cycle. WOW!

“Walmart Health vs. CVS Minute Clinic”

4 key differences between CVS and Walmart (3-20)

Staffing

- ▶ CVS Health Corp/Minute Clinic staffed by mid levels
- ▶ Walmart health primary care MDs including x-rays, dental, counseling.

Care

- ▶ CVS designed to provide ‘episodic care’.
- ▶ Walmart wants MD to replace primary care providers.

Walmart Additional Info

- ▶ In underserved areas -for high deductible pts and no insurance
- ▶ Walmart creating narrow networks for employees 3-20
- ▶ “Centers for Excellence’ for joints/identified hospitals only.

“Insurer Clinic Competition ‘very worrisome for hospitals” (3-20)

- ▶ UnitedHealthcare’s new plan in CA that is built around Optum physicians.
- ▶ Aetna’s decision to drop copayments for member who use CVS Minute Clinic.
- ▶ BCBS of TX offer free primary care at clinics it opened with a partner in Houston and Dallas.

Clinics run by UnitedHealth Group, Blue Cross and Blue Shield and CVS Health/Aetna have hospitals worried that **patients may be steered away** from their doors.(Wall Street Journal)





Walgreens: Consumer Facing Care

Imagine a day when 45% of our Walgreens stores...where you can walk in and see a primary care physician that's attached to Walgreens. ..there are 8 exam rooms with all testing done that day. That is our goal" CEO Brewer 11-21

- ▶ “Walgreens to provide primary care via **VillageMD clinics** in 500-700 of its drugstores. 7-20
- ▶ In-store visual clinics, lab services, retail clinics. Telehealth services. Using ‘smart technology’.
- ▶ Walgreen’s Boots Alliance has invested \$5.2B in primary care startup VillageMD to rollout physician-staffed models. The company announced in Oct that it is making a \$330M investment in post-acute and homecare company CareCentrix. 11-21

“Walgreens partners with Microsoft to develop new Healthcare delivery models” 11-19

- ▶ **Walgreens Boots Alliance** and Microsoft signed a seven-year deal ‘ to develop new healthcare delivery models, technology, and retail innovations to advance and improve the future of healthcare.”
- ▶ Walgreens will test ‘digital health centers’ in some of its stores, which are aimed at merchandising and sale of select healthcare-related hardware devices. They will also collaborate on software research.
- ▶ “WBA will work with Microsoft to harness the information that exists between payers and healthcare providers to leverage, in the interest of patients and with consent, our extraordinary network of accessible and convenient locations to deliver new innovations, greater value and better health outcomes in healthcare systems across the world.”

AMAZON EXPANDS PUSH INTO HEALTH CARE WITH ONLINE PHARMACY — 11/20 AND PURCHASING OF HUGE PRIMARY CARE COMPANY: ONE MEDICAL 8/22

Amazon bought Pillpack /2018- online pharmacy who organizes prescriptions into packets. Set up for more direct competition with Walgreens Boots Alliance & CVS Health Corp. Other drug companies stocks fell with announcement.

Amazon pharmacy, selling prescription drugs with discounts for US Prime members.

Shoppers can pay using their health insurance. If they don't use their insurance, eligible for discounts on generic & brand-name drugs on Amazon.com or at about 50,000 participating pharmacies.

Patients like talking to their pharmacists about their prescriptions. Amazon will likely try to recreate digitally.

Amazon, JP Morgan, Berkshire form new company to tackle healthcare costs.” 1-18 (Haven) 2-21/Dissolved. Each will do their own ‘thing.’ JP starting: Morgan Health 6-21



Payers- United - Largest payer

Contract and Policies/Webpage. Mid -year changes?

United revenues will hit \$243B-\$245B in 2019. 4-21/1st Q Reports profit increase of 44% \$5B

United Healthcare

- ▶ Continues to buy companies that work directly with hospitals. Advisory Group, Optum, physician groups, physician advisor groups/Sound. Change healthcare 2-21
- ▶ NEW: Site of Service determinations for outpt procedures. *URG-11.03 eff 5-18.*
- ▶ *“UnitedHealthcare’s Policy will limit outpatient surgery to hospitals...will only pay in an outpt hospital setting if the insurer determines the site of service is MEDICALLY NECESSARY. ..’hopes to guide patients to ambulatory surgery centers. “ 10-19*
- ▶ *Post ED Audits for “emergent coverage.” CMS states in violation of Surprise Billing rules. Other payers too with like issues... get our A Game on!*

United Healthcare owns Optum

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

****Humana added this audit as well 8-20****

- **Surprise Bill Leg: Watch for post-denial regulatory issues.. Surprise bill to the pt...**

Payers – Changing Climate

“CVS agrees to buy Aetna in \$69B deal that could shake up healthcare industry.” 2018

“We want to get closer to the community as all healthcare is local. “

CVS would provide a broad range of health services to Aetna’s 22 M member at its nationwide network of pharmacies and walk-in clinics.

Think out of network for other pharmacies.

Amerigroup/An Anthem company

- Effective 7-20/non-participating; 9-1-20/participating.
Applicable to ED services provided.
- Emergency Condition: Condition that a lay-person with an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in serious health jeopardy.
- Prudent layperson: To reasonably determine whether an emergency condition exists. Does not have healthcare training with a HC education.
- Only process ED facility claim as emergent.
- Criteria: ICD-10 Emergent Dx have been identified in ‘specific’ claim fields- **Primary DX =field 67.**
<https://providers.Amerigroup.com/TX>

Payer + Provider: ‘Long road from Contention to Cooperation.’ **Money=Power**

‘Anthem/BC (Indianapolis-based) determines ER visits are not covered for 300+ diagnosis. *Non-emergent* 2018>

- ▶ Impacts Kentucky, GA, Ohio, Indiana and Missouri. 40M+ BC members. (And more nationwide rollout)
- ▶ Exceptions: under 14, on IV/new, no other care weekends, physician referrals to the ER, a lack of urgent care available.

American College of ER Physicians:

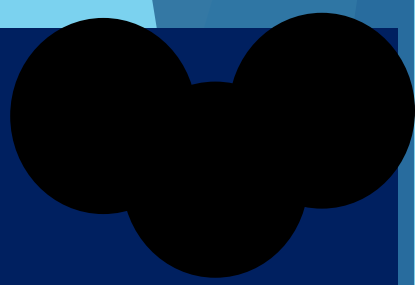
*“The changes do not address the underlying problem... pts have to decide if their symptoms are medical emergencies or not **BEFORE** they seek treatment.”*

- ▶ If the diagnosis does not warrant ‘emergent’ under the payer-specific guidelines, there is no payment to the hospital and providers.
- ▶ **EX: Pt in Frankfort, KY -after experiencing increasing pain on her right side of her stomach, thought appendix had ruptured. ER tested, diagnosed with ovarian cysts.**
- ▶ **Patient owed full \$12,000**
- ▶ **Denials are based on FINAL diagnosis; with little ‘weight’ for presenting diagnosis. Believe 4% denied**

▶ *“This will create deaths. This will make the pt think twice before going to the ER.” - BCBS TX Physicians*



Payer + Provider = New payment relationships



AHA, AHIP and 4 other associations (AMA, BC/BS and MGMA) join to improve prior authorization processes. 1-18

- ▶ Six healthcare groups agreed to take steps to make prior authorization processes more effective and efficient.
- ▶ Decrease the # of providers required to comply with prior authorization based on their ‘performance, adherence to evidence-based medical practices or participation in a value-based agreement with the health insurance provider.’
- ▶ **Prior authorizing only “high value services”.** Insurance plan is determining what value-based payment looks like... is this really value based care based on the physician’s assessment & believes best care plan? Who decides?

Disney partners with 2 Florida health systems to offer HMO. 2-18

- ▶ Directly contracted with Orlando Health/6 acute hospitals and Florida hospital, Orlando/20 campuses to roll out two insurance plans for Disney employees.
- ▶ Goal: lower healthcare costs, higher outcomes
- ▶ Using Cigna/Allegiance to administer the program.
- ▶ NOTE: Remember employer-owned insurance is still looking for ways to reduce their costs..
- ▶ 11% of employers are looking at Direct to health system./ National Bus Group
- ▶ **2021- increase in employer direct to provider contracts**
- ▶ **TRUST IS THE KEY WITH NEW VALUE BASED RISK CONTRACTS- provider and payers.** Who is developing the quality matrix, non-compliant patients, IT functionality, patients understanding of the term VALUE BASED, providing all services to keep leakage from occurring, provider choice, etc. Value over volume.
- ▶ Learn from AHIP - Insurance plan/companies themselves



Denials and being the patient advocate. A Financial Navigator for the most vulnerable. Pt loyalty means?

And when the payer decides to deny a claim, **the patient is overwhelmed.**

Who is the provider navigator to help defend the denial or dispute w/payer?

Ex #1 Pt had a burn on lower leg. Insurance paid for the dressing but then stopped paying. Denied as not medically necessary. Didn't know where to go or who to help. Ended up calling their insurance agent/who sold the MA plan. The agent called the insurance and told the pt - nothing they can do. **He paid out of pocket for multiple months.**

Ex #2 Pt's insurance changed after the pt had 3 corrective surgeries. Specialized surgeon and procedures. A 4th surgery was necessary, but out of network. Pt asked their human resource /broker -nothing to help. Then directed to call the insurance directly and ask for help. After another denial, a navigator -advocate stepped in. Outlined the surgery, involved the surgeon to discuss the case directly with the payer, and asked for exception to continue with the same pt care and surgeon. Insurance plan said - there are plenty of in-network ortho surgeons. Now the battle to prove - can't change and no surgeon would take over this level of complexity. After many calls, the pt and advocate did get limited approval. **Then after-care denied.** (Can't make this stuff up!)

Ex #3 Pt had muscle pain with inability to dx without a test. A Vit D test was ordered as this was the accepted course of dx work- up for uncontrolled muscle pain. Insurance denied as not medically necessary and they had their own indept company who confirmed same. When told that the doctor needed to determine the level of Vit D -as it is directly related to the reason for muscle pain - didn't matter. **Pt was told they had to pay it and other services related to the Vit D test.** Pt asked the provider -what can they do? They stepped in and did do an appeal. All for a simple Vit D test.. Otherwise, the pt is left paying.

The complexity of healthcare - the relationship between the payer and the patient -all difficult for the pt who only believes:

If the physician ordered it, why did the insurance declare it as not medically necessary?

Physician directed care vs payer directed care. So very hard on the patient. Who can help them? Who actually knows what to ask? **Payer's going wild directly impacts the most vulnerable⁴⁵ - the patient.**

Thank You for Joining Us in this Educational Journey



DAY EGUSQUIZA

President, & Founder
AR Systems, Inc. &
Patient Financial Navigator Foundation, Inc.

daylee1@mindspring.com

208 423 9036



<http://arsystemsdayergusquiza.com>

<http://pfnfinc.com>

