AR Systems, Inc
Training Library Presents

Attacking Medicare Advantage Denials - Taking Your Power Back

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!

Instructor: Day Egusquiza, President

Education
Compliance
Commitment

“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.”

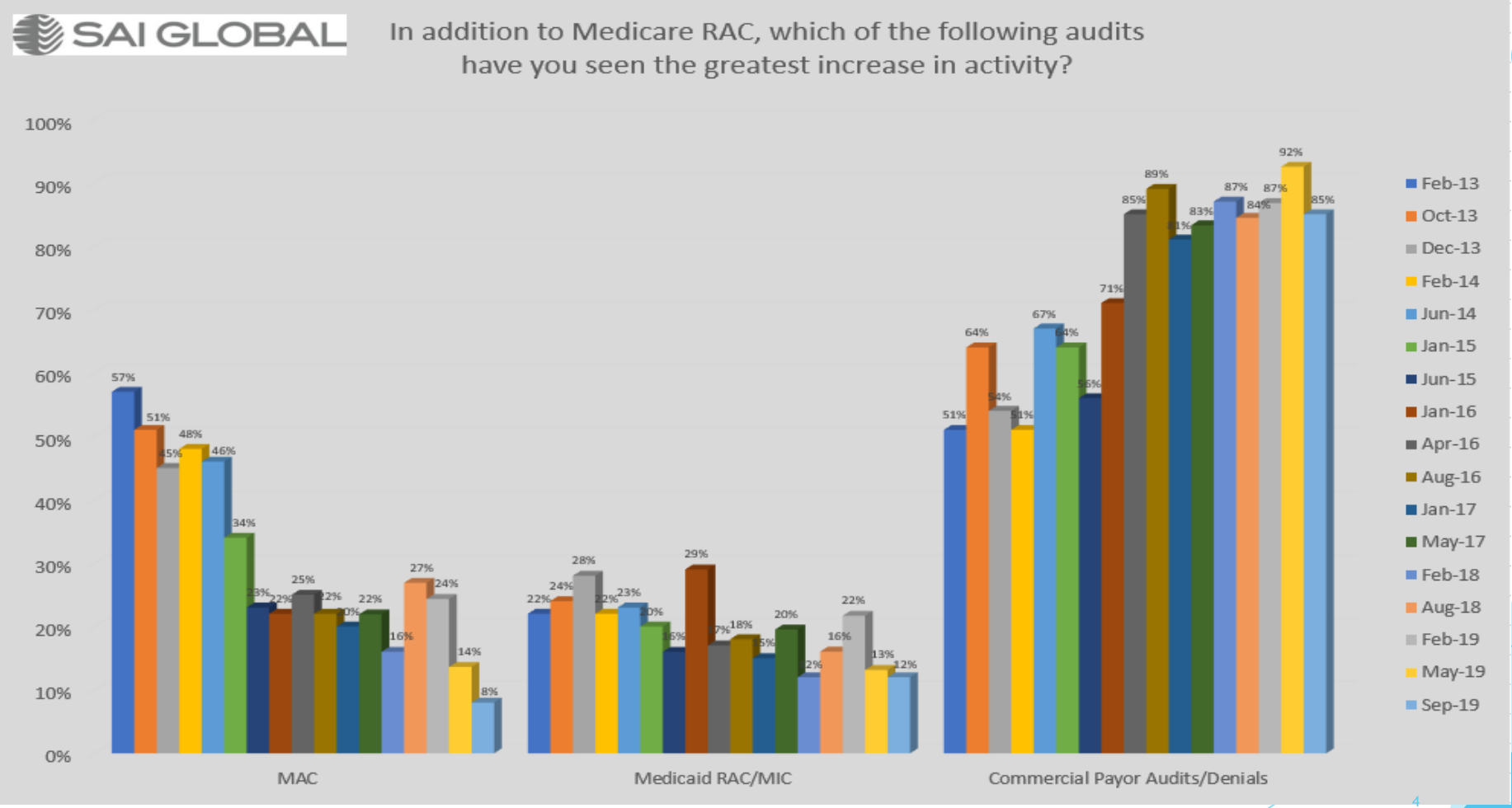
Mgd Care Anguish-
A Brave New World Required-

Payer Policy Changes/Outside the Contract

Significant Growth of Medicare Advantage Plans

= Financial Impact to Providers

8 year history with Compliance 360
SAI Global – free webinars…



CMS: 2021 Medicare Advantage Premium Decrease 9-24-20. Plus Growth + Volume (Put your "A' game on!)

- 9-24-20 CMS stated that average Medicare Advantage premiums/monthly will decrease 11% to an estimated $21 from $23.63 this year.
- CMS estimates enrollment will increase 10% to 26.9 M in 2021, a rate that's on par with growth in 2021 to 40% of all Medicare enrollees.
- There will be 4,800 plans in the Medicare Advantage market -but likely only 6-8 actual insurance companies selling - with an average of 47 plans per county – up from 39 plans this year. Medicare Advantage open enrollment begins 10-5 and ends 12-7, for coverage beginning Jan 1, 2021.
- Extended Open Enrollment: Jan - you can switch once to a different MA plan or switch back to Traditional Medicare w/Part D plan. Ends 3-31. Effective 4-1. **MYMEDICARE/GOV**
- +++Star program can yield up to a 6% bonus for the MA plans who have a 3.5-5 rating. Usually hundreds of millions of dollars..upward. (Pts scoring impacts start ratings.)

Medicare Advantage/Part C/MA –increase enrollments

- By 2021, it is forecast that Medicare Advantage/MA will constitute up to 40% of the Medicare market.
- Significant changes were made to allow revision/expansion supplemental benefits –like hearing aides, health club memberships, in home visits, home delivered meals, glasses, and others 'patient specific needs."
- Allows negotiation with pharmacy pricing
- Significant payments to plans for "Star Rating"(3.5 to 5) rated by pts.
- Limiting out of pocket yearly expense - $6,700 currently/yearly *Some low as $5,400
- ***But not all plans are sold in all counties of the country/state.***
- Very limited ability to have a Medicare Supplemental – pt pays all out of pocket plus monthly premium.
- MA IS NOT TRADITIONAL MEDICARE. Medicare 's rules do not apply if the hospital signs a contract. IF NOT CONTRACTED, Traditional Medicare rules apply.

Why would a patient select MA over **Traditional Medicare?**

- ALL have Part B = monthly premium/out of SS monthly Check. $148/$175 2022 monthly *income impact
- Part D = monthly premium/sold by insurance/but required. $30/$50 monthly*
- To cover co-pays and deductibles = Medicare Supplemental insurance. $180 per person/insurance co (Total Monthly: $372 ave)
- No cap on out of pocket costs with Traditional Medicare
- MA plans = collapse Part A,C, D into 1 monthly premium. Usually much less than Traditional fees.
- Some MA plans are not charging ANY Monthly premiums.(United/AARP) Each plan can develop their own package…
- **MA plans are paid a per-member, per month for all signed up patients. Rate is set on risk, health factors, other/dx from submitted bills, formulas. No additional funds with inpts. Each MA plans has a separate contract with CMS.**
- **AHIP -association for payers/healthplans = good to learn from their free webinars**

AARP United Healthcare Complete PPO - 2020 *Every year, new package

Medicare Advantage: Monthly premium is $38 & $144 Part B Medicare Premium & Part D/$25.= $207 (Immediate savings of approx. $150 per month when had Traditional Medicare with supplemental insurance $368)

******Hint: It is all about the money/1st, then access.*******

- There is a copayment for all services as there is no ability to have a Medicare Supplement with MA plans. *Some are now offering.
- Copayment for drugs - $0,$3, or $9 – depending on the drug tier. Some tier 2 drugs can be up to $70
- Copayment for doctor appts- $10 primary care, $40 specialists.
- Lab tests are capped at $5 each
- Outpt procedures are capped at $295 each. Copayment for the doctor cap $25. Pre-op testing cap $5
- Allowance of $60 monthly for over the counter meds. Order from United's website.
- VOLUME: Economies of Scale – huge power when negotiating with providers.
- 2021 & 2022: AARP UHC is now offering $0 monthly premium & More options yearly.

It is not the same cost in all areas of the country

- The MA plans are sold 'per county.'
- If there is a smaller population with less risk sharing to bring down costs to the MA plan, there could be higher costs or not sold at all.
- Choice is less with smaller counties/communities.
- Cost is different/could be higher in smaller populated areas.
- Out of network – significant as coverage is 'community/county' providers. (MyMedicare.gov)

<u>2022 updates from Better Health Care Alliance – Medicare Advantage Advocates</u>

- Annual notice to all plans to get new rates, program outlines , etc in April (8.5increase 4/22)
- Many new plans, smaller plans, grew in new enrollment period. Taking from the bigger plans
- Adding another focus point- Health Equity. Expect less out of pocket, higher quality requirements and more STAR focusing on customer experience.
- 28 M seniors enrolled in MA in 2021. 62M total on Medicare. (Double enrollment since 2000)
- 1 in 10 voluntary signed up for MA.
- Aver out of pocket in 2021 for MA pts: $1640. NOTE: Usually a OOP for all services. Less than TM

For-Profit Medicare Advantage Plan Growth 2022

- United Health Group nationwide — 765K new lives**Largest MA plan
- Centene Corporation — 338K new lives
- CVS Health/Aetna — 323K new lives
- Humana — 315K new lives
- Bright Health — 109K new lives**
- ++Have you monitored the new Great Resignation of patients moving from commercial to Medicare? WOW! How about from one MA plan to another during open enrollment! Double wow!
- No cost report or settlements with MA plans! Triple WOW for CAHs

Mayo Clinic not accepting Medicare Advantage Out of network appts…while United Healthcare negotiates 2-15-22. 3-22/contract resolved…

- Originally no capacity to accept OON patients
- Now moving to no contract, therefore, they will only accept in-network MA patients
- Mayo indicates they end of up getting paid less when OON patients are seen and the administrative cost is high
- United HealthCare is working to get a contract with Mayo as their patients are not being scheduled.
- Remember – no MA plan can sale in a community without a provider network.. A bit more power

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 "

MedPAC: Overhaul MA payments and streamline CMMI Models Briefing held 6-16-21 (Healthcare Dive)

- Recommendations to Congress to revamp how health plans are paid in the lucrative Medicare Advantage program, culling how many models CMS tests and curbing high-cost drug approvals.
- Measures, the MA program is thriving.
- Despite relative efficiency, MA contracting isn't saving Medicare money; **--actually in 35 years, Medicare Managed care has been active, it has NEVER resulted in net savings for the cash-strapped program",** James Mathews, Executive Director of the Medicare Payment Advisory Commission.
- MedPaC estimates Medicare actually spends 4% more per capita for beneficiaries in MA plans than those in FFS under the existing benchmark policy.
- "Because the rebate $ may be used to provide extra benefits, large rebates result in plans offering a disproportionate level of extra benefits.
- MA Plans can offer 'extra benefits' with the differences. (Hearing aids, dental, eye glasses, home delivered meals, transportation, gym membership.)
- Change formulas between bidding and geographic benchmark.
- Former CMS Adm/Berwick, MD- MA surge offerings in recent years/Life valuations much higher- MAs are a money machine. 10-21

More Federal "Concerns" with the MA plans

Medicare Advantage collected $12B in 'excess payment' – watchdog report says 3-22

- 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?

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.**"

Medical Record Review/Requests: Risk Adjustment!

- “UHC is committed to improving the quality of care provide. HHS to submit complete certain ACA-covered health plans. Accordingly, UHC is review of 2021 dates of service for certainly # of your patients. Engaged Optum and Ciox Health to conduct and retrieval options for the requested member from Jan 2021-Dec 31, 2021. Plz include all of the following medical record documentation. “(Essentially the full record.)
- ‘Aetna: As a MA organization, we are required to submit risk adjustment to CMS. We’re beginning our annual Medicare risk adjustment process. This is not a medical record review and not a claims payment audit. We are using Cotiviti..

And more Risk Adjustment hits/costs

- Amerigroup: Has initiated a program to better serve our Medicaid member and that more accurately reports health status and clinical risk profile. We are using EpiSource, specialize in data collection to increase accuracy of our Medicaid members. Please be assured this is not an audit. *CAH =130 records. (IA)

Obvious concerns:

- What new diagnosis will they find that was not already declared on the UB or 1500 billing form? The coders follow correct coding guidelines for assigning appropriate dx codes. Hospitals have coding accuracy audited thresholds.
- Massive cost to compile and send records. Time to bill the plan for the records:$150 each
- The plans are paid based on dx codes, ie. risk factors. High incentive to 'find new dx' when they weren't declared on the UB. Medicaid Mgd Care – how are these plans paid for Medicaid patients?
- CONTRACT, CONTRACT, CONTRACT… The 'artificial' assigning of new dx codes and cost to compile and send – where does it say you will do it? Have you reported the plans for fraud and abuse violations if they are adding codes that are not supported by Correct Coding guidelines?

Policy Alert –CMS /Advanced notice of change in methodology (MA plans) – IT IS FINAL FOR 2021

- Jan 6, 2020- CMS proposes changes in the Hierarchical Condition Categories (CMS-HCC)Risk Adjustment model for risk-adjusts payments to MA plans. FINAL!
- This year the Advance Notice will be released in 2 parts.
- For CY 2021, CMS proposes calculating risk scores using a 75% ENCOUNTER blend and a 25% Risk Adjustment Processing System (RAPS.) Over the last several years, CMS has been transitioning to greater use of encounter data by incrementally decreasing the weight of the RAPS.
- In CY 2018, CMS calculated risk scores using 25% encounter/75% RAPS
- In CY 2020, each data accounts for 50% of the risk score.
- The goal is to move use of the ENCOUNTER data and phase out the use of RACs entirely.
- Impact to providers? Data is from the UB, 1500 and yes, records!!! Watch for excessive requests of records- because "CMS wants us to.' Where does it say that? And if not contracted – why send any? Remember, the UB has the DX and all procedure codes. File complaint with CMS if necessary.

UR's role: First Touch

Key elements to success of UR:

1. Understanding each payer's rules for determining an inpt status.

   Each payer has their own

   Traditional Medicare does not use IQ or MCG. The 2 MN – presumption and benchmark

   Develop a payer matrix that includes timelines for payer notification, type of payment from each payer/per day/DRG/% of billed charges, arbitrary guidelines, observation guidelines, etc.

2. Physician documentation will guide the supporting of inpt acuity.

3. Coordinate with providers, CDI and internal physician advisor for ongoing education.

UR's 2nd touch- Traditional Medicare

Traditional Medicare/TM – it is all done internally using the 2 MN rules.

2 MN presumption – anticipate the pt will need an estimated 2 MN to resolve care. What is the plan? (First touch)

2 MN benchmark – as the 2nd MN approaches in an outpt status (ER 1st MN/need 1 more to be an inpt or 2 MN in obs) –is there a clinical reason to be in a bed? Yes, what is the plan?

Is a 1 MN stay allowed under TM's 2 MN rule? Absolutely. If there was a plan for 2 and the pt had an early unexpected discharge = 1 MN inpt billable. If the pt had 1 outpt MN and then a 2nd medically appropriate midnight = 1 MN inpt billable.

Key- the plan outlined. Documented and met early or met the 2nd MN.

UR's 2nd Touch- Other payers

Other non-Traditional Medicare payers

1. Submission of records using the payer's KNOWN definition of inpt.
2. Reviewing the record – from the ED as all records from CDI or other interaction with the pt may not be available by the time records are due to the payer. Clarify internally
3. Outline WHY the pt is an inpt – using their criteria PLUS co-morbid conditions, risk factors, other documentation to support inpt.
4. Observation is a 'fall back position'. Doesn't meet, no other factors… but don't ASK for observation. ASK for inpt. Learn why the payer won't approve inpt.
5. Track and trend/TNT by payer.
6. Develop a payer matrix – all rules, timelines, etc tied to contract. Knowledge is power!

Prior Authorization Request for Inpatient
Non-Traditional Medicare/TM Payers (TM – we do our own/2 MN)

Patient Name DOB:

Insurance name: Subscriber #: (SAMPLE FOR SUBMISSION WITH RECORDS TO PAYER/UR)

Records sent /attached to support inpt request:

- ER physician
- ER nursing notes
- Lab results
- Imaging results
- H&P
- Other _____

Additional justification to support inpt request:

Meets clinical guidelines for the following diagnosis and course of treatment: (List)

IQ or MCG: (List their supporting info)

Other co-morbid conditions that will impact the need for inpt level of care: (List)

Known or suspected risk factors that further support inpt: (List)

Based on the attached and the above additional justification:

Inpatient patient status is requested. _____
If inpt is denied, we would request the justification for same to be included in the decision letter. A Peer-to-Peer call will be immediately scheduled as necessary. (CMS Form 1696/Appointment of a Representative has been completed by the patient.)

Outpt observation level of care, at the beginning of care, with the immediate intervention to move to inpt if the patient's condition 'rules in,' or other clinical indicators are identified. _____ NOTE: Inpt will be requested immediately upon meeting inpt criteria.

Respectfully submitted,
Name, UR Team
Date /time sent to payer_____

Strategies for “Demanding an inpt” and Keeping it - Crazy FUN (More Better Practice Ideas)

- 1) Always know what clinical guidelines the payer is using. ALWAYS! (IQ, MCG)
- 2) When submitted records to ‘request’ inpt – a) include the clinical guidelines that clearly outline ‘why an inpt. b) a standard cover page that demands an inpt and why, c) if not clearly meeting inpt, the inpt cover page should also include additional justification. (co-morbid conditions, risk factors, etc)
- 3) The inpt started in the ER to an inpt bed. It does not start after the pt has been in a bed for a # of hrs. Huge !!
- 4) ER TO INPT – ER to Hospitalist/attending- UR outlines the reason why the pt is an inpt and the provider documents his plan for inpt in the patient record.
- 5) **Hint: CONCURRENT** review by payers during the stay. When will they give you the final INPT decision? Waiting until ‘days have passed’ = risk for obs inappropriately. Inpt happened at first touch… Lots to consider prior to allowing direct access/portal for designated records/decision timeline=w/in hrs

UR's 3rd touch- No inpt?

1. Don't agree with the payer's determination. Review case and hand off to the Physician advisor for a 2nd opinion. How to do a P2P call with the payer? TNT all reasons…
2. Traditional Medicare – have a 'short stay. Less than 2 MN. Review case and ensure a) the plan was clear for 2 MN and b) there was an unexpected early d/c. The initial review should be done at the point of admit and reviewed again as the early d/c occurs.
3. Traditional Medicare – 1 outpt MN + 1 more MN = inpt. Review case to ensure the PLAN for the 2nd MN is clearly outlined in the record.
4. Ensure the record is ready to support INPT. If deciding on OBS, there should be a PLAN for obs with TM – resolved home or converted prior to the 2nd MN. Aggressively resolve all TM accounts prior to the 2nd MN if 1st MN is outpatient.
5. If obvious ERROR as made with inpt order, then conditional code 44 must be done/followed prior to billing observation. (UR committee, attending, pt notified – then start the obs hrs) Very difficult to get done correctly.
6. NOPE WE WON'T BE BORED!!

Key Measures when beginning to work with 'payers." Every payer has their own rules!
Medicare Advantage is Not Traditional Medicare!

- UR/Case Mgr and Physician Advisors have a working knowledge:
  - Payer Mix- Every payer has their own definition of inpt.
  - Observation rate/analysis – Every payer has their own determination of inpt vs obs.

  EX) OBS RATE FY20: T Medicare 21.3% MA 28.6% All payer 25.0%

  - UR/Care Management Leaders Outline- includes Interqual or MCG or both that is being used. *Optum/UHC bought ChangeHealthCare which own IQ. AHA asked to have reviewed. 5-1-21 UHC using IQ.
  - Census- volume of work is based on payer mix and average census of inpt and obs.
  - P2P successes, attempts, negotiated-per payer
  - Clinical denials, by payer, with overturns and reason
  - Catch phrase: Does not meet Medically Necessity. Means???

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"

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.)*

Patterns from payer determination letters: Aetna (ex)

- 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.

Is patient still inhouse? (ex)

- United. MA plan. Level of care determination/while in house.
  Note: Moved from MCG to IQ, May 2021. Bought Optum who owns IQ.

- "Not met? My determination is based on the health plans and *Medicare criteria* that says a member *must show signs and/or symptoms severe enough to need services that can only be provided safely and effectively on an inpt basis. (Major subjective!)*
- Based on my review, these criteria haven't been met. My rationale: this pt was admitted on 4-7-21 with sepsis unspecified organism. We reviewed the medical information made available to use, as well as the health plan criteria for admission to the hospital, and have determined that this does stay does not meet inpt admission.
- The reason is there was no hemodynamic instability. Hypoxemia, altered mental status, bacteremia, parenteral antimicrobial regimen that must be implemented on an inpt basis. Consequently, acute inpt hospital admission is not covered." (IQ guidelines + UHC)
- What to do if disagree? You can request a P2P review. Send secure email or call #.
- Can a claim be submitted for this claim? If you submit an inpt claim, it will automatically be denied. You will received reconsideration process on your remittance. **DOS: 4-17 Ltr Rcd: 4-21 (4 days)**

You can still submit an outpt claim for all medically necessary services. Look to Medicare Claims Processing Manual, 100-04, Chapter 1, Section 50.3.2. (Condition code 44/TM)

WOW! UHC is using their own criteria, **not the 2 MN rule**, requiring hospitals to submit for review and then requiring the hospital to follow Traditional Guidelines/CC 44 when denying. WOW! NO WAY!

- HUMANA: what guidelines are they using? Letter was written to the pt, copied to the hospital (DOS 4-4; letter recd 4-8. 4 days)

- '***Based on Medicare guidelines, the services your provider is requesting do not meet the requirements for approval***. We reviewed your records and they show you were admitted to the hospital with stroke-like problems that went away quickly. You got blood tests. You had special pictures of your brain and heart taken. You got extra fluids and medicine by mouth.
- In order for the requested services to be an inpt, you would have to have:
  - Abnormal blood pressure or heartbeats that do not get better with treatment (hemodynamic instability.
  - Weakness in one area of the body that keeps happening (recurrent focal neurological signs)
  - Finding on brain imaging that requires inpt level of care (eg mass)
  - Trouble thinking clearly which is new alerted mental status.
  - Dangerous heartbeats (cardiac arrhythmias of immediate concern)
  - Urgent inpt procedure is needed (eg carotid endarterectomy, carotid artery stenting)

  Your records do not indicate the above problems. You had no trouble with…….

  IF YOU HAVE NOT YET BEEN DISCHARGED FROM THE HOSPITAL, then we may be able to approve hospital observation services. Even if you stay in the hospital overnight or longer…

  Decision was based on Medicare Benefit Policy Manual, Chpt 1, Section 10. (Severity/intensity) THESE ARE CLINICAL GUIDELINES –their own? MCG? IQ?

Timing of Determination Letters Contract language on timelines (ex)

- UHC: Faxed

DOS: 2-26	Received letter	3-1	
DOS: 4-17	Received letter	4-21	
DOS: 1-22	Received letter	1-25	
DOS: 5-12	Received letter	5-16	
DOS: 4-3	Letter dated:	4-6	Fax received: 4-8
DOS: 3-24	Received letter	3-28	**AVE: 4 days**

What if the pt has been discharged? Has the UB/claim already been sent as inpt? Was the PFS team told to hold these in a 'disputed status?" What is the timeline for the UR/Case Mgt team to submit original determination request?

- Humana: Faxed

DOS: 4-3	Received letter	4-6	
DOS: 5-8	Received letter	5-12	
DOS: 1-9	Received letter	1-13	**AVE: 4 days**

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 – use regulations

- "**If the plan approved the furnishing of a service thru an advantage determination of coverage, it MAY NOT deny coverage later on the basis of a lack of medical necessity." Medicare Mgd Care Manual/Medical Necessity, Chpt 4. 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.

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 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.

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- 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 advantage

determination of coverage,

it MAY NOT deny

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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.**

- Once the records are sent, then the denial occurs. Recoupment of funds and the appeal struggles and costs kick off. OR the hospital accepts the downgrade or full denial as it 'just too much cost/time/resources to fight.' The payers know what you are doing …

And more from Medicare Managed Care Manual – Post stabilization & Post acute care

- 42 CFR 422.113 . (2) The MA organization financial responsibility – the MA organization is financially responsible (consistent with 422.214) for post – stabilization obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative.
- If the pt is approved for post-acute care, the **MA plan is responsible to find placement**. They must have a post-acute care provider network.
- If they can't find placement, ensure there is contract language to pay a **'per diem/day' rate for any days beyond the safe discharge order**.

- HUGE! The MA plan has to have a SNF provider network to sell in your community. The pt has to be placed in an in-network SNF facility. If no in-network plan, then file complaint with CMS. Track and trend. But also get payment for the delayed 'days' while awaiting placement. HUGE!

3 Legs of Anguish – Pt Status, DRG Downgrades, Re-Admissions

- DRG **Downgrades** – what documentation standards are required to allow all physician inclusion of ALL dx the pt has and are included in the thought process/not always the actual treatment?
- Pt Status **Disputes**– what is their definition of an inpt?
- Readmission **Denials** - Related means? 30 days when CMS does not use this standard. Preventable means?
- Hint – all must be in the contract! Usually silent.
- Look to operational addendums vs
- Payer –specific policies… UGLY
- **Why are you contracting**? No directing of patients. So what is the win for the provider? Payer win is discounting. Out of network, competition. MA plan cannot sell in your community without a provider network.

DRG Downgrades

- Lots of discussion regarding tying in the diagnosis outlined to the treatment. Simply listing dx is not sufficient to ‘earn the higher DRG payment.”
- Differing interpretations of ‘co-morbid’ conditions.
- Differing interpretations of ‘primary and secondary ….reasons for admit.’ Different DRG assigned.
- **DENIAL PREVENTION: The HIPAA standard transactions.. Required all covered entities/payers to follow the outlined coding rules. They have to follow correct coding rules; so quote HIPAA and share the coding rules that makes the dx code correct, order of dx codes, etc.**

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 $. (**CAH, pd differently**)**
- 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 conducted. 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**

One RAC Relief User Issue- Lost Medical Records??

- Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.

- Suggested Response: “Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession? **

- Track and trend patterns by payers.

Patient Status "Touches"

1st touch: UR & Requests to payers

- UR in the ER
- Bed placement UR
- Pre-placement/pre-admission/pre-screening UR
- Eliminate Place and Chase
- Works to confirm inpt pt status with the payer or internally if Traditional Medicare/TM
- If starts as outpt, then condition meets a) 2 MN benchmark or b) Payer's condition "rules in"/worsens = UR works with provider to write conversion order. 2 MN Benchmark = clinical reason to stay a 2nd MN . Other payers = work within their clinical guidelines and involve the PA with any payer (or ordering physician) dispute.
- Outpt surgeries- confusion over 'moving to the floor to finish recovering' including medically necessary extended recovery vs "observation/unplanned event" -with focus on moving to inpt per 2 MN benchmark or other payer's rules/authorization. Can't 'pre-order outpt observation at the time ordering an outpt procedure. Forecasting an adverse event.
- Review all TM 'inpt only' prior to scheduling.**
- Outpt in a bed = nothing clinical = Free

2nd touch: Internal Physician Advisor

- Thru direct referrals from the UR
- Thru daily reports: 1 day stays/Traditional Medicare; 1 MN Traditional Medicare/TM = looking for potential conversions to INPT or timely discharge; 1 day stays with observation for other payers.
- Decision to move to P2P calls.

Then on to 3rd Touch: **P2P call** with non-Traditional Medicare payers. (Coordination)

Or the payer won't allow a P2P, so another choice.

Decision: Move ahead and accept obs/Change to outpt/send bill. Move ahead and leave as an inpt disputed status/bill inpt anyway.

4th touch: Move to submission of the claim as the original order states/registered in the computer/inpt. Wait for the denial. File a formal **appeal** with the payer.

Hot spots: Communication of disputed status/claim Communication of dialogue on appeal strategies from the PA advisor. Documentation of same.

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."**
- **EX) If you are treating physician Or "if you are not discharged" – payer letters**
- **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.**

General Guidelines For Effective P2P Interaction with the Payer's MD (All non-T Medicare payers)

BE PREPARED. YOU ARE READY TO GO FOR INPT. That is the primary reason for the call.

Know the answers to the questions: Payer specific.

- **Why was the account denied** ? What are the Clinical guidelines/CG for this case? Is it a 'gray' case or a CG slam dunk?
- **Who is payer?** What is the historical pattern with the MD? What is this payer's MD looking for to approve the INPT? Are there 'key words' this payer likes when looking for specific dx/courses of treatment? What are the 'hot words' NOT to use? (Observing for vs actively treating)
- **Place the request**. What are the contractual guidelines for a) scheduling a P2P, b) can the pt's status be changed post discharge with no aguish/bill type 131/obs from time of initial 'admit?.
- **Ensure there is clarity on when to schedule the call - time and date**. Again, very payer specific
- **Know the Levels the payer is using** Ex) Humana -4 hrs from request; if missed, move to pre-dispute.
- **MA Plans-** Use of CMS form 1696/appointing of a representative. Submitted with the Request for P2P, if needed.
- **If not allowing P2P or a non-contracted payer, then what**? How can inpt be challenged without going to appeal/very costly/delays in payment? And if so, know the appeal rights/levels with each payer's contract.
- **Ensure timeline for DECISION on P2P if not done concurrently during the call.** Can post-discharge be done & concurrent? Get authorization #.
- **If the P2P call is attempted but missed**/did not get scheduled well, it is a '1x and done' -move to appeal or accept obs?
- **Bullet Highlights of the case.** Ex) MCG met/if it helps. Comorbid conditions. Updated issue since original request for inpt/UR 1st touch. Why inpt Level of care is necessary. If DRG payer, once approved for inpt. # of days is a mute issue. Same DRG payment.
- **Communicate with PFS/Rev Cycle on what is the final status of the account** -inpt or obs. Update medical record &/or AR file w/same

Peer to Peer Discussion: Preparation for the call & Outcome

Company: Phone Number: Date:

Name: Date of Birth:

Insurance Number: Chart Number:

Date of Admission: Hospital:
Date of Discharge/if applicable:

Current Status: Dx & Comorbid:

What does the payer use to define inpt? (IQ, MCG, other) _____

Medicare Advantage -CMS1696 Signed: ___Yes ___No

What was the justification for the dispute of inpt per the payer's response? (Review UR notes, meets clinical guidelines, co-morbid conditions, at risk issues, etc. Why can't this patient's condition be safely treated as obs?)

Clinical Presentation:

Pertinent Labs, other highlighted areas:

Changes since clinicals sent to payer?

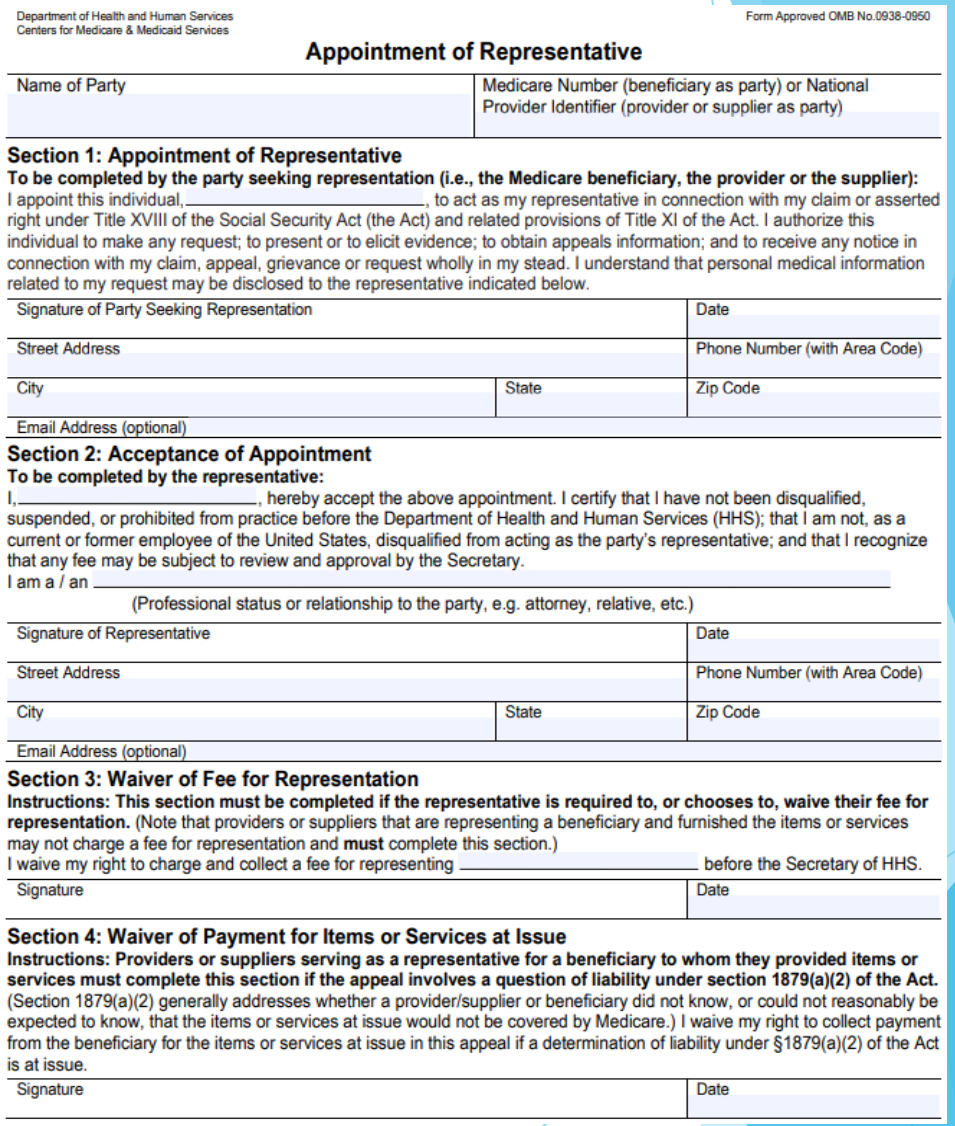
Payer Medical Director: _____ Direct Phone Number if Given: _____
Outcome: ___IP approved Authorization # _____ ___OBS approved.
Readmission issue? Yes ____ No____ "Related issues" at risk?_____

Recommend Appeal: ___ Yes ___ No ___N/A
Accept downgrade to obs? ____ Yes ____No
If recommend Appeal: Basis for appeal _____

Completed by:

CMS Form 1696 – formal representative

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

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

- United Health Care **Policy Number: H-006**
- **Coverage Statement:** Hospital services (inpatient and outpatient) are covered when Medicare criteria are met. **DANGER ZONE***

- For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Update - United =25% market share

- As of Aug 2015, UHC no longer uses the CMS two-midnight standard to make inpt admission determination.
- UHC believes the best way to help UHC's members get access to the care they need is to relay on evidence-based guidelines and treatments. Evidence-based guidelines allow UHC to review a member's health condition based on the clinical documentation and provide consistent, clinically validated decisions for hospital admissions.
- **Sites should now consider: "If appeal results in an adverse decision, we request a copy of the individual criteria used to determine medical necessity be provided with the determination."**
- Per UHC 2016 Provider Manual – pp 113-114 Criteria for Determining Medical Necessity.
- May 2021- UHC moving to IQ/owns Optum which bought Change HealthCare which owns IQ. From UHC's MA policy #H-006. 2020 pg 2: "Physicians should use a 24-hr period as a benchmark, i.e. they should order admission for patients who are expected to need hospital care for 24 hrs other patients on a outpt basis." IQ= 48hrs in guidelines.
- Reported UHC IQ impact: much longer to get replies to 'disputed status' –P2P calls, etc.

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!**
- Turn in abuse to CMS – as oversight for all MA Plans.

More payer anguish -Place of service Audits

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

More payer anguish - Outpt

- "For the last month or so, we have been getting letters from UHC wanting the medical records on all our outpt services and even if they are the 2nd payer and owe us under $100, they want the records. They are asking for records for a simple CBC, strep test, drug screening, mammo,and colonoscopies. In many cases, it is costing us more to send them the medical record than what our actual reimbursement would be. I filed a complaint with our UHC Advocate and we have a phone call set up. They are calling it "pre-payment letters.' In many cases we have a prior authorization and they are still wanting the complete medical records. Now other payers are starting to do the same thing." Ill 80 bed hospital

- Most are commercial UHC and we are contracted..
- Why asking? More dx = better long term payments for MA plans
- No idea why we would agree to this but under PROTOCOL, we have to respond.

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. 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. Cptr 3, Sect 40 2.5

30-Day Readmission CMS

CMS Hospital Readmissions Reduction Program (HRRP)

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions,** effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection (d) hospital **within 30 days of a discharge from the same or another subsection (d) hospital;**
- Adopted **readmission measures for the applicable conditions of acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN).**

In the FY 2014 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2015 program to include:

(1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease **(COPD);** and

(2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA).**

In the FY 2015 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2017 program to include patients admitted for **coronary artery bypass graft (CABG) surgery.**

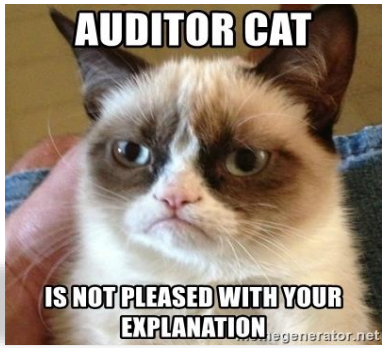
- READMISSION PENALTIES: CMS FINES 2545 HOSPITAL FOR HIGH READMISSION RATES. 83% OF 3080 HOSPITALS EVALUATED. COULD CUT UP TO 3% FROM EACH MEDICARE CASE DURING FISCAL YEAR 2021
- 10-28-21 CMS JUST FINED 2499 HOSPITALS FOR ABOVE THRESHOLD FOR 30 DAY ADMISSIONS. PROGRAM 10 YEARS OLD .

United Health Care Readmission- 30 days for any related reasons *common language

- 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.**

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.**

Operational Addendum's for Payer Contracts – All insurance types, all non-Traditional Medicare Payers.

- Many payer contracts are the same nationwide. (EX United)
- The challenge is to clarify OPERATIONAL Issues thru an Addendum to the contact.
- Operational issues are historically not addressed in the language of the contract. The key challenges adding cost to the contract are seldom known by the Contracting Department.
- Payers will direct providers to the Webpage for Policy Updates. (Who knows, who teaches, how are they rolled out, what if disputed. EX: (on hold now) United new mandatory United-specific lab codes, effective 1-1-22 for all contracted providers. Adding same special provision for Imaging. "Designated Diagnostic Provider' status.
- Becoming a member of the Contracting Team, Care Mgt & PAs can interject factual data- tracking and trending of patterns, by payer – while outlining additional elements into the Operational Addendum while working closely with the back end/rejection/denial prevention team.
- Per CMS: 75% of MA appeals are overturned. Games? But only 1% are appealed.

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

Does directing of pts even occur? What is the win for the provider?

<u>Outline key elements prior to signing the contract</u>. 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.

- **DRG hot spots**: Ex) Sepsis, ensure there is adherence to the HIPAA Standard Transactions- all covered entities.
- **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.
- **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.)
- **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

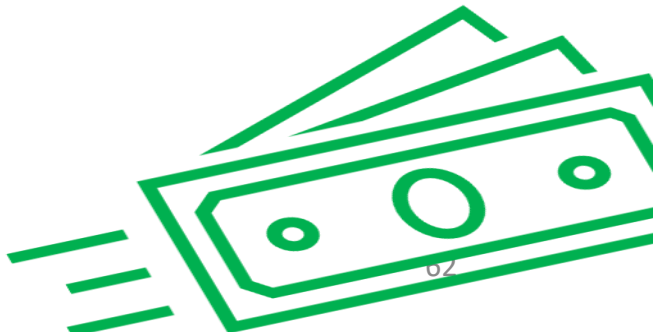
Post –discharge, outlier payment, line item audits. Commercial, MA, Medicaid Mgt Care. Each payer has their own list, their own justification, internal.

- 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 discontinue the contract, etc.
- What to expect? CMS: R&B covers routine services =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. NEW: ALL 02 and RT done by an RN.

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

DEATH BY A 1000 CUTS…



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 to do with line item audits?

- 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 pt 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?
- Is there a fee for having your staff away from their regular job?
- **Be ready to discontinue contract. Where does it say this is allowed? Join with others.**

Contract Checklist of Utilization Needs

Utilization Review Contract Checklist	
I.	**Review Criteria**
	Request: Interqual
	Request: If contract will not allow for exclusive use of Interqual then P2P Opportunity must be available when Criteria Conflict; P2P must then be based off of medical necessity & Provider input
II.	**Concurrent Denials**
	Request: Inpatient Hospitalization authorization can only be denied by a Medical Director/Physician Reviewer after it has failed to meet utilized criteria by the 1st level reviewer. A non-physician reviewer can not concurrently deny an Inpatient Hospitalization Authorization
	Request: Concurrent Denials due to failure of the payor's 1st level reviewer to provide the Medical Director with all pertinent chart documentation pertaining to the visit will be immediately overturned
	Request: P2P Opportunity available whenever the payor denies a visit concurrently. The P2P will be a review of the medical necessity of the cases; not how it does or does not meet criteria used
	Request: P2P should occur while the patient is in-house but must also be allowed up to 48hrs after discharge; P2P cannot be disallowed just because pt. was discharged. If the denial was received post discharge then the P2P shall be allowed & is to occur within 72 hrs of discharge
	Request: P2P can be conducted by the Attending Physician, Physician Advisor, CMO, &/or any applicable Consulting Physician pertinent to the hospitalization
	Request: Concurrently denied stays that are overturned on P2P appeal shall not be denied again post discharge upon retrospective review

Contract Checklist of Utilization Needs Thanks, Ms Slavin/Strong Memorial, NY

III.	**Elective Surgeries**
	Request: Medicare lines follow the CMS Inpatient Only Surgical List Annually as CMS publishes
	Request: Transparency of any internal Surgical Lists defining procedures as shrot stay 23 hrs, Ambulatory, or Inpatient designated
	Request: Payor will not automatically deny procedure changes made during the time of surgery based on the new procedure was not pre-authorized. EI: Scheduled Short Stay 23 hrs lap spinal fusion that converts to open out of necessity
IV.	**Readmissions**
	Request: Clear & Transparent Readmissions Policy that clarifies when 2 Inpatient Hospitalizations will be combined by payor; limit to Same Day Returns for Same Condition/Diagnosis
	Request: Payor will not automatically deny to combine return Inpatient Hospitalization Stays outside of the Same Day return policy. *In the event a premature discharge may have occurred the payor has the right to challenge/concurrently deny those 2 stays for combination to 1 continuous stay. Payor will not deny to combine 2 Inpatient stays on the sole basis that the patient returned to the hospital within a 30 day window of time
V.	**Retrospective Denials**
	Request: Payor shall not deny retrospectively any Inpatient visit they have already concurrently authorized & approved as Inpatient
	Request: Appeal Responses - Failure of Payor to respond to appeal within the defined timeframe will result in automatic overturn of denial.
	Request: If Denial is based off of internal medical policy as defined by payor then denial letter will explicitly state this including the link to the Policy resource utilized
	Request: All appeals allowed an External Review Level of Appeal; Facility has the right to have the appeal reviewed by a 3rd party entity if the Payor upholds the denial at last level of appeal

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..

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

More filing of complaints – "Helping the contractor do the right thing." 3-20

- To report issues to CMS. (Thanks, Dr Hirsch)
- MAC issues: CMSlistens@cms.hhs.gov
- QIO issues: QIOconcerns@cms.hhs.gov
- RAC issues: RAC@cms.hhs.gov
- Medicare Advantage issues: https://appeals.lmi.org/DAPmailbox/mailbox?pageFilter=pca

- Note – when 'discussing' issues with the MA plans – be very clear that you will report to CMS on behalf of the pt and will ensure it goes against their STAR Ratings… last major power statement.
- Ensure you have already tried to resolve with the payer.

AR Systems' Contact Info

Day Egusquiza, President
AR Systems, Inc
Box 2521
Twin Falls, Id 83303
208 423 9036
daylee1@mindspring.com

NEW EXPANDED WEBPAGE: http://arsystemsdayegusquiza.com