AR Systems, Inc
Training Library Presents

What is going on with the Payers?
Managed Medicare /Part C & Commercial
Attacking Mgd Care Anguish.

Instructor:

Day Egusquiza, Pres
AR Systems, Inc

Mgd Care Anguish- A Brave New World is Required-
Attacking DRG changes, Pt Status Disputes, Re-Admission Denials...
Which payers are causing you the most anguish?
By volume of accounts (pick 2)
Results from 2016 PA & UR Boot camp

1. Medicare/MAC
2. Humana /Part C Medicare
3. Humana/commercial
4. United/part C Medicare
5. United/Commercial
6. Aetna/Part C Medicare
7. Aetna/Commercial
8. Managed Medicaid
9. Other – Part C Medicare
10. Other - Commercial
Which payers are causing you the most anguish?
By dollar amount (pick 2)
Results from 2016 PA & UR Boot camp

1. Medicare/MAC
2. Humana /Part C Medicare
3. Humana/commercial
4. United/part C Medicare
5. United/Commercial
6. Aetna/Part C Medicare
7. Aetna/Commercial
8. Managed Medicaid
9. Other – Part C Medicare
10. Other - Commercial

What strategy best describes your UR and PA’s role with non-Traditional Medicare and Commercial disputes and denials: (2016)

1. Just fight them as they happen
2. Just fight them but give direct feedback to contracting
3. Just fight them but give direct feedback to the denial mgt team
4. Just fight them but give feedback to the CFO and BEG for help with contracting
5. Just fight them and have limited internal help
6. None of the above
What is your current strategy for fighting denials? (2016)

1. Overwhelmed so only appeal the really strong ones
2. Appeal all
3. Only appeal based on dollars at risk
4. Appeal complex only
5. Don’t appeal
6. Don’t know

Do you have a physician advisor designated to assist with your appeal strategy? (2016)

1. Yes
2. No
Do you use peer to peer with the payers as part of your appeal strategy? (2016)

1. Yes
2. No

92%
8%

GAO Slams CMS on MA Audits

• GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments.

• CMS's goal of eventually conducting annual RADV/Risk Adjustment Data Validation audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments.

• CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act.

• GAO-16-76 Published: Apr 8, 2016
Risk adjustment data validation

RADV

• The diagnoses that PacifiCare submitted to CMS for use in CMS’s risk score calculations did not always comply with Federal requirements. For 55 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that PacifiCare submitted were valid. The risk scores for the remaining 45 beneficiaries were invalid because the diagnoses were not supported by the documentation that PacifiCare provided.

• As a result of these unsupported diagnoses, PacifiCare received $224,388 in overpayments from CMS. Based on our sample results, we estimated that PacifiCare was overpaid approximately $423,709,068 in CY 2007. (Not recovered yet)

What is the Regulation for Mgd Medicare?

(Deon Ronald Hirsch/Accretive Health, 2016 PA & UR Boot camp**) 

Medicare Advantage/Part C plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medicare Managed Care Manual, Ch 4
What’s your Case Manager’s Reality?

- Demand patients stay observation for days on end
- Rarely approve LTACH, acute rehab or even SNF
- 48-72-96 hrs to get approval for post-acute care
- Contracted home care agency has bad reputation
- DME supplier will not deliver supplies in a timely manner
- Bundling all readmissions within 30 days

And UR/UM has the first point of contact challenge...

- Who is the primary payer?
- What are their rules for inpt?
- Is this payer contracted? What are the pt status contract terms? If not contracted, then what?
- What guidelines is the payer using to support /determine inpt? Milliman? Interqual? Neither?
- Who is the provider who will write the inpt order?
- What if the payer disputes the inpt request?
- What are the payer’s rules for resolving a pt status dispute?
- Does UR know ANY of the contract terms? Why not..
It’s all in the Contract

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

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

Cigna Obs Policy 0411

- In general, the duration of observation care services does not exceed 24 hours, although in some circumstances, individuals may require a second day. **Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary and may be subject to medical review.**

(Dr Ron Hirsch/Accretive – from PA & UR boot camp 2016.**)
One RAC Relief User Issue

• 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? **

Aetna Precertification List

• Observation stays greater than 24 hours will require precertification. Observation stays greater than 24 hours are considered an inpatient stay and are subject to all inpatient policies, including the timely notification requirement. **
• Inpatient admission required rather than observation care because of 1 or more of the following:

  • Significant finding or clinical condition judged too severe (eg, treatment intensity or expected duration requires inpatient admission) or too persistent (eg, insufficient improvement or worsening despite initial intervention or treatment for up to 24 hours) to be within scope of observation care, including 1 or more of the following:
  • Vomiting that is severe or persistent
  • Severe electrolyte abnormalities requiring inpatient care
  • Hemodynamic instability that is severe or persistent
  • Acute renal failure
  • Other significant finding or clinical condition judged not to be within scope of observation care
  • Treatment or monitoring requiring inpatient admission (eg, due to intensity or expected duration) as indicated by need for 1 or more of the following(6)(7)(8):
    • Continued inpatient IV hydration due to failure of rehydration treatment (eg, for greater than 24 hours) and expected improvement with further inpatient evaluation and treatment

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**Readmissions - CMS Policy**

• When a patient is discharged/ transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay’s medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.
Aetna Readmission Policy

• Effective July 1, 2015, we’re changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we’re also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays. **

Regence Readmission

Hospital readmission review (group and individual plans)
All hospital readmissions for the same, similar or related condition which occur within 48 hours of the original discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.

The two hospital stays will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.
United Health Care Readmission

- A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.
- If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.
- The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system. **

Anthem/Part C Medicare Readmission

- Anthem Medicare Advantage considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment. Anthem Medicare Advantage defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers. **
• Anthem Medicare Advantage will utilize clinical criteria and licensed clinical medical review for readmissions from day 2 to day 30 in order to determine if the second admission is for:
  ▪ The same or closely-related condition or procedure as the prior discharge
  ▪ An infection or other complication of care
  ▪ A condition or procedure indicative of a failed surgical intervention
  ▪ An acute decompensation of a coexisting chronic disease
  ▪ A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period
  ▪ An issue caused by a premature discharge from the same facility **

How Did We Address Humana? - Dr Baker, 2016 PA & UR Boot Camp++

• Received two main areas of denials- prior authorization for inpatient only months later to deny and DRG validation audits going after cases with single CC or MCC
• Filed multiple appeals trying to address the issues directly with Humana
• Set up a meeting with Human Corporate Compliance Group to address the egregious nature of these denials.
• No progress when trying to deal directly
Humana Continued++

• Worked with SCHA /South Carolina to develop a complaint mechanism through the Atlanta Regional Office for CMS via email: PartDComplaintsRO4@cms.hhs.gov
• First complaint on the prior authorization issue presenting to CMS that if concurrently reviewed and approved should not be able to change based on outcome “risk realized” and that since as a facility we had every right to expect payment then we should be able to hold the beneficiary financially liable
• Received call from Humana within twenty four hours to correct these denials and to assure that this practice was to stop immediately the problem had been they had not checked the box on their form allowing the financial recovery group to audit these accounts

Humana ongoing++

• Secondly addressed the DRG validation audits by raising the question with CMS that if Humana is paid on a “Risk Adjustment Data Validation” or a risk score on each beneficiary based off billing data but was not allowing diagnoses which had been billed for DRG assignment had they reported this to CMS and if not was this fraud?
• Again received almost immediate response that of course this was not an issue as all these claims were being paid.
Regional Implications++

• Continuing work with SCHA reaching out to SC Department of Insurance to try to address who has regulatory authority over the MAPs
• Reaching further to the NAIC to get their input as well since CMS has stated their only role is financial viability but these are federally mandated programs and as such not regulated by the states
• Continuing work with this task force
• Currently starting a letter writing campaign from hospital C Suite to state representatives to increase the postal poundage in their inbox
• Ongoing Discussions with anyone willing to listen

National Impact ++

• Published results on a list serv known as RAC-Relief@googlegroups.com
• Dramatic increase in the filing of complaints about all of the Advantage Plans with CMS to the point that most now have specific people assigned for complaints
• American College of Physician Advisors has a Governmental Task Force bringing to bear on CMS issues around the same plans.
• All others welcome to join in the fight
National Contacts at CMS for Complaints:

- **Humana**
  - Uvonda Meinholdt
  - Health Insurance Specialist
  - Kansas City Regional Office
  - Phone: 816-426-6544
  - FAX: 443-380-6220
  - Uvonda.Meinholdt@cms.hhs.gov

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

- **Coventry Health / Aetna**
  - Don Marek
  - Health Insurance Specialist
  - Denver Regional Office
  - Phone: 303-844-2646
  - Don.Marek@cms.hhs.gov

- **BCBS Anthem**
  - Anne McMillan
  - Health Insurance Specialist
  - Chicago Regional Office
  - Phone: 312-353-1668

Future Implications for the Medicare Part C/Advantage++

- Significant decrease in denials from Humana at our facility
- CMS involvement in regulating the plans as evidenced by a ban on CIGNA for enrolling new beneficiaries and a fine on Humana for $3.1 million for improper administration of Part D and some Part C benefits
- Medicare Advantage Plans now subject to RAC audits
Proactive Strategies - Contracts

- Develop a template for terms for all payers – commercial and Medicare Part C/Advantage – beyond payment.

Areas to include:
- Timeline to submit clinicals – inpt vs obs
- Timeline for determination from the payer - within 12 hrs
- Immediate call/appeal including guarantee of a peer to peer call within 24 hrs.
- Clearly outline criteria being used to determine inpt status. (Beyond ‘medically necessary’ care.)
- DRG – Correct coding guidelines being used. (Disallowing dx that are not being treated...lower the DRG payment.)
- Re-admission guidelines. (Related? Like CMS?)
- Appeal rights – post discharge. Ensure all 5 levels with Traditional Medicare are included for all Part C plans.
- “Using Traditional Medicare/CMS” rules – but what happens when they don’t?

And more updates- Part C

- Managed Medicare Plans/Part C = HUGE
- They do not have to adapt Traditional coverage rules.
- Treat them like a Commercial Payers – get pre-certs, determine if they are using ‘2 MN’ rule methodology and/or clinical guidelines.
- Update contracts to CLEARLY outline the tools used to determine: what is an inpt.
- Always use: Physician order with rationale for why? (Sound familiar??)
- Big increase in denials...& disputes of status
- WHAT IS THE PAYER’S DEFINITION OF AN INPT!
Proactive Strategies - Payers

• Schedule monthly meetings with the primary contracted payers.
• Have examples of ‘abuse’ with inpt status and DRG and readmission. (3 hot spots)
• Involve contracting with all payer operational meetings/calls.
• Involve UM with all payer operational calls.
• Involve Coding leadership and/or CDI with meetings.

Complexity from all directions- Patients impacted

• Patients unaware they are ‘seamlessly converted’ to the Mgd Medicare Plan when they had the same carrier as a Commercial plan. HOLY MOLY!
• Patients received letter /one of many as they approach 65. They MUST opt OUT of the plan or they are seamlessly being enrolled. “With Medicare’s specific approval, a health insurance company can enroll a member of its marketplace or other commercial plan into its Medicare Advantage plan...which takes effect within 60 days unless the member opts out.”
Final Hints!

- **Medicare Part C is NOT Part A/Traditional Medicare.** All rules of Part A do not apply!
- **If NOT contracted,** then the hospital would revert to Traditional Medicare Part A. (Expect a battle, but involve CMS/complaint process.)
- **Part A rules only apply if contracted.**
  - “Can’t change status after discharge.” HUGE! Many disputed statuses are not resolved until after discharge. Ensure this is allowed in contract language.
  - “Condition Code 44 has to be done” HUGE! Since Part C Medicare has to be contracted for status confirmation, it is not applicable unless contractually included.

AR Systems’ Contact Info

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

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