Having Issues with Patient Status?

Central Pennsylvania HFMA 2024 Fall Meeting

September 19, 2024

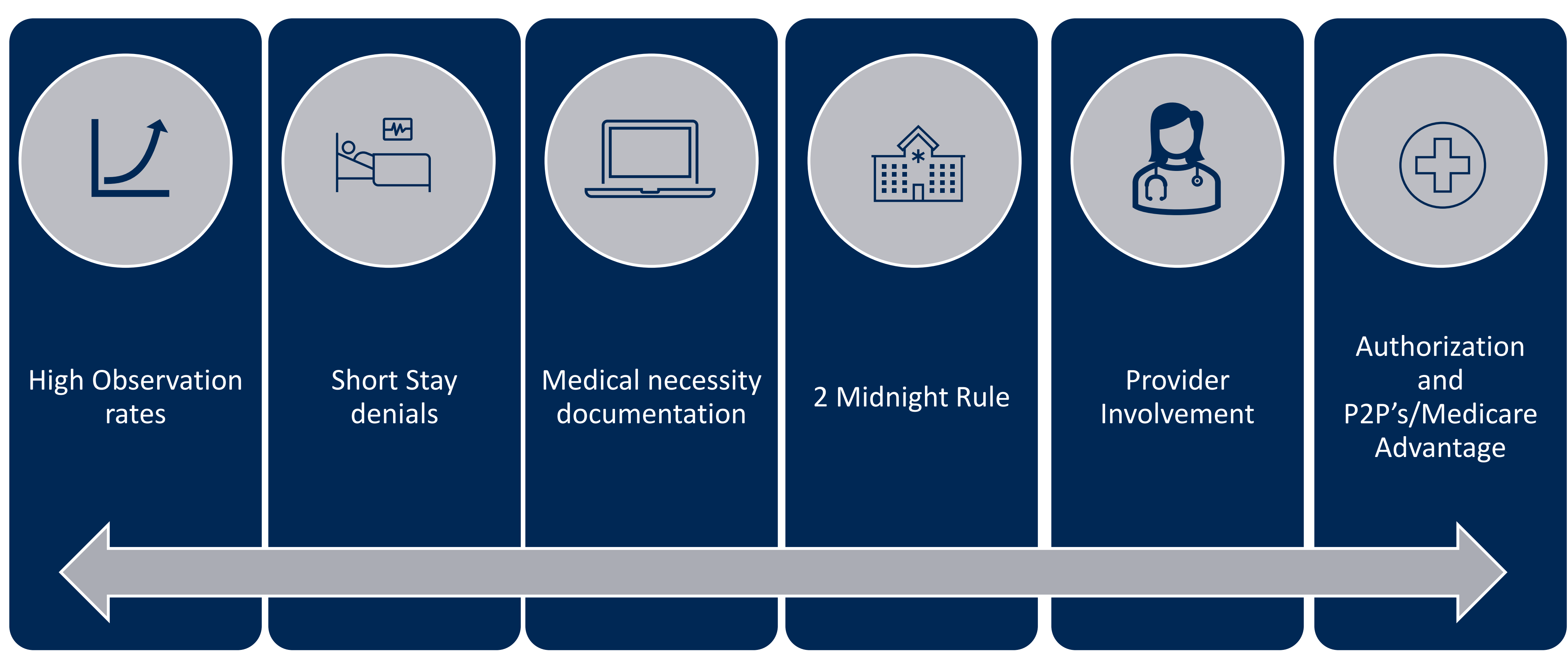
Speaker

Carol Howard, BSN, MBA
VP of Clinical Strategy
EvidenceCare
carol.howard@evidence.care

AGENDA

- Patient Status issues
  - Physician disconnect
  - Utilization Review process
  - Medicare Advantage Plans
  - Medicare 2 MDN rule
  - Revenue Risk
- Potential Solutions
  - UR process
  - Contracting
  - IT related solutions

Patient Status Issues $$$



Physician Disconnect

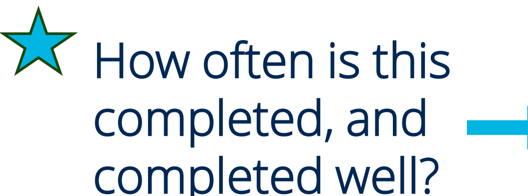
The admitting physician is responsible for documenting the patient's medical necessity and expectation that the patient may require hospital care that crosses two midnights.

Physician Disconnect

The admitting physician is responsible for documenting the patient's medical necessity and expectation that the patient may require hospital care that crosses two midnights.

Expectation should be based on:

Complexity of medical factors (such as patient history and comorbidities)	Severity of signs and symptoms	Current medical needs	Risk of an adverse event



How often is this completed, and completed well?

The factors contributing to a particular clinical **expectation must be documented in the medical record to be in compliance.**

Utilization Review Process

Admitting physician enters LOC order

UR review of LOC order and documentation?

Yes / No

Level of Care order correct?

Yes / No

Contact admitting physician for further info-given

Yes

Medical records and "review" sent to payer's UR nurse

Enter authorization and set up next review date

Change status to inpatient?

Yes

Contact admitting physician to correct LOC order

Concurrent review documentation sent to insurance

Downgrade stay to observation, inform patient and ensure CC 44 on claim

Patient discharged

UR feel it meets inpatient / continued stay?

Yes / No

Payer returns authorization?

Yes / No

Peer to peer completed?

Yes

Overturned?

Yes / No

Keep current LOC order and document

Is patient still in the facility?

Yes / No

Change to inpatient or obs?

OBS / Inpt

Upgrad stay to inpatient, submit documentation to payer

Send Medical records and appeal to payor

Send to physician advisor for initial review

Level of care correct?

Yes / No

Set up peer to peer review with insurance MD

Appeal letter written by UR and/ or physician advisor

Overturned?

Yes / No

Bill insurance company for LOC ordered

Provider liable claim?

No / Yes

Ensure Medical records has re-coded account

Bill as inpatient and enter CC W2 on claim

Send claim to payor

Denial?

No / Yes

Paid

Appeal?

No

Fatal write off

- Admitting Physician
- UR Nurse
- Payor
- Physician Advisor
- Hospital Billing

What is the root cause of the denial?

There could be...

Admitting physician orders the wrong level of care

Documentation does not support

Utilization Review Process

Admitting physician enters LOC order

UR review of LOC order and documentation?

Ye

Medical records and "review" sent to payer's UR nurse

Enter authorization and set up next review date

Change status to inpatient?

Yes

Contact admitting physician to correct LOC order

Concurrent review documentation sent to insurance

Downgrade stay to observation, inform patient and ensure CC 44 on claim

Patient discharged

OBS

Keep current LOC order and document

Change to inpatient or obs?

Inpt

Upgrad stay to inpatient, submit documentation to payer

Yes

Payer returns authorization?

Peer to peer completed?

Yes

Overturned?

No

Is patient still in the facility?

Send Medical records and appeal to payor

No

Level of care correct?

Yes

Set up peer to peer review with insurance MD

Appeal letter written by UR and/ or physician advisor

Yes

Overturned?

No

Yes

No

No

Ensure Medical records has re-coded account

Bill insurance company for LOC ordered

Provider liable claim?

Send claim to payor

Denial?

No

Paid

Yes

as inpatient and enter CC W2 claim

Appeal?

No

Fatal write off

Admitting Physician

UR Nurse

Payor

Physician Advisor

Hospital Billing

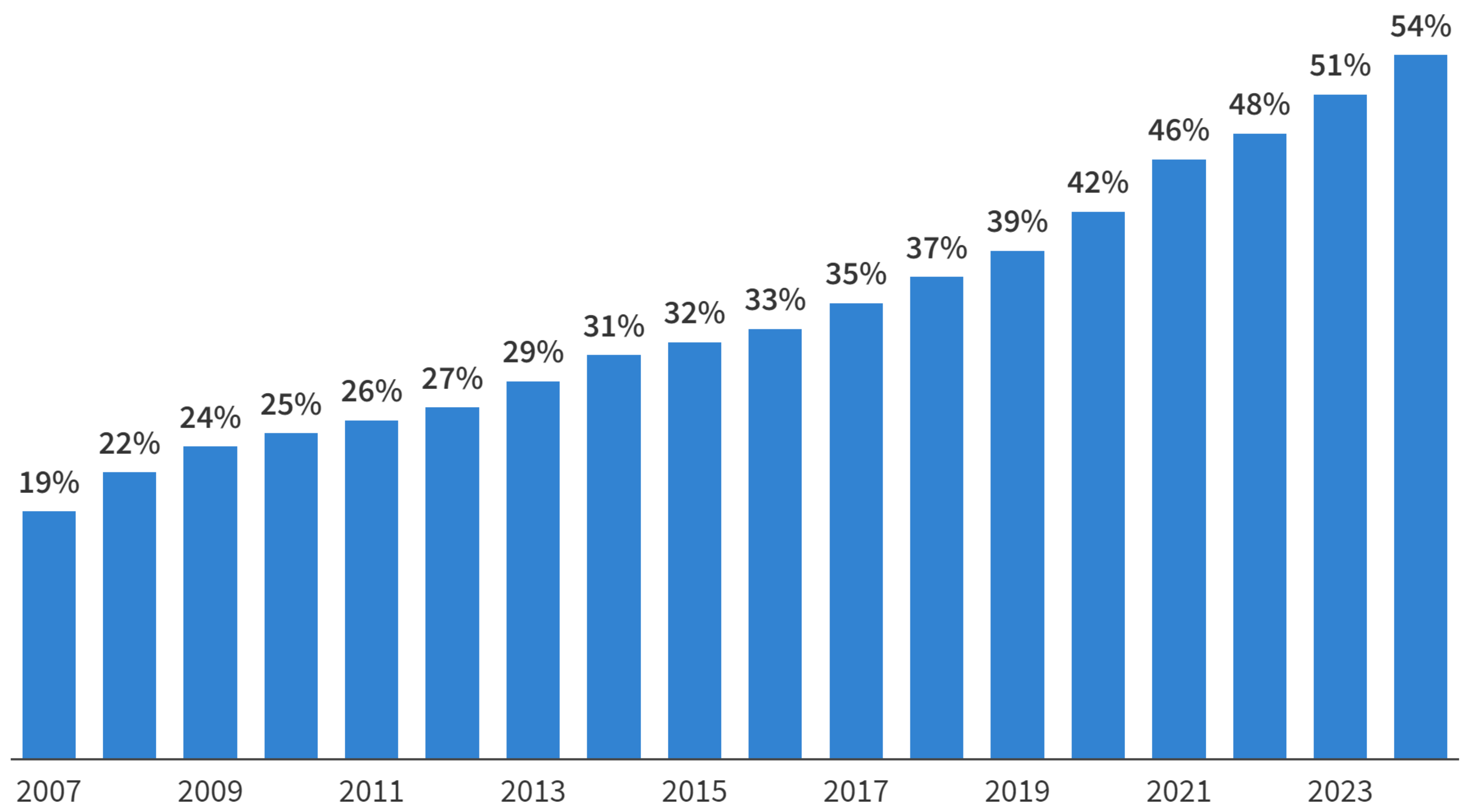
What is the root cause of the denial?

There could be...

Admitting physician orders the wrong level of care

Documentation does not support

Medicare Advantage Plans



Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/#:~:text=In%202024%2C%2032.8%20million%20people,of%20plans%20offered%20in%202018.

Bipartisan support to limit MA spending is leading to changes

While Biden admin has been generally favorable to payers, small changes/ clarified rules are chipping at margins

Changes	**Version 28 HCC model:** CMS cut the number of ICD-10 codes eligible for reimbursement.	**Star ratings:** CMS is making it harder to get 5 stars, relying on more outcome measures.	**RADV audits:** CMS is clawing back $4.7B in overpayments with a PY2018 lookback.	**2025 Final Rule:** CMS reins in marketing and broker incentives; mandates notification of unused supp benefits to enrollees, annual health equity analysis, and stronger behavioral health access.	**Prior Authorization Final Rule:** Starting in 2026, payers must send decisions within 72 hrs for urgent requests, 7 days for standard requests; provide reasons for denials; and publicly report metrics.	**2025 Final Rate Announcement:** CMS proposed 0.16% decrease in average benchmark payment rates.
Potential Consequences	Decline in profits for payers/ disruptors who relied on aggressive risk coding for margin	Uncertainty and variability for payers on what stars to expect and who gets $13B in payments	Payer reevaluation of the profitability of certain markets More opportunities for health systems and new entrants	Improvement in bene protection and more market competition	Expected savings of $15B for hospitals and other providers over 10 years	Expected average increase of 3.7% in payers' revenue in 2025 ($16B), given a projected 3.86% increase in the risk score trend
Projected change in MA plans' average revenues	-2.2%	-1%+	Not clear	Not clear	Not clear	-.16%

Beyond regulations, payers hit by a flurry of additional headwinds

Payers see unexpected utilization, dropping share prices, and public scrutiny over post-acute denials

1 Higher-than-expected medical benefit ratio and utilization

More outpatient procedures

Higher hospitalization rates, fewer observation stays

A higher proportion of age-in's

"*The industry is experiencing a dynamic and challenging time…**I don't how [we] will take this kind of increase in utilization along with regulatory changes** that will persist in 2025 and 2026.*"

– CEO, Humana

2 Incorrect forecasting

Humana

-40.2%
Decrease in net income in Q1 compared to Q1 2023

-37%
Drop in share price in the past 6 months

89%
MLR for Q1 2024

1/3
Of expected enrollment volumes actualized during 2024 open enrollment

3 United Healthcare and Humana facing class action lawsuits for inappropriate care denials using algorithm

"*Things changed after Optum took over. Instead of the [naviHealth nPredict] algorithm being a tool that was used to anticipate a length of stay, **it became a tool that you'd better make it happen or there's consequences**.*"

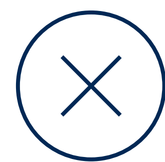
– Former NaviHealth case manager

Potential repercussions:

- CMS says in new memo that AI cannot be sole basis of refusing care
- May put ROI from alternative post-acute care site investments at risk

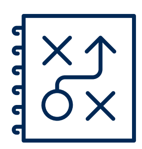
Medicare 2 Midnight Rule/MA plans

Growth in denials and prior authorizations



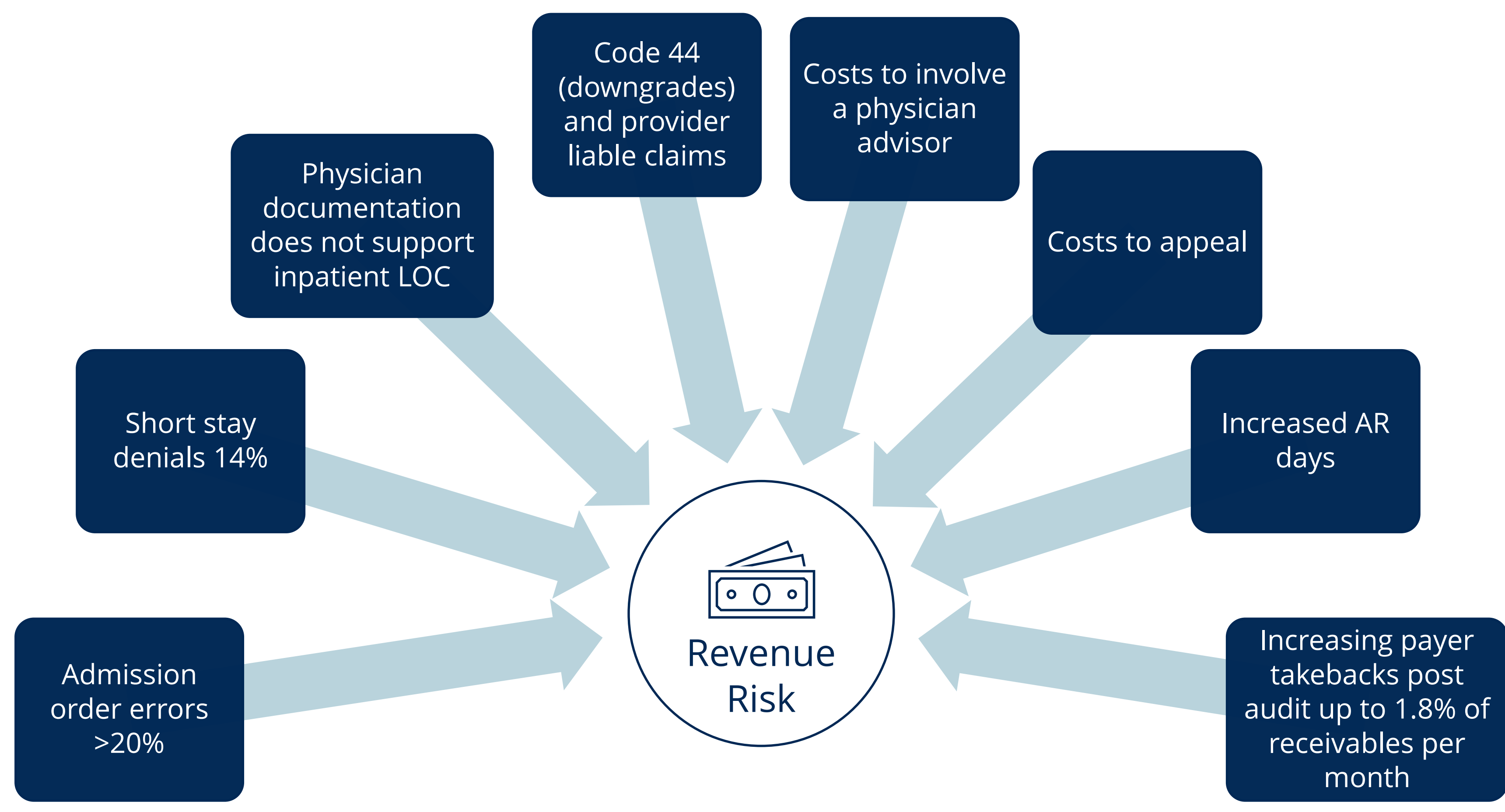
More downgrades

Increased post payment audits



Revenue Risk

Revenue Risk



Potential Solutions- UR

Inconsistent application of the 2 MDN rule

- Payers will use different criteria or apply the 2 MDN rule inappropriately
- Report payer to CMS
- Ensure your UR team is well trained on process and use of evidence-based tools
- Communication with Rev Cycle

Physician documentation

- Implement a medical necessity documentation tool to train your physicians

Potential Solutions- UR/RC

Denials

- Short stays, or downgrades on second day
- Inpatient only procedures
- Establish a robust denials management process
  - P2P, PA program
  - Appeal all claims denied,
  - Use of AI to generate appeal letter
- Reports/tracking
- Root cause analysis, A3 methodology

Potential Solutions- Contracts

Strong contract language

- 100% of FFS rates
- Timely payments/limit scope of denial reviews and post payment audits- types of claims/retro date limit
- How to defend yourself
  - Require provisions requiring payer transparency into how they use AI in the claims review process
  - LOC reviews- require payer to review 5-10% of AI generated denials
- Use evidence-based guidelines- which ones
- Dispute resolution plan in contract

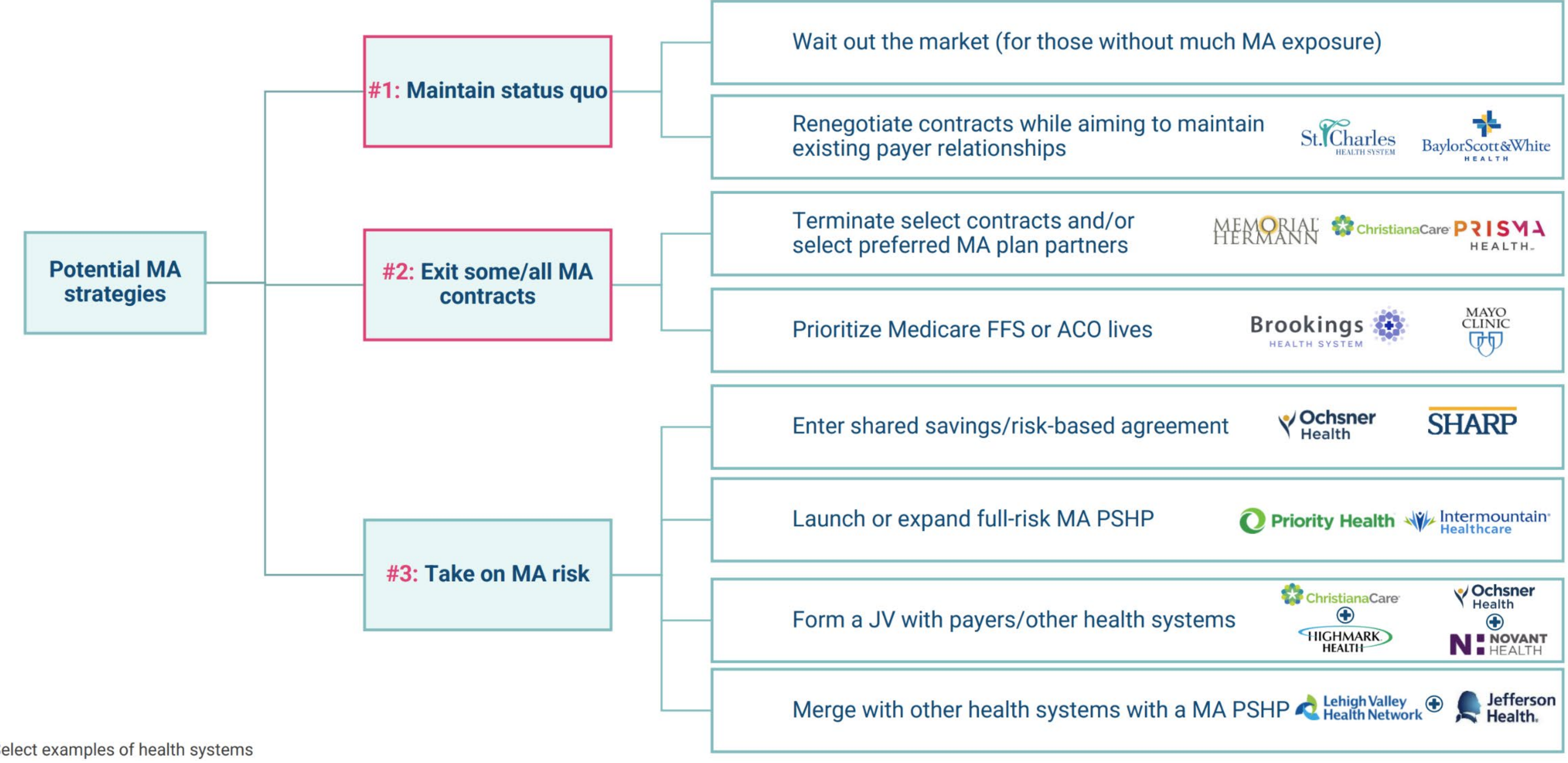
Potential Solutions- MA Contract

Drop MA plan

- Members switch to different more favorable plans
- Could affect volumes
- Marketing attacks
- Impact on patient
- Risk based contract?

Health systems need an active MA strategy

Health systems characteristics and market position dictate the best approach



Note: Select examples of health systems

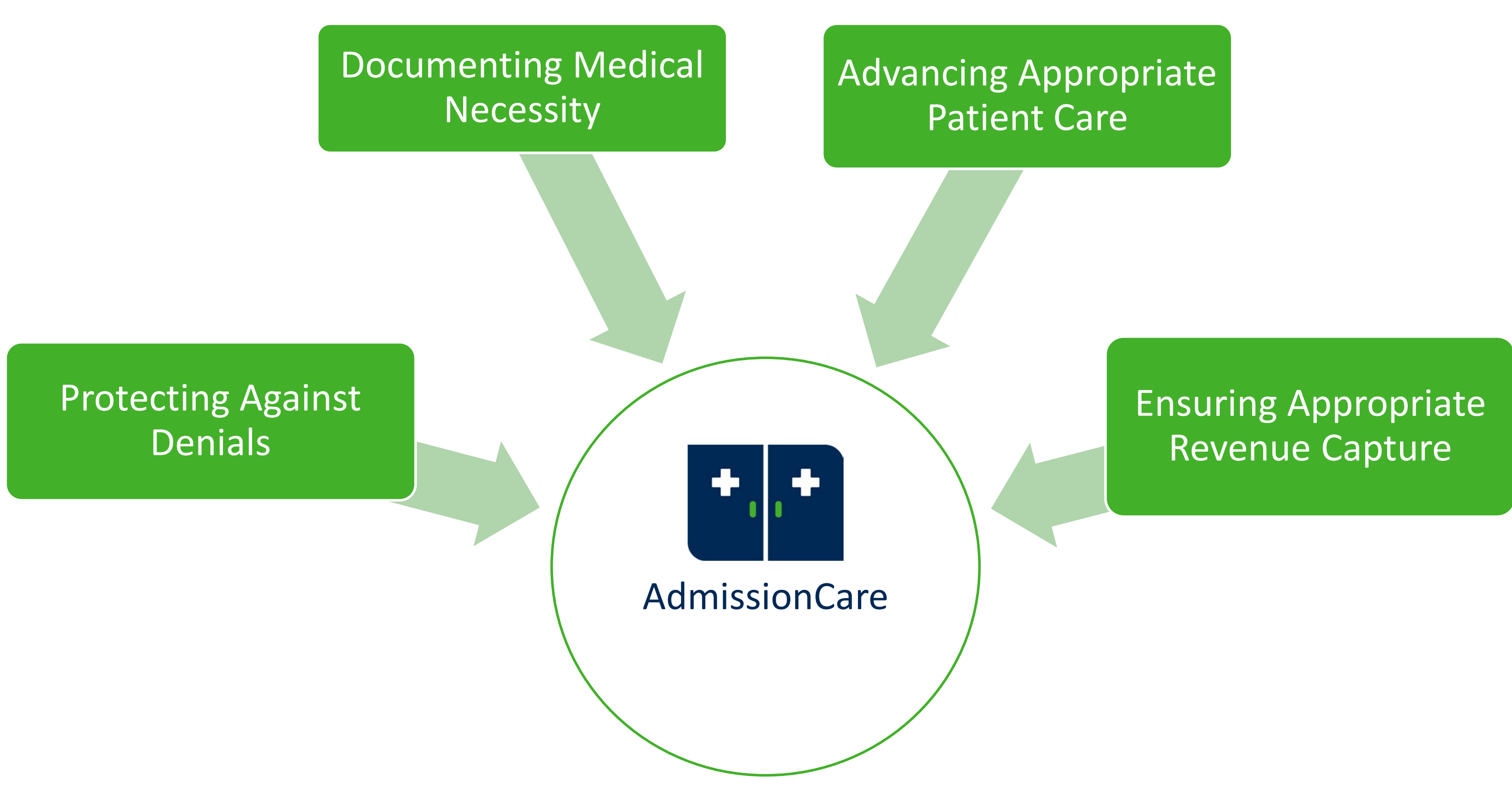
Private & Confidential

A Tech-Enabled Solution

Empowering Clinicians at Point-of-Care

A Tech-Enabled Solution

Empowering Clinicians at Point-of-Care



Defining A New Admission Workflow

"This new workflow allowed us to achieve adoption over hours, rather than months."

AdmissionCare is mandatory for all admissions except elective surgeries.

Clinicians must complete AdmissionCare before entering ADT order.

A Cerner Discern Rule will remind clinicians when placing an ADT order to use AdmissionCare first.

Feedback And Refining Of The Process

Internal physician champions

Explained the "why" to clinicians.

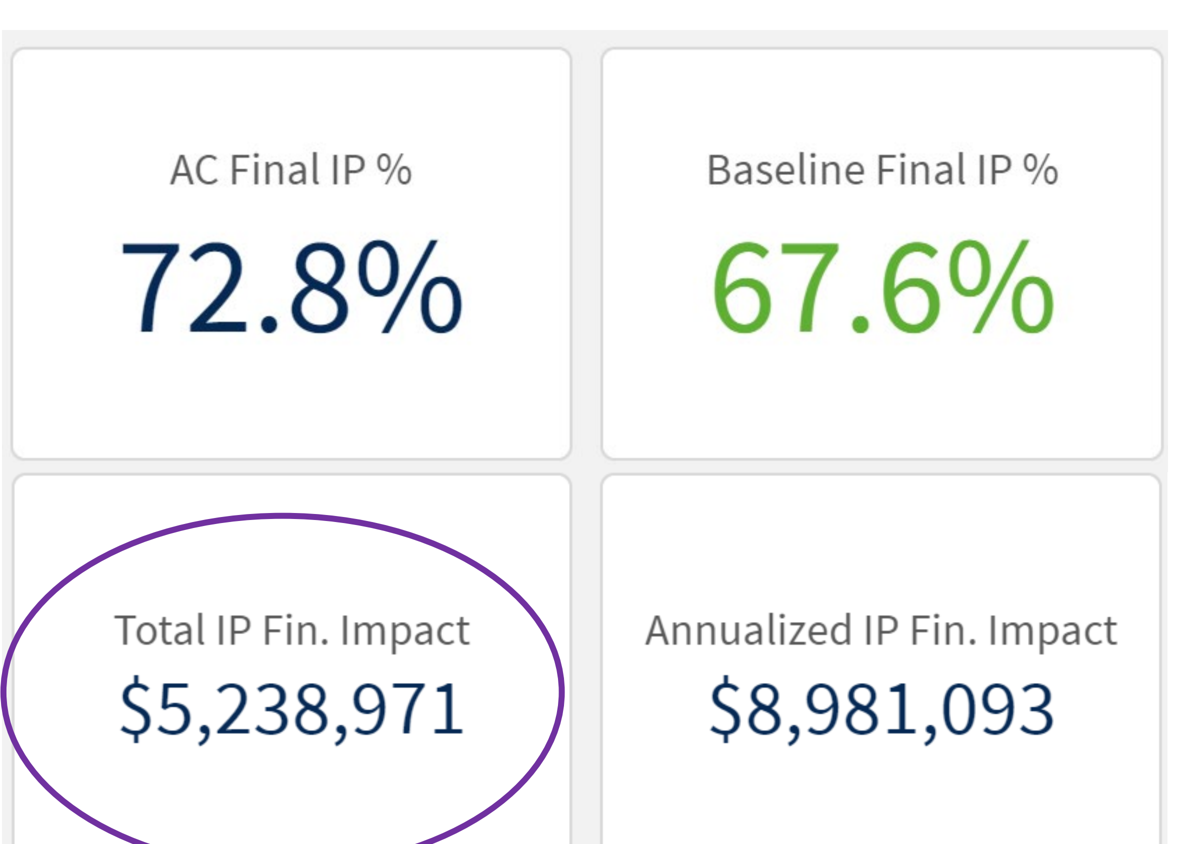
Provides feedback through EvidenceCare proficiency assessments.

- Evaluates admission diagnoses influencing bed status criteria.
- Investigates discrepancies, such as reviewing OBS guidelines but placing an INPT order.
- Integrates revenue cycle guidance for psych, renal dialysis, social admits, etc.

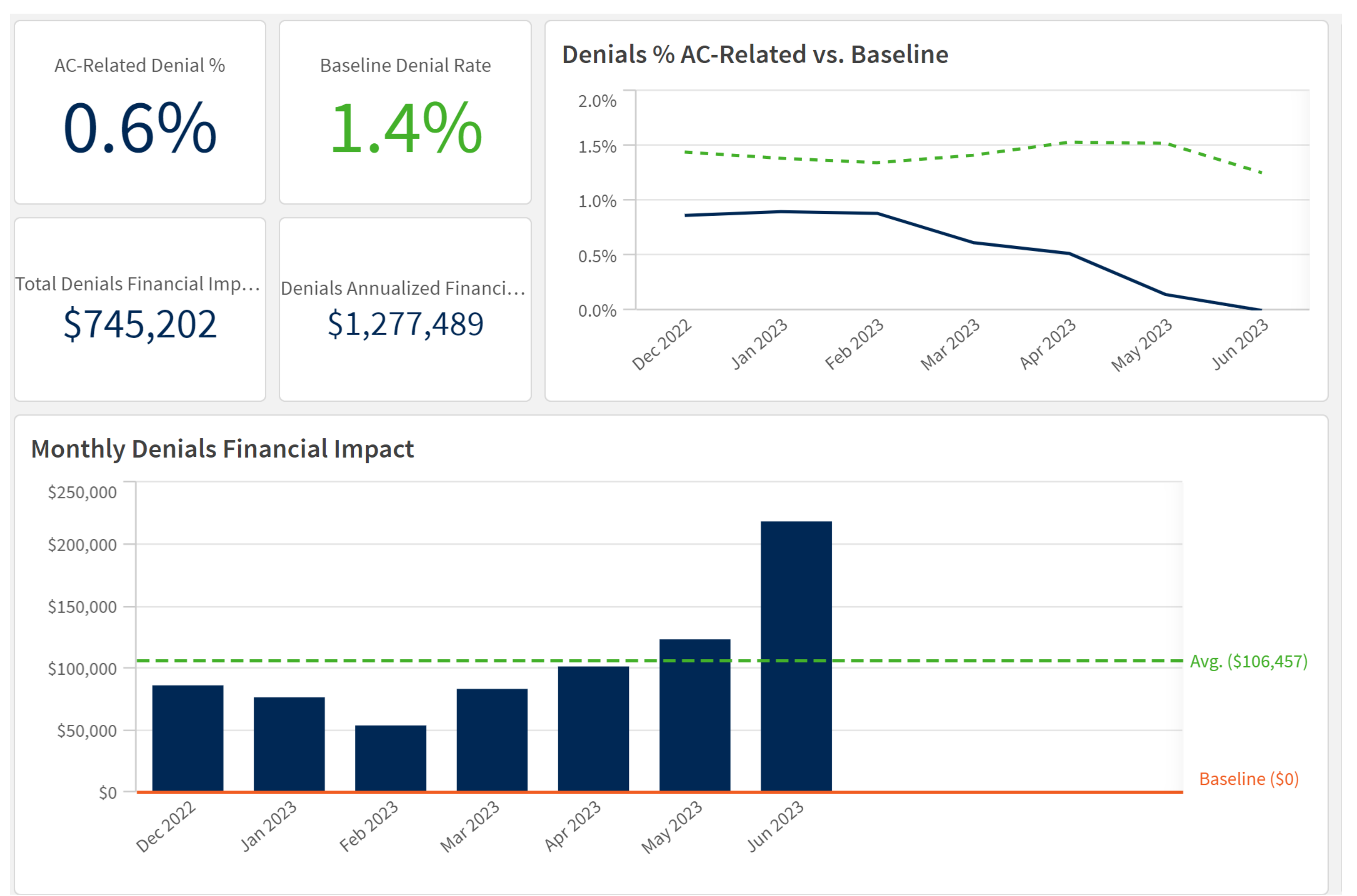
Case Examples
Health system A
Health system B

Health System A -Final INPT %

Dec 2023 – Jun 2023



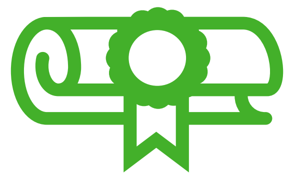
Health System A- Denials



Lessons Learned

Recruit Internal Champions

A dedicated project manager, physician champion and engaged informatics team played vital roles in testing, training, and leading the implementation of AdmissionCare



Education/Change Management

Training sessions emphasizing the "why" behind AdmissionCare to ensure end users understand the value of a new admission process. Including residents, hospitalists, and attendings

Lessons Learned

The Why

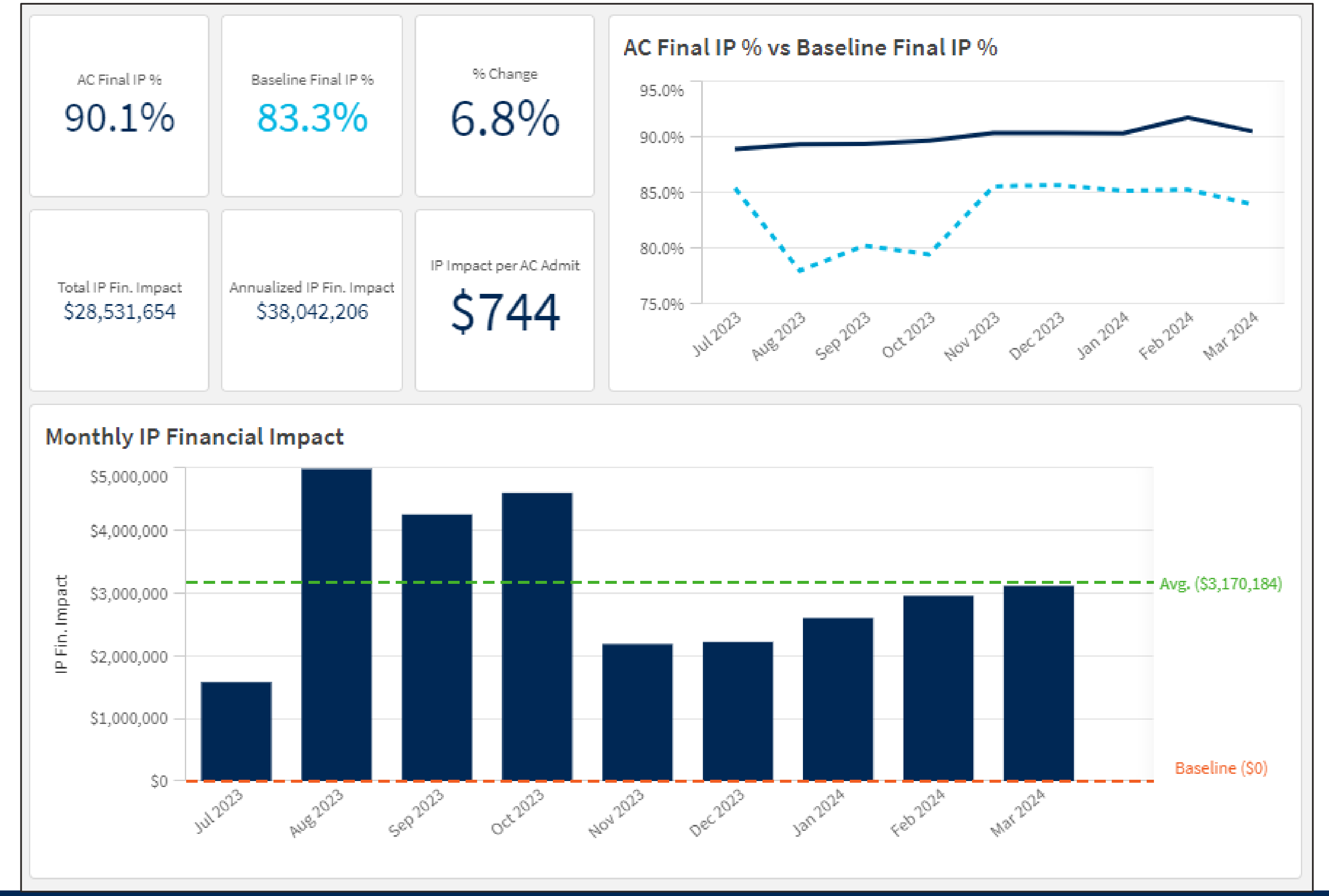
- Physicians receive no education or training on patient status criteria
- Physicians are responsible for placing appropriate bed status orders and have to document payer compliance
- Insurance billing documentation is a different "language or lingo" from physicians' clinical documentation

Error proof workflow

- Involve UR team
- Provide end-user feedback including positive results
- Continuous process improvement
- Train new residents yearly

Health System B- Final INPT

July 23 – March 24: All Facilities



Health System B- Denials

July 23 – March 24: All Facilities

AC-Related Denial %	Baseline Denial %
1.3%	2.9%

Total Denials Financial Imp...	Denials Annualized Financi...
$7,736,680	$10,315,574

Denials % AC-Related vs. Baseline

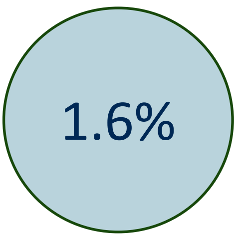
4.0%
3.0%
2.0%
1.0%
0.0%
Jul 2023 Aug 2023 Sep 2023 Oct 2023 Nov 2023 Dec 2023 Jan 2024 Feb 2024 Mar 2024

Monthly Denials Financial Impact

$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
Avg. ($859,631)
Baseline ($0)
Jul 2023 Aug 2023 Sep 2023 Oct 2023 Nov 2023 Dec 2023 Jan 2024 Feb 2024 Mar 2024

Summary by CARC

CARC	AC-Related Denials
Totals	**454**
197	230
39	104
50	104
150	18



Reduction in first pass IP denials on AdmissionCare encounters compared to baseline

Denials reviewed through April remits and metrics will vary over time.

Questions?