Case Management and Revenue Cycle Team Collaboration to Improve Patient and Financial Outcomes

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R1 RCM

In The GREAT Old Days

Doctor orders a service

Patient calls to schedule the service

Hospital performs the service

Everyone bills for the service

Everyone gets paid for the service

Patient placed in hospital

Patient receives care

Everyone gets paid

Today’s Reality

Hospitals overflowing with patients

Burnout at epidemic levels after COVID-19

Distrust of health care due to social media “influencers”

Outpatient access to primary care and specialty care difficult at best

Aging population with little preparation for costs of growing old

US health care system with fragmentation beyond belief

The Epic Battle

Insurance companies with goal of increasing profit margin

Health systems seemingly struggling to get paid so they can stay open and serve community

VS

The Epic Battle

Payers are:

Increasing audits, denials, administrative requirements

Paying bounty hunters to audit old claims and recoup last decade's payments

Deceptive marketing to increase Medicare Advantage market share

Hospitals are:

"Finding" more inpatient admissions

Leading doctors to higher paid diagnoses

Adding high margin services and reducing low margin care

Medicare Advantage – We all Know

PacifiCare of California (PacifiCare) is an MA organization owned by UnitedHealth Group. For calendar year (CY) 2007, PacifiCare had multiple contracts with CMS, including contract H0543, which we refer to as "the contract." Under the contract, CMS paid PacifiCare approximately $3.6 billion to administer health care plans for approximately 344,000 beneficiaries. Our review covered approximately $2.3 billion of the payments that CMS made to PacifiCare on behalf of 188,829 beneficiaries.

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. (This amount represents our point estimate. The confidence interval for this estimate has a lower limit of $288 million and an upper limit of $559 million. See Appendix B.)

Providers are not Fault-free

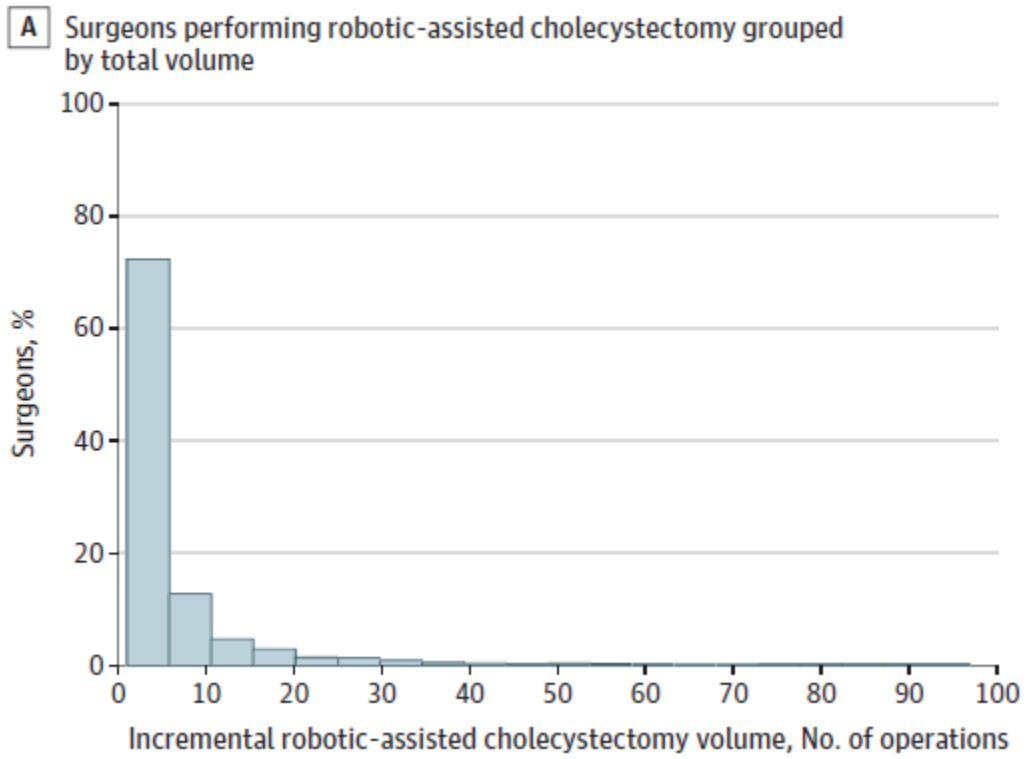
Every hospital purchases a robot

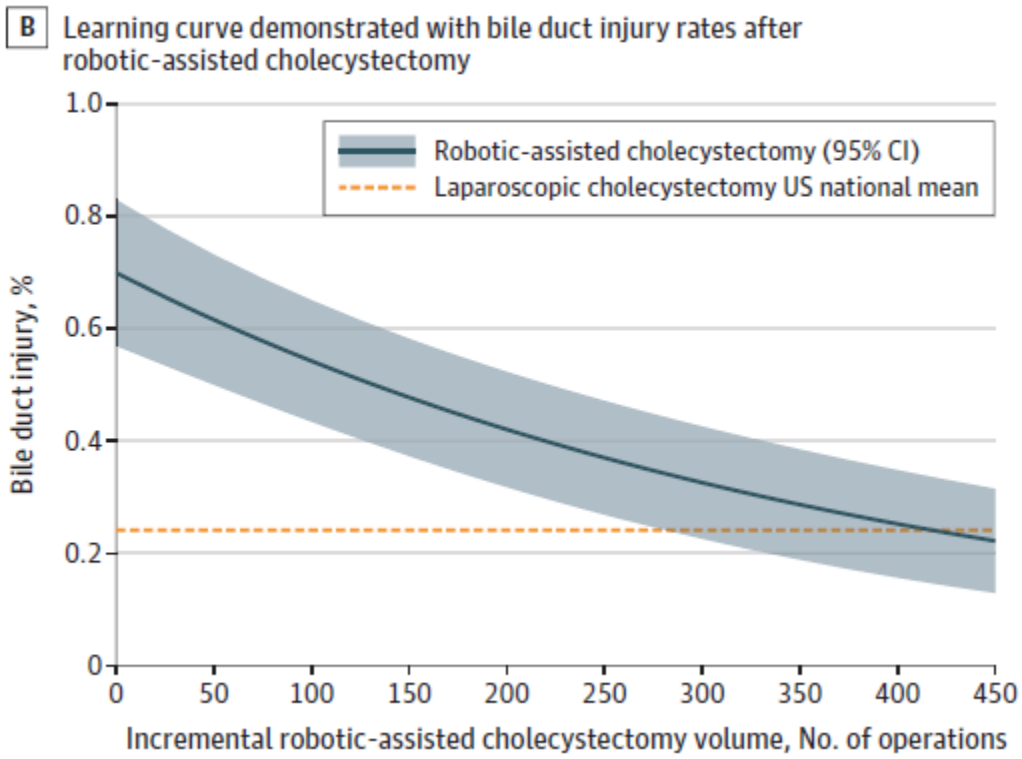
Media attention on high CEO salaries, large endowments and investment income, non-for-profit status but aggressive collection practices

Claims of poverty but build lavish new facilities

Lack of coordination between financial and clinical teams

Learning Curve for Laparoscopic Cholecystectomy





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The Few Ruin it for the Rest

Rockford Physician Arrested on Charge of Health Care Fraud

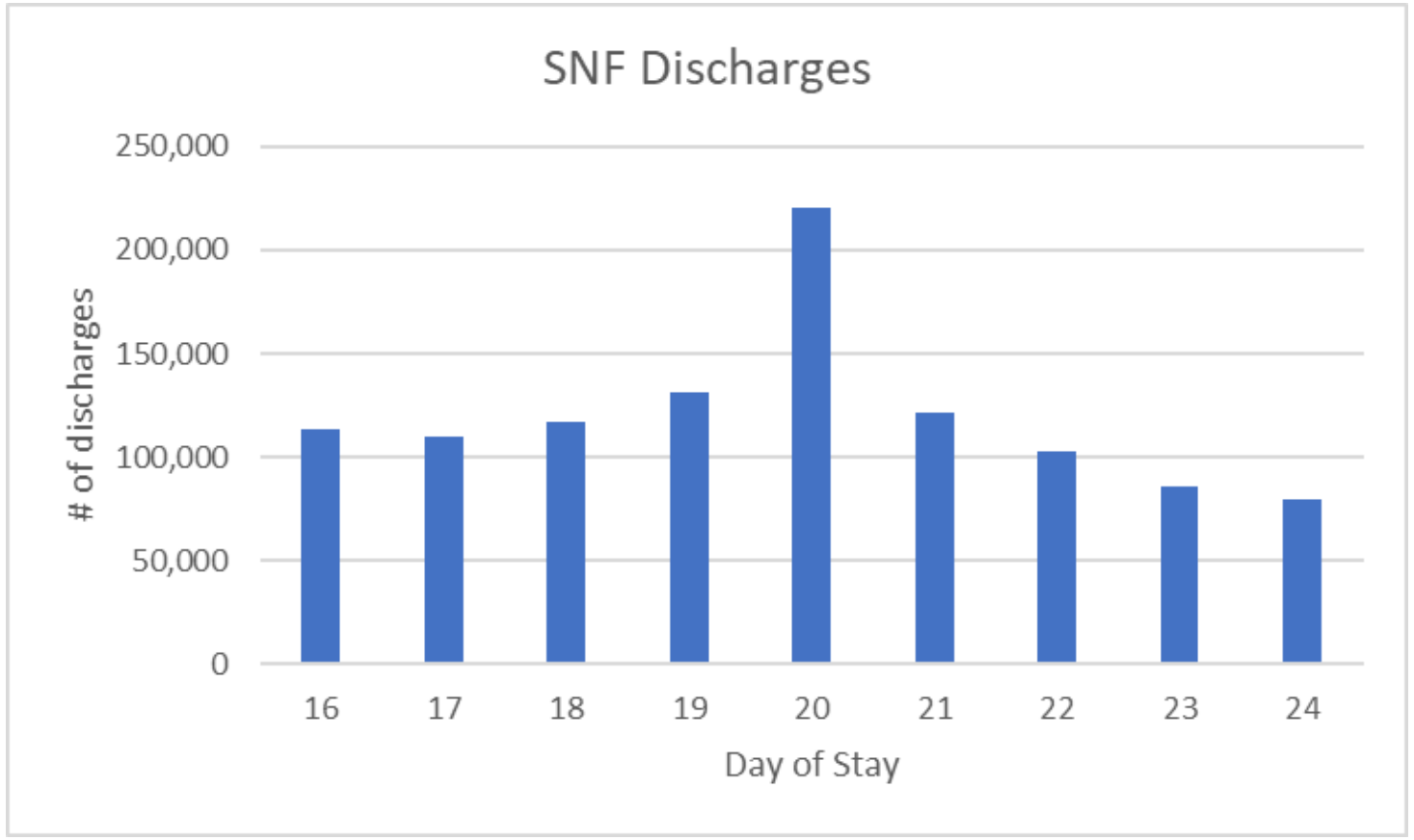
U.S. Attorney's Office — **Northern District of Illinois**

January 25, 2014 — (312) 353-5300

Law enforcement interviewed M.H., and M.H. stated that M.H. had sex with DEHAAN numerous times in approximately 2010 because DEHAAN agreed to prescribe her controlled substances, including Ritalin and Norco. In exchange for the prescribed medications, M.H. had sex with DEHAAN approximately two to three times a month for approximately six months. M.H. stated that on one occasion, DEHAAN performed a breast exam on M.H, but he did not perform any other medical services. According to Medicare billing data, DEHAAN billed, and was paid by Medicare, for the following services for M.H….

- http://www.justice.gov/usao/iln/pr/rockford/2014/pr0125_01a.pdf

Part A SNF Discharges – Random???



Characteristic	16	17	18	19	20	21	22	23	24
Discharges, No.	113 343	109 700	117 186	131 558	220 037	121 339	103 062	85 377	79 305

JAMA Internal Medicine Published Online: May 28, 2019.
doi:10.1001/jamainternmed.2019.1209

LTACH Length of Stay – Random???

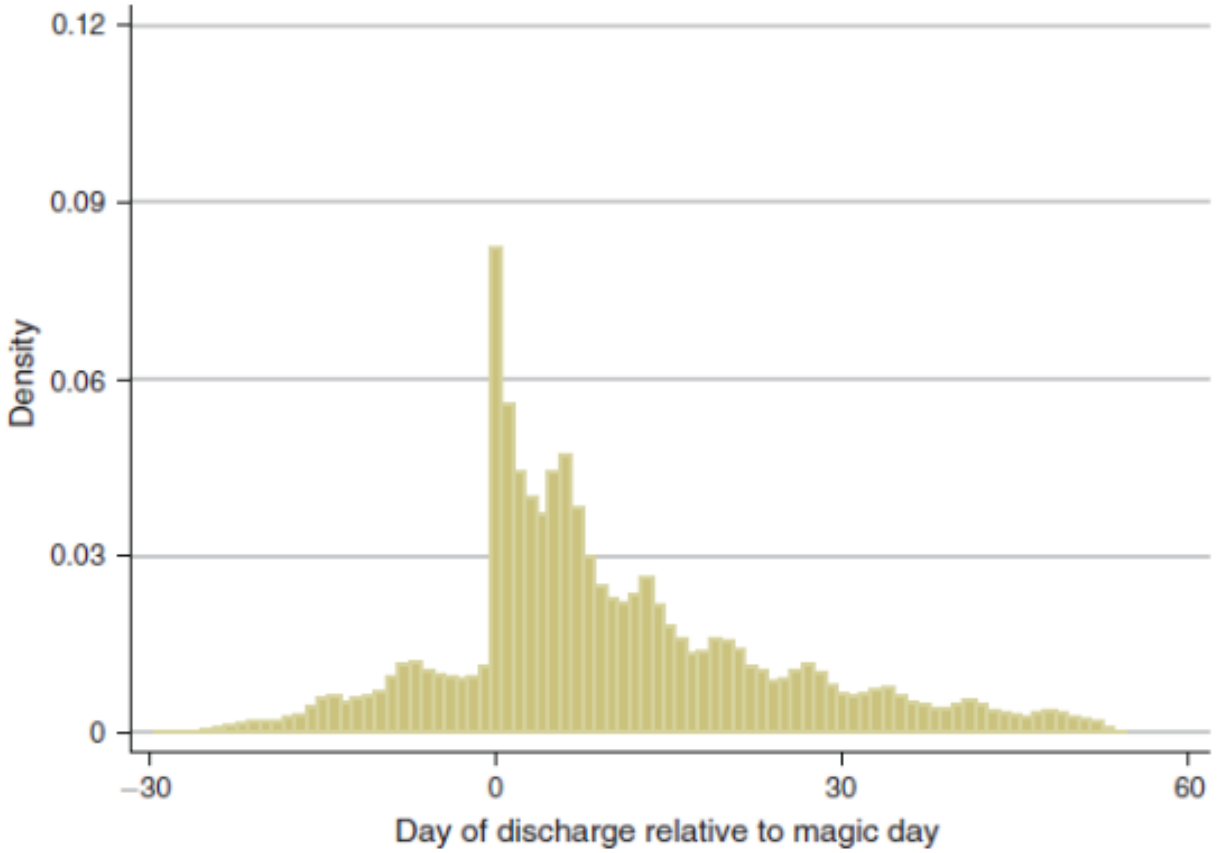


FIGURE 2. DISTRIBUTION OF LENGTH OF STAY RELATIVE TO MAGIC DAY, FY 2004–2013

American Economic Review 2018, 108(11): 3232–3265

Where is there Revenue is at Risk?

- Ambulatory Services
  - Physician Practices
    - E&M guideline changes not disseminated to docs
  - Ambulatory Surgery Centers
    - Shifting high margin care to ASC
      - CMS to start prior auth demonstration for ASCs in 2025
  - Infusion Clinic/Oncology Clinic
    - New drug costs, new indications, complex payment
      - Audits focusing on drug choice, sequencing, clinical monitoring
  - Advanced Imaging
    - Scan interval, diagnostic v screening

Keytruda for Cancer

Keytruda® (Pembrolizumab)	Per the Food and Drug Administration (FDA) label, Keytruda® is a programmed death receptor-1 (PD-L1)-blocking antibody with multiple approved indications. Careful review of the FDA label is warranted to ensure all prescribing requirements are supported in the documentation submitted for review. When submitting documentation for review of Keytruda® claims, ensure the documentation clearly supports the patient's diagnosis, pathology information, any prior or current treatments being completed, and review the FDA label for that indication to determine if any additional documentation is required. Examples of required additional documentation to support include, but are not limited to: • Prior lines of anti-cancer drugs administered prior to starting Keytruda® • Keytruda® administered in combination with another medication • Tumor expressions and biomarker testing

The list price for each indicated dose of KEYTRUDA when given every 3 weeks is $11,337.36. The list price for each indicated dose of KEYTRUDA when given every 6 weeks is $22,674.72.* Most people will not pay the list price, although it may have an impact on your out-of-pocket costs. The amount you pay will depend on many factors, including your insurance situation.

Keytruda for Cancer

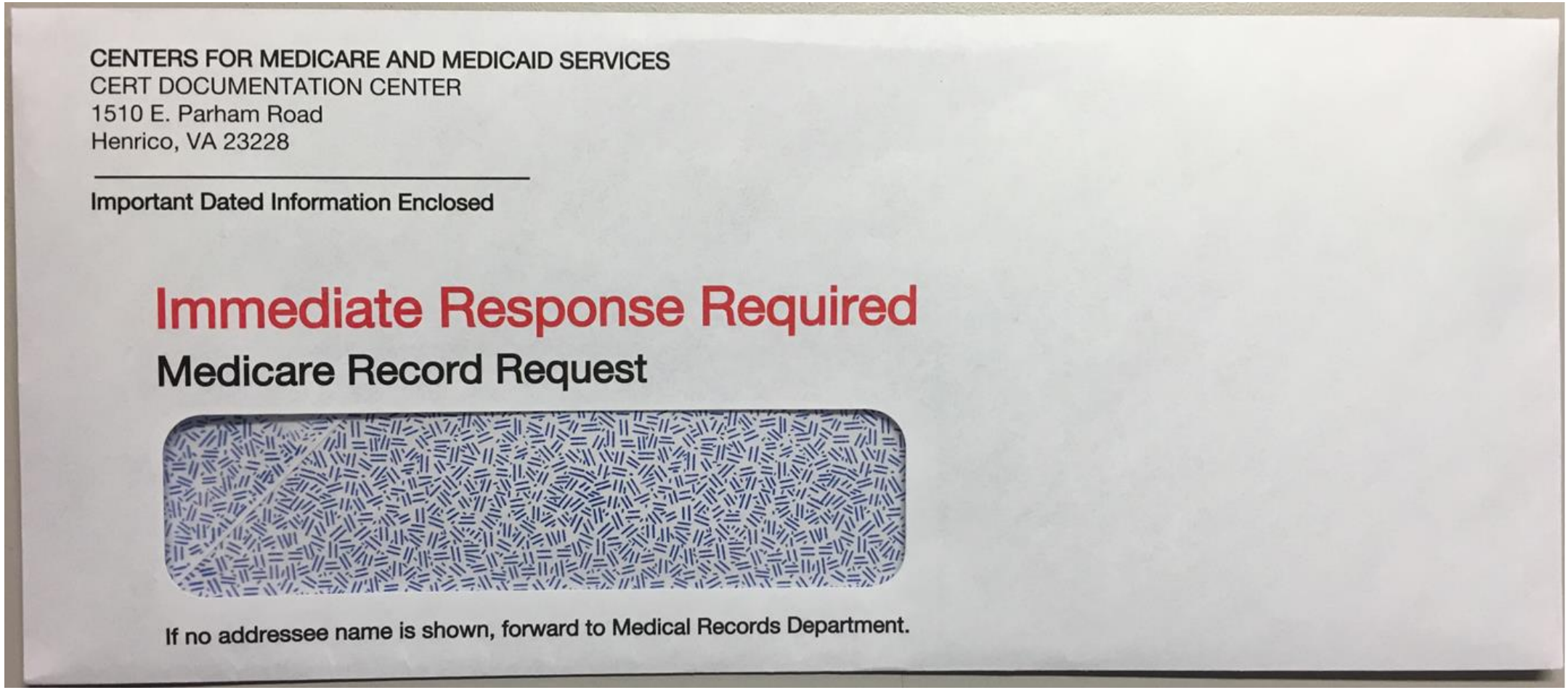
Summary of Findings

Since the initiation of the review, 150 claims were reviewed from May 3, 2021 through November 22, 2021 with an overall claim error rate of 25.3% and payment error rate of 20.6%. The breakdown of those findings are as follows:

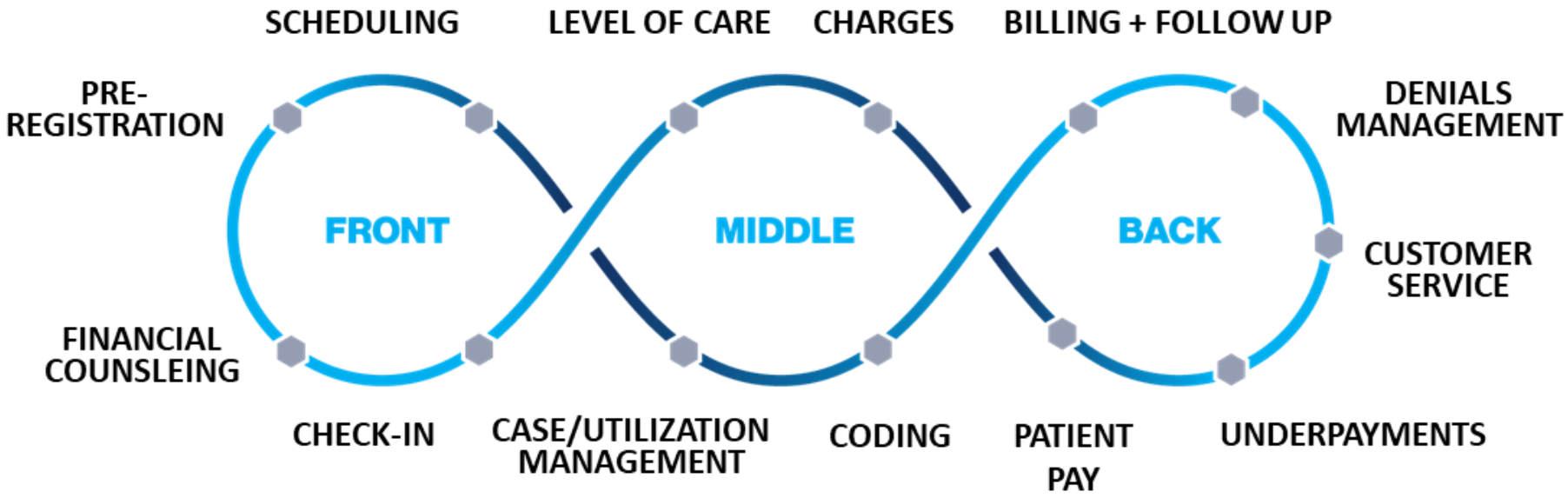
- 112 claims were accepted
- 38 claims were denied in full for the following reasons:
  - Documentation did not support medical necessity of pembrolizumab/Keytruda.
  - Documentation did not support the medication was administered per FDA guidelines.
  - No documentation was received in response to ADR.

https://med.noridianmedicare.com/web/jea/cert-reviews/post-pay-reviews/pembrolizumab-service-specific-post-payment-final-findings

No Documentation Received --- Really?



Health Care is Complicated



The Chargemaster

Proper name= Charge Description Master - CDM

“Retail” prices for every service provided

Includes HCPCS/CPT code, revenue code, price, dept code, etc.

Requires updating with every regulation update

Must be updated with any new service, new device, new drug offered in hospital

Must decide what is bundled into charge and what is separately billed

Every hospital has a cost to charge ratio (CCR) that CMS applies to determine true cost to provide care.

Chargemaster cost ≠ what hospital gets paid

Chargemaster from Unnamed Hospital

Evaluation & Management Services (CPT Codes 99201-99499)	2023 CPT Code	Average Charge
Emergency Room Visit (straightforward)	99282	$5,043.32
Emergency Room Visit (low level)	99283	$7,758.95
Emergency Room Visit (moderate level)	99284	$11,146.40
Emergency Room Visit (high level)	99285	$12,315.80
Outpatient Visit, established patient, 20-29 minutes	99213	$511.60
Laboratory & Pathology Services (CPT Codes 80047-89398)	**2023 CPT Code**	**Average Charge**
Basic Metabolic Panel	80048	$984.41
Blood Gas Analysis, including 02 saturation	82805	n/a
Complete Blood Count, automated	85027	$438.05
Complete Blood Count, with differential WBC, automated	85025	$802.05
Comprehensive Metabolic Panel	80053	$1,694.52
Creatine Kinase (CK), (CPK), Total	82550	$688.12
Lipid Panel	80061	$949.84

CAR-T – The Perfect Storm – Clinical v Financial

Chimeric Antigen Receptor – Treatment

Amazing treatment for cancers but costly!

MS-DRG	FY 2024 Final Post-Acute DRG	FY 2024 Final Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights - Before Cap	Weights - 10% Cap Applied	Geometric mean LOS	Arithmetic mean LOS
018	No	No	PRE	MED	CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHE	36.8427	36.8427	12.9	15.1
019	No	No	PRE	SURG	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIA	7.9935	7.9935	11.6	14.0

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	Adjusted Beneficiary Copayment
Q2056	Ciltacabtagene car-pos t	G	9498		$497,024.646		$99,404.93	$1,600.00
Q2042	Tisagenlecleucel car-pos t	K	9194		$484,623.489		$96,924.70	$1,600.00
Q2055	Idecabtagene vicleucel car	G	9422		$483,453.660		$96,690.74	$1,600.00
Q2054	Lisocabtagene mara car pos t	G	9413		$473,458.426		$94,691.69	$1,600.00
Q2053	Brexucabtagene car pos t	G	9391		$449,440.000		$89,888.00	$1,600.00
Q2041	Axicabtagene ciloleucel car+	K	9035		$449,341.851		$89,868.38	$1,600.00

SI=G – paid separately; SI=K – paid separately unless bundled

CAR-T – The Perfect Storm – Clinical v Financial

When CAR-T program starts, chargemaster pricing must be set

Two hospitals start program, both have CCR of 0.25

Hospital A sets CAR-T CDM price as $489,979

Hospital B sets price at $1,781,740

CAR-T – The Perfect Storm – Clinical v Financial

CAR-T infusion administered in oncology clinic. Patient monitored 4 hours then discharged. At home patient develops fever and rigors, goes to ED. Mild cytokine release diagnosed, placed Observation, discharged next day.

Observation C-APC applies, CAR-T "bundled" into APC payment but outpatient outlier payment kicks in

	Hospital A	Hospital B
Estimated Case Cost	$130,412.38	$453,352.75
Observation C-APC Payment	$2,439.32	$2,439.32
2023 Outlier Fixed Loss Threshold	$8,350.00	$8,350.00
Cost > 1.75 times the APC Payment ($2439.32 for CY 2023)	$4,268.81	$4,268.81
Threshold criteria	$10,789.32	$10,789.32
Both criteria met (Y/N)	Y	Y
Hospital A outlier payment	$63,071.78	
Hospital B outlier payment		$224,541.97
Total APC Payment	$65,511.10	$226,981.29

What Does CAR-T Pay as Inpatient?

C-APC 8011 if Outpatient with Observation

DRG 018 if admitted inpatient

	payment from Medicare	
CAR-T charge	DRG 018	C-APC 8011
$1,781,740	$472,843	$226,981
$489,979	$265,787	$65,511

CMS payment for CAR-T makes no sense at all. But we need to ensure proper pricing to get paid what is available.

And cell collection payment is another big mess.

Revenue at Risk

- Hospital Services
  - ED – Final Dx v presenting Dx
    - Payer use of proprietary programs to assign codes
  - Observation – payment < actual cost of care
    - 7% increase for 2024, 1.8% increase for 2025
  - Inpatient efficiencies, better outpatient treatments– shorter LOS = fewer inpatients
  - LTACH – no payer wants to approve
    - Must establish medical necessity for specialty care
  - SNF/Inpt Rehab – why can’t they go home/to SNF?
    - How is your documentation for need for SNF/IRF?

One Patient’s Journey

Mrs. Smith – 76-yr-old female with right sided weakness and lethargy, called 911, no family with her

“Stroke code” called, patient immediately taken back to trauma bay

ED doc sees patient, CT scan with small hemorrhage

ED – The Hospital's Front Door

Constant pressure from every side

- Accurate Registration v. get them in a bed
  - What is Mrs. Smith's actual coverage?
- Faster throughput v. complete evaluation
  - Review your short Obs patients – was Obs even needed?
- Patient satisfaction v. doing what is indicated

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Conclusion In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Easier Way to Improve Press-Ganey Scores

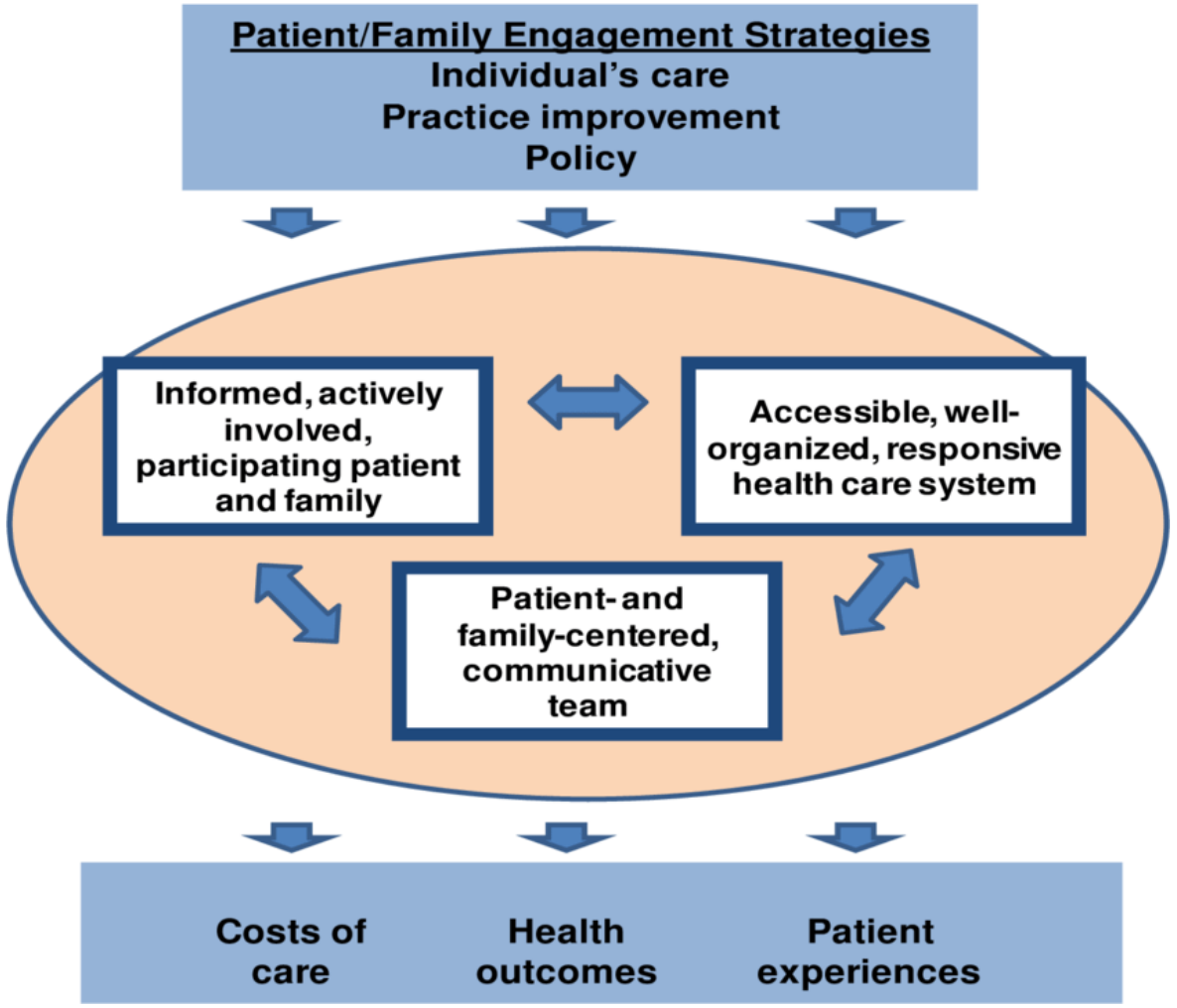
The Influence of an Unexpected Symbolic Gift on Postoperative Arthroplasty Patients' Press Ganey Scores

Jonathan J. Lee, MD, Allison R. Mitchell, MD, James I. Huddleston III, MD, Stuart B. Goodman, MD, PhD, William J. Maloney, MD, Derek F. Amanatullah, MD, PhD *

Department of Orthopaedic Surgery, Stanford Medicine, Redwood City, California

It works but is it an illegal inducement? Ask compliance first!

Patient Satisfaction is Dangerous – Engage Patients!



“Admission Avoidance” in ED

- ED case management/SW: Ideally 24/7/365.

- CM: Arrange alternative care directly from ED
  - SNF – MA coverage, Hospital fund, patient pays
  - Acute rehab; Assisted living; Psych hospital
  - Family; Home; Home health services

  - Develop relationships ahead of time
    - Plan for the 2 am patient with nowhere to go – ED SWAT team

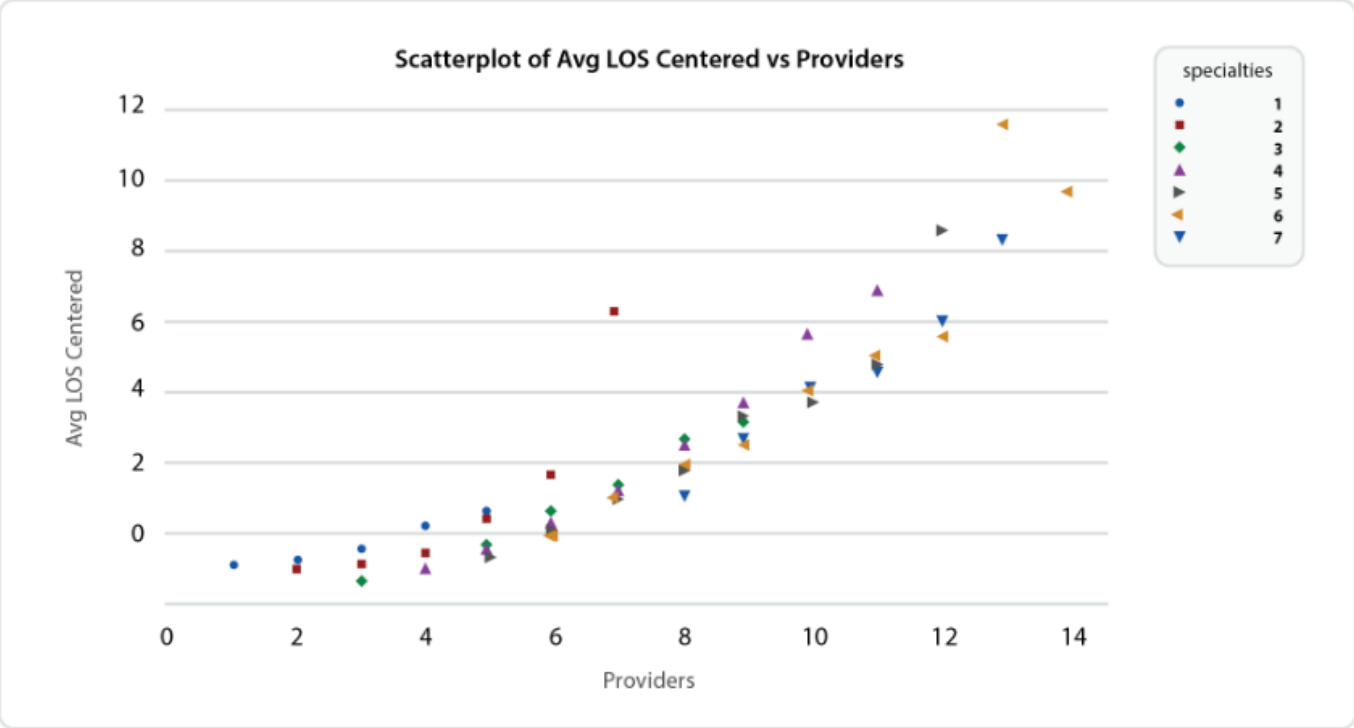
Mrs. Smith is Admitted

Patient arrives at ICU

Admitted to Hospitalist on call

Stroke care plan initiated

Consultations with Neurosurgery, Neurology, Cardiology



https://illumicare.com/ereport-2/

When Hospital Care is Needed

UR must screen for proper admission status

- First level review with MCG/IQ
- Second level review with Physician Advisor/Physician Advisory Service

Notify payer if applicable

- Hospitals open 24/7 but insurers open 10/5
- Miss notification- technical denial, can’t appeal

It’s Not Enough…

for the contract to specify the reimbursement for a service if the contract never lets you bill for that service.

Case managers/physician advisors see the daily obstacles. Involve them in the contract review and discussions.

You also have to be able to not only collect the money but also keep the money.

Get data on denials – was it approved concurrently then denied on retrospective audit?

Notification v. Authorization

Can a payer deny a claim for an admission when proper notification was made?

Can a payer retro-deny when they do concurrent review thru your EMR?

Can a payer deny a claim for an admission when notification could not be made due to payer factors?

What Status?

Admission v. Observation

- 2 Midnight Rule for Medicare/MA Plans
- Unknown rules for many plans
- Do commercial contracts specify admission rules? If they don’t, they should!

- Meets IQ IN but goes home after one day?
  - Deny- did not meet 2 MN Rule
- Fails IQ IN but requires over 2 MN?
  - Deny- did not pass criteria

The Two Midnight Benchmark

Fee for service Medicare/Medicare Advantage

- If the patient requires hospital care beyond the second midnight, you should admit them as inpatient.
- If the patient does not require hospital care, find out why they are staying.
- Caveat- convenience/delay midnights don’t count

What to Do with Convenience?

Quantify and Qualify

- How many convenience days?
- Why did they happen?
  - Patient factors, physician factors, hospital factors, payer factors
  - HCPCS A9270, rev code 0760 for “custodial care” - outpatients
  - Occurrence span code 74 for inpatients

Decide which can be fixed

- Should we use ABN/HINNs for “it’s dark” patients?
- Should we offer stress tests/MRI on Sundays?
- Should we talk to SNFs about accepting patients later?

Remember

There is no optimal observation to inpatient conversion rate!!!!

You can’t admit as inpatient a patient who should have gone home from the ED.

You can’t admit as inpatient the patient whose spouse does not drive in the dark.

KPI WARNING -- More inpatients will mean a lower CMI!

What is done in the Hospital?

The WIGS Syndrome

Address every finding completely prior to discharge.

~15% of ED patients get a CT scan

~25% of those CT scans have an incidental finding

Doctors feel compelled to evaluate every finding

What is done in the Hospital?

While you are here, let's check…

Most time in the hospital is spent doing nothing.

Let's get that…MRI, mammogram, colonoscopy

Let's call all your specialists!

- Recruit your nurses as spies – they know the ultrasound can wait

What is done in the Hospital?

New treatments and technology abounds

Do you consider these factors?

- FDA/CMS/Insurance approvals
- Medical Necessity, Appropriate Use Guidelines
- Equipment costs- fixed and per procedure
- Staff training
- Reimbursement- DRG / APC / fee schedule
- Precertification requirements
- Expertise of physicians

Before you offer it, find out if you'll get paid for it

Where does Mrs. Smith Belong?

ICU- 1:2 nursing, most technology intensive, most patient movement restrictive

Telemetry- higher RN:pt ratio, pt still wired- comforts MD but restricts patient, massively overused

Med/surg- no telemetry, patients free to move about, lowest cost for payers

Do contracts pay variable rates by unit? Are there criteria for use of each unit? Does anyone know those exist?

Is this addressed on multidisciplinary rounds? Do we even have rounds?

How long to stay in the Hospital?

“The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care.”

2014 IPPS Final Rule, p. 50945

We need to ask this question on every day of every hospital stay- “why is the patient still in the hospital?”

How Long to Stay in Hospital?

DRG payment- want to optimize LOS- move to next LOC when stable, both in hospital and discharge

Per diem/% of charges- want to ensure every day is medically necessary

- Approve day 1-4, 7, deny day 5, 6
- Need notes beyond “stable, CPM”

Determining Length of Stay

GMLOS- Mean LOS established by Medicare per DRG

- Requires determining a concurrent working DRG
- Serves as a guide, not a red line
- Actionable data requires a large volume of cases – not one/two

MCG Care Guidelines- Goal LOS

- assumes optimal recovery, decision making, and care

Post-Discharge Issues

Pharmacy Benefit Managers, Medicare D Plan

- Formulary restrictions, step therapy
- Pre-authorizations

Follow up testing issues

- Who orders test?
- Who follows up on results?- “Not my patient” syndrome

Readmissions

Medicare- no pay if same day, same diagnosis

- QIO may review and determine to be preventable

MA Plans- make up their own rules

- “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.”

CMS aware of MA games but not ready to act on it

Elective Services

Know your authorization requirements

- Medicare now requiring prior auth for select procedures

Nothing happens without an authorization

- Who is responsible for pre-auth? Provider/Hospital?
- What if procedure changes?

What happens if service provided without auth?

- Can auth be obtained post-test?
- Do you have procedure to get that done?

Surgery- What status?

Medicare/MA plans - Inpatient Only List

Commercial insurers - whatever they want

It’s not about the status, it’s about the payment!

Sort out status prior to surgery and get the right order

Mrs. Smith’s Hospital Course

Admitted as FFS Medicare, actually had Medicare Advantage

UR team had to fight MA plan to get inpatient approved since > 24 hours passed

MA plan took 72 hours to evaluate IRF request and denied it

MA plan took 72 hours to approve SNF

Contracted SNF was 2 star, family refused transfer

3 days spent setting up home care, DME with MA providers

Contracting Take Aways

Hide the rates but let lots of people read it!
No changes via website- must be in writing and signed by you
ED E&M visit codes will not be adjusted by payer
No bundling charges unless it is in contract
Prior auth means pay the claim unless valid fraud
Readmissions paid in full unless hospital at fault
Additional per diem to be paid for every day awaiting approval for care
Set limit on record request volume
Two Midnight rule for all patients
Clinical validation definitions must adhere to professional society guidelines

Summary

Case managers want to provide efficient care

Finance wants to get paid for the services provided by the hospital

Doctors want…well, I am not sure…

Understanding each other’s struggles benefits both

You can’t win the game if you don’t know the rules

Thank you.

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