BATTLEFIELD
REVENUE CYCLE

Strategies to Avoid Insurance Barriers to Payment

Presented by

Chris Loftin
System Director, Regional Business Office
Baptist Memorial Health Care Corporation

Battle Plans

- Get to know your fellow Warriors
- Get to know your Adversaries
- Understand your current environment
- Understand the environment of your Adversaries
- Get to know the Battlefield
- Understand strategies to avoid barriers on the Battlefield
- Develop your own strategies and win on the Battlefield

BATTLEFIELD
REVENUE CYCLE

Opening Questions

www.menti.com

Mentimeter

BATTLEFIELD REVENUE CYCLE

Average Claim Denial Rate for Large Hospitals

Geographic Region	Denial Rate
• Northern Plains	10.58%
• South Central	8.88%
• Midwest	7.89%
• Southern Plains	7.72%
• Pacific	7.58%
• Northeast	7.21%
• Mountain	7.18%
• Southeast	7.14%

Source: Becker's Hospital Review, as reported by Forbes
https://www.beckershospitalreview.com/finance/average-claim-denial-rate-for-large-hospitals-by-region.html

BATTLEFIELD REVENUE CYCLE

Battlefield Warriors

Audience Organizational Analysis

www.menti.com

Mentimeter

BATTLEFIELD REVENUE CYCLE

Battlefield Warriors

Audience Role Analysis

www.menti.com

Mentimeter

BATTLEFIELD REVENUE CYCLE

Battlefield Adversaries

Insurance Companies

BATTLEFIELD
REVENUE CYCLE

Largest U.S. Insurance Companies

Insurance	2017 revenue	2018 revenue	2019 revenue	2020 revenue	Revenue increase from 2017 to 2020	% Revenue Increase (2017 to 2020)	2017 net income	2018 net income	2019 net income	2020 net income	Net Income increase from 2017 to 2020	% Net Income Increase (2017 to 2020)
United Healthcare	$201.16 billion	$226.25 billion	$242.16 billion	$257.14 billion	$55.98 billion	27.83%	$10.56 billion	$11.99 billion	$13.84 billion	$15.40 billion	$4.84 billion	45.83%
Cigna	$41.81 billion	$48.65 billion	$153.57 billion	$160.40 billion	$118.59 billion	283.64%	$2.27 billion	$2.64 billion	$5.10 billion	$8.46 billion	$6.19 billion	272.69%
Anthem	$90.04 billion	$92.10 billion	$104.21 billion	$121.87 billion	$31.83 billion	35.35%	$3.84 billion	$3.75 billion	$4.81 billion	$4.57 billion	$0.73 billion	19.01%
Humana	$53.77 billion	$56.91 billion	$64.89 billion	$77.16 billion	$23.39 billion	43.50%	$2.45 billion	$1.68 billion	$2.71 billion	$3.37 billion	$920 million	37.55%
Centene	$48.38 billion	$60.12 billion	$74.64 billion	$111.12 billion	$62.74 billion	129.68%	$828 million	$900 million	$1.32 billion	$1.81 billion	$982 million	118.60%
Molina	$19.88 billion	$18.89 billion	$16.83 billion	$19.42 billion	$-0.46 billion	-2.31%	$-512 million (loss)	$707 million	$737 million	$673 million	$1.19 billion	231.45%
TOTALS	**$455.04 billion**	**$502.92 billion**	**$656.30 billion**	**$747.11 billion**	**$292.07 billion**	**64.19%**	**$19.44 billion**	**$21.67 billion**	**$28.52 billion**	**$34.28 billion**	**$14.84 billion**	**76.39%**

BATTLEFIELD
REVENUE CYCLE

Current Environment

Hospitals

BATTLEFIELD
REVENUE CYCLE

Hospital Revenue Cycle

BATTLEFIELD
REVENUE CYCLE

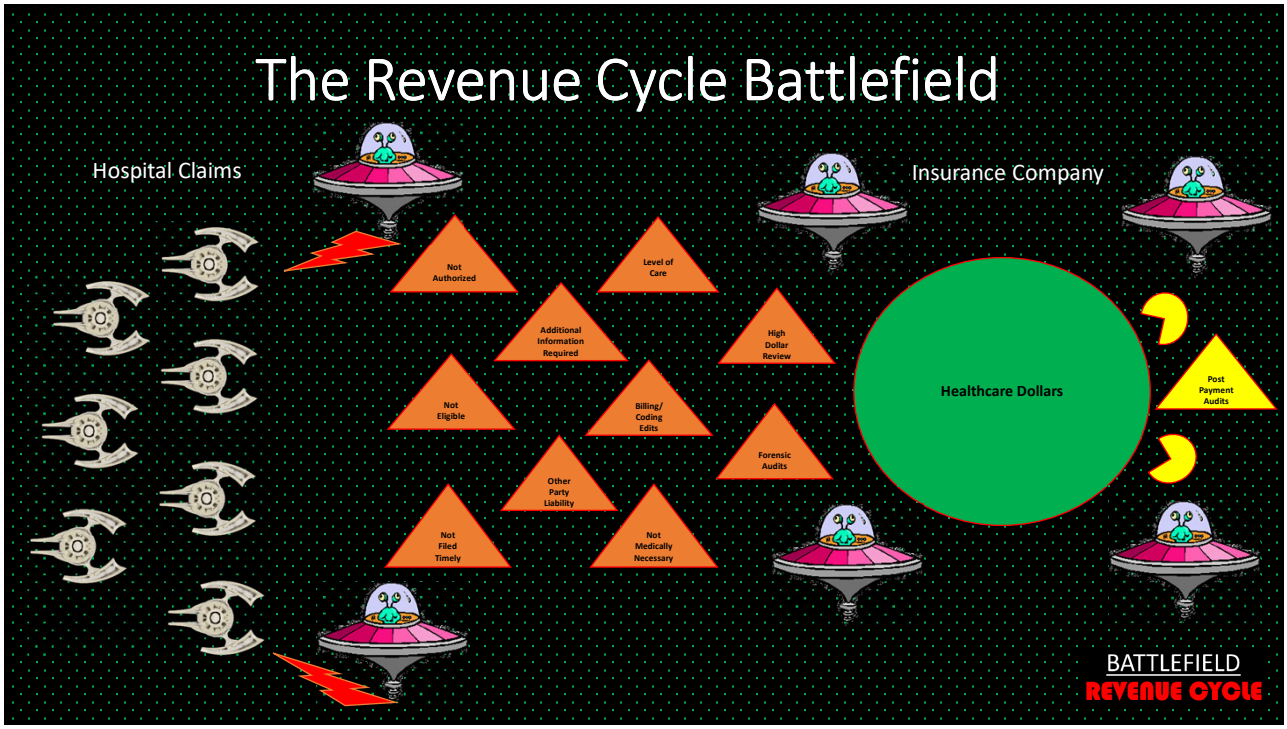
Current Environment

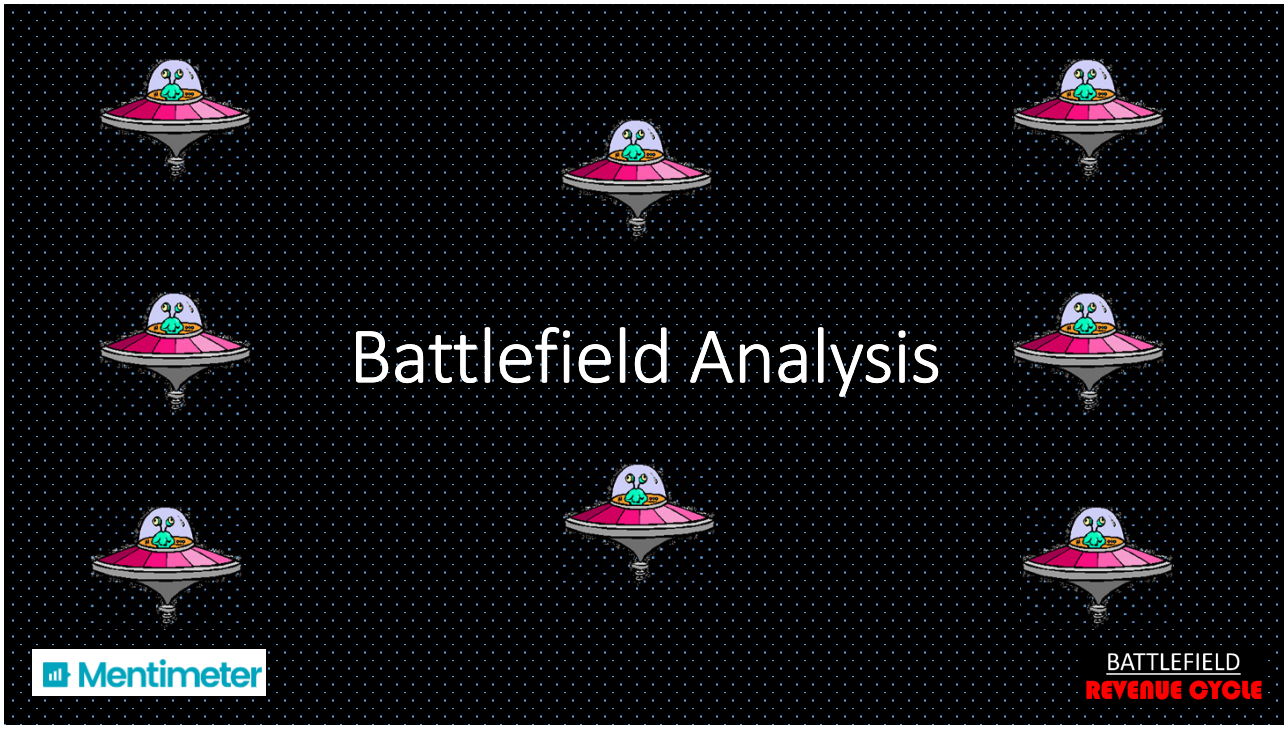
Insurance Company

BATTLEFIELD
REVENUE CYCLE

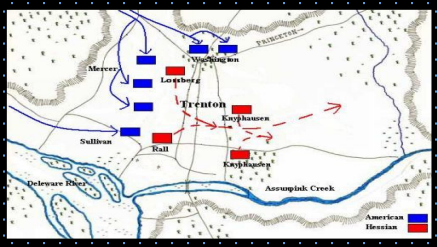
Insurance Company

BATTLEFIELD
REVENUE CYCLE

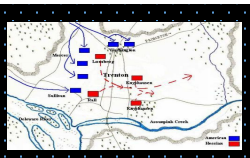

The Revenue Cycle Battlefield
Hospital Claims
Insurance Company
Not Authorized
Level of Care
Additional Information Required
High Dollar Review
Not Eligible
Billing/ Coding Edits
Forensic Audits
Other Party Liability
Not Filed Timely
Not Medically Necessary
Healthcare Dollars
Post Payment Audits
BATTLEFIELD
REVENUE CYCLE


Battlefield Analysis
Mentimeter
BATTLEFIELD
REVENUE CYCLE

Battlefield Strategies



BATTLEFIELD
REVENUE CYCLE



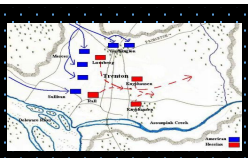
Battlefield Strategy

Not Eligible

Patient Access is the most important part of the Hospital Revenue Cycle in eliminating eligibility barriers. If you get it right on the front-end of your revenue cycle, you won't have to deal with it on the back-end of your revenue cycle.

- ✓ Copy ID and insurance cards
- ✓ Capture and document insurance company reference numbers
- ✓ Capture screen shots from the insurance company
- ✓ Utilize real-time eligibility software/tools to verify coverage
- ✓ Implement post-discharge eligibility scrubbing processes

BATTLEFIELD
REVENUE CYCLE



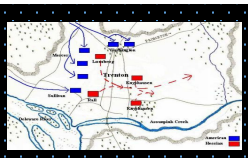
Battlefield Strategy

Not Authorized

Patient Access and Case Management are critical in eliminating authorization barriers.

- ✓ Keep current on all insurance company authorization requirements
- ✓ Carefully review insurance company contracts and provider manuals
- ✓ Demand that contracted insurance companies provide your office with a list of all services that require an authorization
- ✓ Make sure the authorization you have obtained is for the service you are billing
- ✓ Demand that your contracted insurance companies have an on-line portal or on-site presence to obtain authorizations

BATTLEFIELD
REVENUE CYCLE



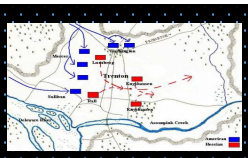
Battlefield Strategy

Timely Filing

Patient Access and the Business Office is responsible for making sure the correct insurance is added and billed in a timely manner.

- ✓ Carefully review insurance company contracts and provider manuals
- ✓ Copy ID and insurance cards
- ✓ Capture and document insurance company reference numbers
- ✓ Capture screen shots from the insurance company
- ✓ Implement post-discharge eligibility scrubbing processes
- ✓ Maintain all claim acknowledgements from the insurance company
- ✓ Implement a contract management system that helps monitor the timely filing requirements
- ✓ Assign accountability to vendors working inventory on your behalf

BATTLEFIELD
REVENUE CYCLE



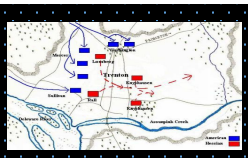
Battlefield Strategy

Arkansas Prompt Pay Law

Code Ark. R . § 43. 12 – Processing of Clean Claims

A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically , or within 45 days after receipt if the claim was submitted by other means. A Health Carrier shall notify the Health Claimant within 30 days after receipt of the claim if the Health Carrier determines that additional information is needed. A Health Carrier shall pay a penalty to the Health Claimant for the period beginning on the sixty-first day after receipt of the clean claim and ending on the clean claim payment date (the delinquent payment period), calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such penalty shall be paid without any action by the Health Claimant.

BATTLEFIELD
REVENUE CYCLE



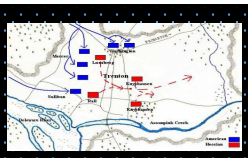
Battlefield Strategy

Additional Information Required

It is extremely important to route requests for additional information to the correct area to respond in a timely manner. It is equally important to document your actions and respond to the requests via Certified Mail as needed. Insurance Company requests for additional information include, but are not limited to, the following:

- ✓ **Medical Records** – Upload information quickly to the Insurance Company portal or mail it to them via Certified Mail.
- ✓ **Device Invoices** – Streamline processes to insure that you can obtain these from your Purchasing Department quickly.
- ✓ **Coordination of Benefits** – Get patients involved early and often!

BATTLEFIELD
REVENUE CYCLE



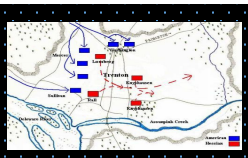
Battlefield Strategy

Other Party Liability

Other Party Liability can involve basic Coordination of Benefits (COB) or it can involve Third Party Liability (TPL) cases (i.e. Motor Vehicle Accident, Slip/Fall, etc)

- ✓ Patient Access is key to identifying who is responsible for the bill
- ✓ Get the patient involved early and often!
- ✓ Use letters to notify patients of their responsibility with updating COB information with their insurance company
- ✓ Verify whether or not the patient is being treated for a TPL case
  - In most cases, we are required to bill the responsible party before billing the patient's health insurance company
  - Consider contracting with a TPL vendor
    - Arkansas Code § 18-46-104 creates a hospital lien in favor of any hospital or medical provider that renders treatment to a patient who is injured by another (e.g. Motor Vehicle Accident). The lien covers the full billed charges by the provider. The lien is valid for 180 days and must be renewed with the court clerk.
  - In some cases, the patient simply needs to close out an old segment in the Common Working File (CWF) with Medicare

BATTLEFIELD REVENUE CYCLE



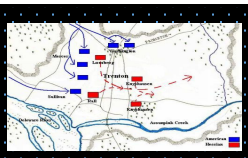
Battlefield Strategy

Level of Care – Inpatient Downgrades

Insurance Companies are becoming more aggressive in forcing inpatient downgrades, forcing DRG downgrades, sneaking in ER E&M level charge downgrades, applying readmission penalties, and site of care denials. If your organization has not already done so, you have to go on the offensive to mitigate your losses.

- ✓ Humana and UHC are the most aggressive in using the inpatient downgrade cost-containment strategy.
  - Utilize both InterQual and Milliman
  - If the documentation and order warrants an inpatient status, don't be so quick to voluntarily downgrade your claim
  - Physician documentation is critical – Audit the documentation to make sure all Physicians are capturing everything to warrant the inpatient status
  - Demand Peer-to-Peer Reviews – Consider designating a Physician leader to head the process or utilize outside Physician services to assist in these reviews
  - Demand that your contracted Insurance Companies clearly define their processes in your contract
  - Challenge Medicare Advantage Plans with the Medicare Guidelines found in the CMS Manual System Pub 100-08 Medicare Program Integrity
    - "Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption."

BATTLEFIELD REVENUE CYCLE



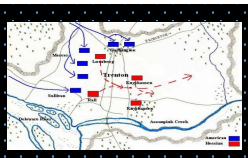
Battlefield Strategy

Level of Care – DRG Downgrades

Humana, UHC and WellCare are the most aggressive in using this cost-containment strategy but others are adopting it quickly.

- Physician documentation is critical – Audit the documentation to make sure the coding is accurate and capturing the acuity of care.
- Use your Clinical Documentation Improvement (CDI) to review and dispute DRG downgrades.
- Demand that the insurance company provide you with logical rationale regarding the downgrade.
- If your documentation and coding are accurate but the insurance company maintains their downgrade through all levels of appeal, consider using an outside law firm to review and challenge the insurance company on the merits of the hospital documentation.

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Level of Care – ER E&M Level Downgrades

Blue Cross & Blue Shield, Humana and UHC are the most aggressive in using this cost-containment strategy. Magnolia recently joined the battle. Most have adopted the use of the Optum EDC Analyzer.

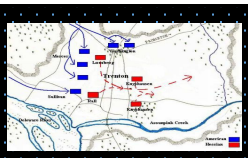
- The only way you will know that it happened is if you utilize a contract management system to monitor your expected insurance payments.
- The Centers for Medicare and Medicaid Services (CMS) acknowledged from the beginning of the OPPS that CPT Evaluation and Management (E/M) codes were designed to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of facility-specific codes and guidelines, providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes. If an insurance company has not provided you with a specific facility E&M criterion to use and your hospital has been following CMS' instructions and guidelines, you have grounds to challenge all downgrades.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
http://bok.ahima.org/PdfView?oid=91983
https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines/

CMS' Expectations of Hospital Internal Guidelines

1. The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
2. The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
3. The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
4. The coding guidelines should meet the HIPAA requirements.
5. The coding guidelines should only require documentation that is clinically necessary for patient care.
6. The coding guidelines should not facilitate upcoding or gaming.
7. The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
8. The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
9. The coding guidelines should not change with great frequency.
10. The coding guidelines should be readily available for fiscal intermediary (or, if applicable, Medicare Administrative Contractor) review.
11. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Level of Care Continued

- ✓ **Readmission Penalty** – Medicare Advantage Plans are attempting to penalize you twice
  - Remind them that the Medicare Inpatient Pricer already imposes the readmission penalty to all of your organization's inpatients claims

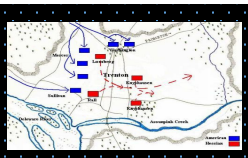
    "CMS calculates the payment reduction and component results for each hospital based on its performance during a rolling three-year performance period. The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospital payments. Payment reductions are applied to all Medicare fee-for-service base operating diagnosis-related group payments during the FY (October 1 to September 30). The payment reduction is capped at 3 percent (that is, a payment adjustment factor of 0.97)."

    https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program
  - "The A/B MACs (A) may choose to review claims if data analysis deems it a priority. AB/MACs (A) will review the claim selected, based on the medical records associated with that claim and make a payment determination on that claim. They will then refer the claim to the QIO, in accordance with IOM 100-08, chapter 6, §6.5.7."

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
  - "The MACs shall only refer Quality of (Health) Care Concerns to the QIOs. A Quality of (Health) Care Concern is defined as "a concern that care provided did not meet a professionally recognized standard of health care." The Contractor shall follow the referral process as agreed upon in the QIO-MAC Joint Operating Agreement. The QIOs will retain their responsibility for performing expedited determinations, Hospital-Issued Notices of Non-Coverage (HINN) reviews, quality reviews, transfer reviews, readmission reviews and, provider-requested higher-weighted DRG reviews."

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf
  - According to the Centers for Medicare and Medicaid Services (CMS), your organization will need to address this in the insurance company contract.
- ✓ **Site of Care** – UHC implemented a site of care review in 2019 for certain outpatient imaging procedures and certain arthroscopic and foot surgeries. Expect them and others to continue expanding this cost-containment tactic.
- ✓ **ER High Acuity Radiology Utilization** – WellCare updated their policy to deny services that don't fit the level of care.

BATTLEFIELD REVENUE CYCLE



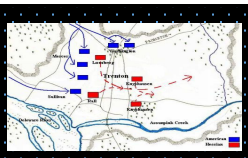
Battlefield Strategy

Billing/Coding Edits

Insurance Companies utilize front-end coding and billing edits to place barriers to their claim adjudication systems to force you to adhere to national and/or internal requirements

- ✓ Capture the coding and billing requirements in your Health Information System to fix these early in the process
- ✓ Implement/maintain solid code editing software
- ✓ Implement/maintain a top clearinghouse that also has DDE Direct capability
- ✓ Hire or contract top-notch Coders to insure the acuity of all patients is being captured accurately
- ✓ Hire and maintain top-notch Billers/Collectors to insure accounts are being expedited with a sense of urgency

BATTLEFIELD REVENUE CYCLE



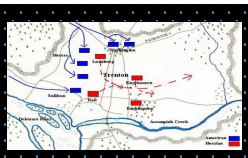
Battlefield Strategy

Not Medically Necessary

Insurance Companies love using this as a catch-all and hope that you don't utilize the correct techniques to contest denials in an effective manner

- ✓ Monitor and educate employees on insurance company medical policy updates
- ✓ Monitor and educate employees on insurance company provider manual updates
- ✓ Utilize Advance Beneficiary Notices (ABN) in accordance with Medicare regulations
- ✓ Consider using a cash pay only process on elective services to be performed on non-Medicare patients where you know the insurance company is not going to pay for the service
- ✓ Vigorously appeal denials with skillfully crafted letters utilizing language from the patient's chart and reference specifically in the insurance company's medical policy where they should consider the service(s) as medically necessary

BATTLEFIELD
REVENUE CYCLE



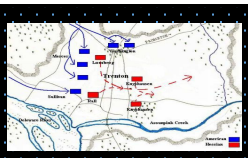
Battlefield Strategy

High Dollar Review

Some insurance companies use this as a delay tactic

- ✓ Maintain solid records on when your claim was submitted
- ✓ Document all status calls you have with the insurance company
- ✓ Use the Arkansas Prompt Pay Law
  - Consider using letters to prompt a response and request interest, if applicable

BATTLEFIELD
REVENUE CYCLE



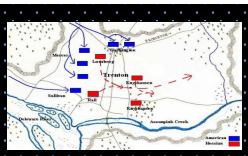
Battlefield Strategy

Forensic Audits

Medicare Advantage Plans are using vendors to perform forensic audits prior to processing claims to bundle charges for the sole purpose of reducing the hospital's payment. It appears that they are focusing heavily on claims that involve an outlier payment.

- ✓ Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The regulations governing for operating costs under the Inpatient Prospective Payment System (IPPS) are located at 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86. CMS publishes the outlier threshold in the annual IPPS Final Rule.
- ✓ Medicare Advantage Plans and their Cost Containment Vendors (if applicable) currently using the forensic audit strategy.
  - Humana
  - United Health Care – CERiS and MedReview
  - WellCare – Equian

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits

Example of Cost Containment Vendor Justification

Unbundling

The Forensic Review evaluated this claim to determine whether it contained charges for supplies or services that appear to be either "routine," and/or are integral and necessary components of underlying daily service or procedure charges.

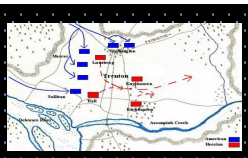
Section 2202.6 of the CMS Provider Reimbursement Manual ("PRM") directs facilities to include routine supplies and services within underlying daily room or procedure charges and specifies that such routine charges include "the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

PRM Section 2202.8 limits a facility's ability to separately charge for ancillary services and defines separately billable ancillary services as including "laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational)."

PRM Section 2203 requires that each facility create and maintain "an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services." Accordingly, this provision instructs that all facility bills shall comply with the above PRM provisions and that a facility's charges need to "reasonably and consistently" relate to the facility's underlying cost.

Resolution of Unbundling Questions – If you disagree with any of the Forensic Review Report's unbundling findings, please submit the explanations and/or documentation necessary to show that these charges are separately payable.

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits

The Medicare Advantage Plan Cost Containment Vendors attempt to use the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) to justify their tactics but you can use the same rules to fight and win the battles.

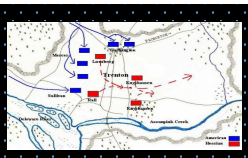
2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components: (1) general routine services, and (2) special care units (SCUs), including coronary care units (CCUs) and intensive care Units (ICUs). 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.

- ✓ The Cost Containment Vendor claims that this section directs hospitals to include routine supplies and services within the underlying daily room or procedure charge. The language in this section simply states that a room and board or procedure charge is intended to encompass a variety of services but does not mandate anything.

2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)

- ✓ The Cost Containment Vendor claims that this section limits a hospital's ability to separately charge. The language in this section simply defines Ancillary Services and limits nothing. The part that the Cost Containment Vendor chose to exclude reads, "Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge."

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits

2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges described in §2314.B.

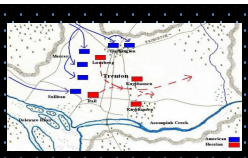
In determining reimbursement for the costs of routine services, providers do not use charges but use patient days for apportionment purposes in a skilled nursing facility (to the extent certified) or in a hospital (with separate computation for each separate care unit). Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.

The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in §2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement. A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge. Where there is no

common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program. Ancillary charges for items or services furnished Medicare beneficiaries, including those enumerated in §2202.8, are not recognized by the program if separate charges are not also recorded by the provider for all non-Medicare patients receiving these same items or services directly from the provider.

- ✓ Section 2203 simply states that providers need to have a charge structure that accurately allows for the determination of cost to the program and that Medicare is entitled to contest certain charges if they determine that they inflate costs to the program.
- ✓ Section 2203 gives providers the latitude on creating and maintaining a charge structure as long as that charge structure is charged consistently to all patients. Bottom line, section 2203 does not give the Medicare Advantage Plan or their Cost Containment Vendor the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits – Win the Battle

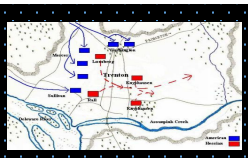
Develop letter templates to dispute the forensic audits

- ✓ Use language from your hospital's Provider Participation Agreement
- ✓ Use language from Medicare Law
  - Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs.
  - The Centers for Medicaid and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) gives providers the latitude on creating and maintaining a charge structure as long as the charge structure is charged consistently to all patients. The PRM does not mandate or give the MA Plan the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- ✓ Use language from the Medicare Managed Care Manual
  - MA organizations are required to pay "Clean Claims" within 30 days of receipt;
  - Otherwise, the MA organization must pay interest on claims that are not paid in a timely manner.

The best option is to re-negotiate your payer contract to give your hospital/health system an opt-out if the payer chooses to use cost-containment strategies not clearly defined and agreed to in the contract.

https://www.racmonitor.com/fighting-spurious-forensic-audits

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Post Payment Audits

Insurance Companies are findings new cost containment strategies to recoup money after the fact through post payment audits

- ✓ DRG audits
  - Make sure you have a strong team of experienced Coders reviewing and contesting these as appropriate
- ✓ RAC audits
  - Again, make sure you have a strong team of experienced Coders reviewing and contesting these as appropriate
- ✓ Readmissions
  - As previously discussed, contest these through your Payer Contracting Department
  - Your organization is already getting penalized for all inpatient admissions, don't let the insurance company penalize you again
- ✓ Coordination of Benefits (COB)
  - As previously discussed, mitigate this by maintaining strong Patient Access processes
- ✓ Use Arkansas Code to fight recoupments, if applicable
  - Title 23, Subtitle 3, Chapter 63, Subchapter 18 – Audits of Medical Providers, § 23-63-1802 - Time for recoupment
    - Except in cases of fraud committed by the health care provider, a health care insurer may exercise recoupment from a provider only during the eighteen-month period after the date that the health care insurer paid the claim submitted by the health care provider. A health care insurer that exercises recoupment under this section shall give the health care provider a written or electronic statement specifying the basis for the recoupment. At a minimum, the statement shall contain the information required by § 23-63-1804.

BATTLEFIELD REVENUE CYCLE

Closing Question

www.menti.com

Mentimeter

BATTLEFIELD REVENUE CYCLE

Battle Plans Recap

- ✓Get to know your fellow Warriors
- ✓Get to know your Adversaries
- ✓Understand your current environment
- ✓Understand the environment of your Adversaries
- ✓Get to know the Battlefield
- ✓Understand strategies to avoid barriers on the Battlefield

Pearls of Wisdom to win your Battles

- Assemble strong Warriors
- Develop your strategies to fit the Battlefield
- Regroup and modify your strategies as changes occur on the Battlefield
- Win on the Battlefield – Financial survival is up to you!

BATTLEFIELD REVENUE CYCLE

BATTLEFIELD
REVENUE CYCLE

Revenue Cycle Warriors – Win the Battle!

Chris Loftin
ChristopherLoftin@bmhcc.org
(601) 960-3322