Regulatory Compliance and Finance – A Balancing Act

Ronald Hirsch, MD, FACP, ACPA-C, CHRI, CHCQM

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Objectives

After this session, participants will be able to

- Understand how to bridge finance and case management divide achieving compliant financial and clinical goals.
- Decipher the flaws in the commonly used KPIs and provide alternatives.
- Explain medical necessity and its importance in the provision of care.
- Ensure a compliant process for shifting financial liability to the patient.

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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

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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 and mega-consolidation at the same time

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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

7 HEALTH INSURANCE CEOS MADE $335 MILLION IN 2022

VS

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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

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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.)

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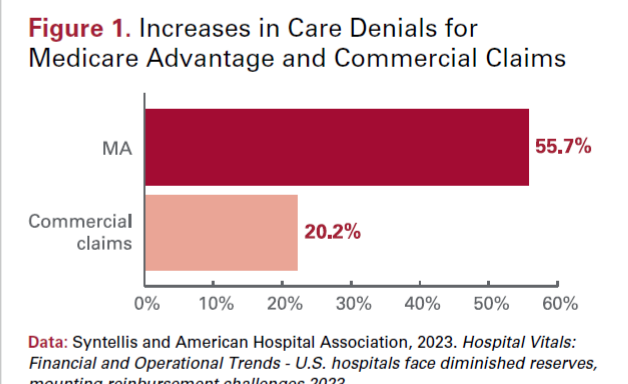
Medicare Advantage – We all Know

Figure 1. Increases in Care Denials for Medicare Advantage and Commercial Claims



Data: Syntellis and American Hospital Association, 2023. *Hospital Vitals: Financial and Operational Trends - U.S. hospitals face diminished reserves, mounting reimbursement challenges 2023.*

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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

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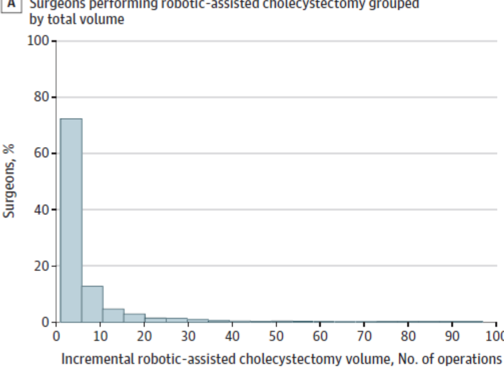
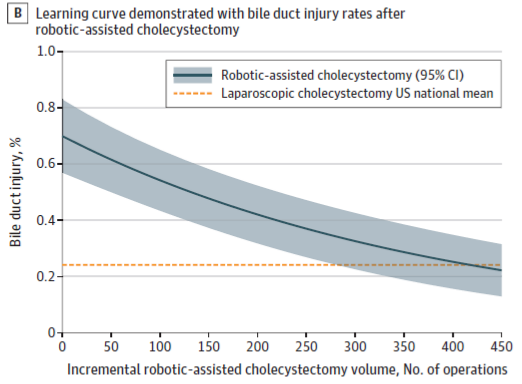
Learning Curve for Robotic Cholecystectomy





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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 — January 25, 2014

Northern District of Illinois — (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

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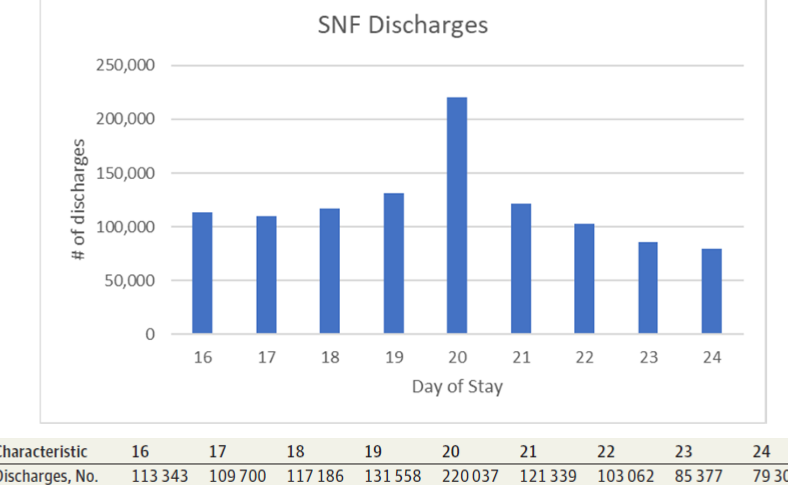
Part A SNF Discharges – Random???



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

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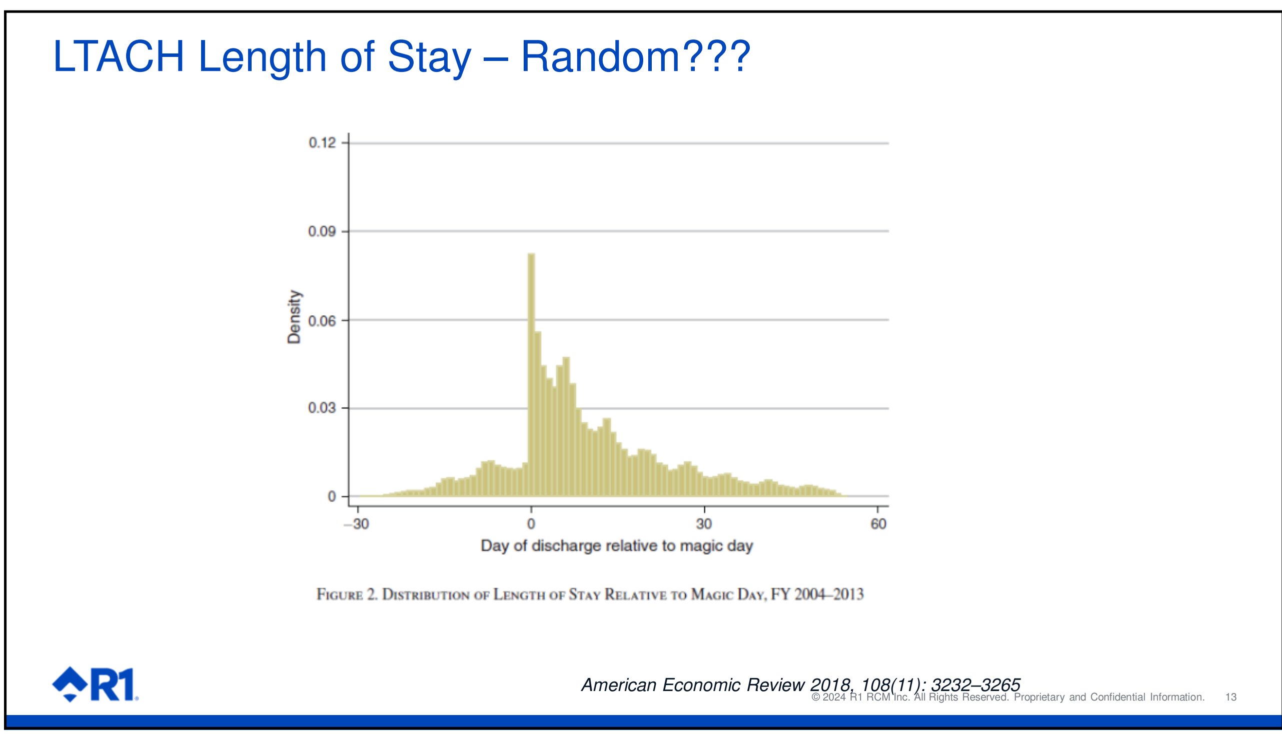

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One Patient's Journey

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

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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?

First KPI Warning – ED throughput leads to hospitalizing patients that could go home from ED. Likely will be Observation, will fill a bed an inpatient may need, and at risk of denial.

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ED – The Hospital's Front Door – HCAHPS Scores

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.

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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!

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Patient Satisfaction is Dangerous – Engage Patients!

Patient/Family Engagement Strategies
Individual's care
Practice improvement
Policy

Informed, actively involved, participating patient and family

Accessible, well-organized, responsive health care system

Patient-and family-centered, communicative team

Costs of care | Health outcomes | Patient experiences

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“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

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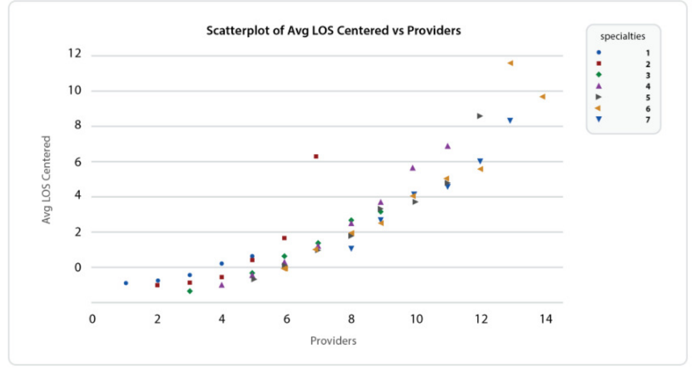
Mrs. Smith is Admitted

Patient arrives at ICU

Admitted to Hospitalist on call

Stroke care plan initiated

Consultations with Neurosurgery, Neurology, Cardiology



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

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When Hospital Care is Needed

UR must screen for proper admission status

- First level review with MCG/InterQual
- 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

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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?

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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?

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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!

- Games they play- Meets IQ IN but goes home after one day?
  - Deny- did not meet two midnight benchmark
- Fails IQ IN but requires over 2 MN?
  - Deny- did not pass InterQual criteria

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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

- Does your staff review every Observation patient every day?

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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?

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Observation Rate / Conversion Rate – A Bad KPI

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!

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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

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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

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What about Medical Necessity?

"health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms – and that meet accepted standards of medicine."

Not included-

The patient wants it

The doctor wants to do it

The device rep says it will work

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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

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CMS iDoesn't Pay for New Toys

Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on projected utilization for Medicare beneficiaries and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment.

We rely on hospitals to make informed business decisions regarding the acquisition of high-cost capital equipment, taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payers' payment policies.

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But some things do get paid extra…

Technology	Maximum Add-on Payment
Annalise Enterprise CTB Triage - OH	$241.39
ASTar® System	$97.50
Edwards EVOQUE™ Tricuspid Valve Replacement System	$31,850.00
GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)	$47,238.75
LimFlow™ System	$16,250.00
Paradise™ Ultrasound Renal Denervation System	$14,950.00
PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter	$6,337.50
Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter	$10,400.00
TriClip™ G4	$26,000.00
VADER® Pedicle System	$28,242.50
ZEVTERA™ (ceftobiprole medocaril); ABSSSI and CABP indications	$2,812.50
ZEVTERA™ (ceftobiprole medocaril); SAB indication	$8,625.00
CASGEVY™ (exagamglogene autotemcel); Sickle Cell Disease indication	$1,650,000.00
ELREXFIO™ (elranatamab-bcmm) and TALVEY™ (talquetamab-tgvs)*	$12,899.59
HEPZATO™ KIT (melphalan for injection/hepatic delivery system)	$118,625.00
LYFGENIA™ (lovotibeglogene autotemcel))	$2,325,000.00

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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?

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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?"

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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"

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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

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A Helpful KPI for LOS – Avoidable Days

Any day the patient did not require hospital care but was in the hospital

Attribution critical!

Patient- doesn't want to leave, slow to pick nursing home
Doctor- rounds late, keeps for incidental workups, old fashioned
Hospital- no weekend services
Payer- 3 days to approve SNF, home care, transfer
System- SNFs won't accept after Fri 4 pm, no ambulance to transport

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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

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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

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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

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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

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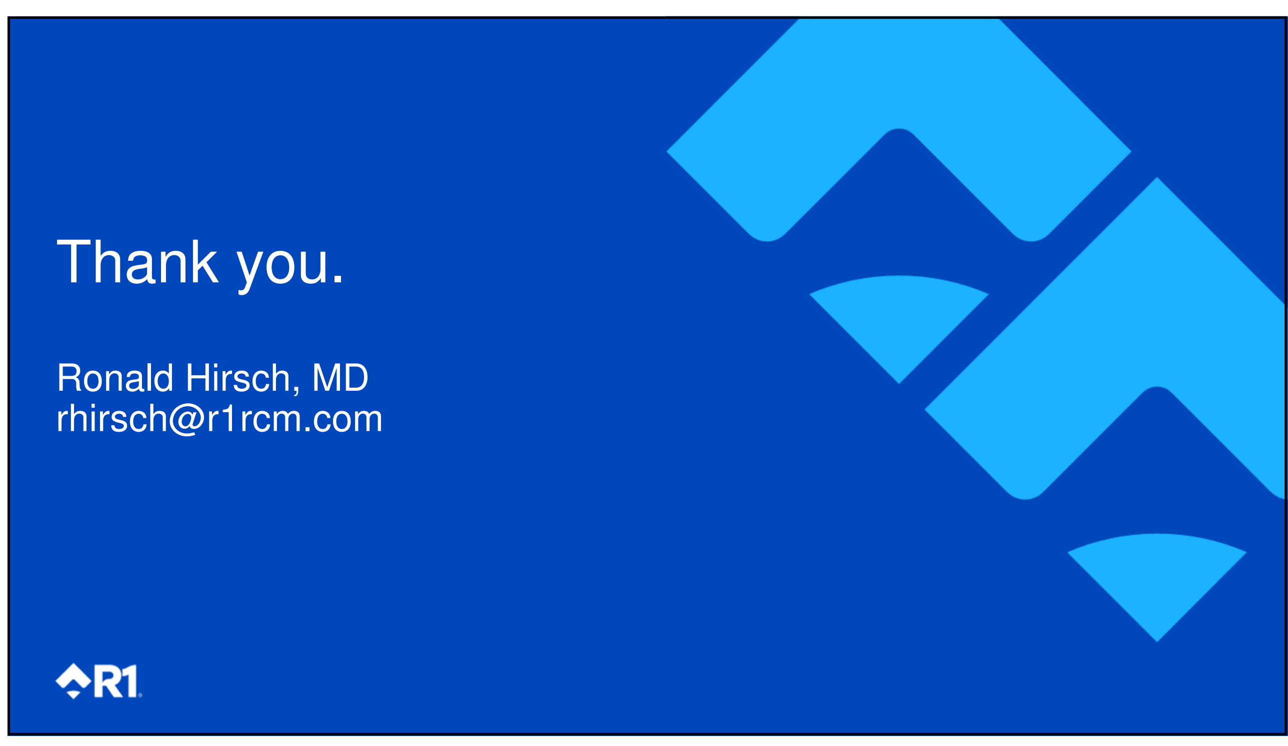

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