Utilization Management: Meeting Challenges in a Value-Based Reimbursement Environment

Bev Cunningham, MS, RN, ACM,
Toni Cesta, PhD, RN, FAAN

RELIAS LEARNING

Speakers

- **Toni Cesta**, PhD, RN, FAAN

Founding partner of Case Management Concepts, LLC. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of Case Management. Dr. Cesta also writes a monthly column called *Case Management Insider* in AHC Media's *Hospital Case Management* newsletter. She has been active in the research and development of Case Management for over 20 years

- **Beverly Cunningham**, MS, RN, ACM

- Founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board. Bev is also the former Vice President of Resource Management at Medical City Dallas Hospital

RELIAS | LEARNING

OBJECTIVES

- Describe the utilization management process to ensure payment in value-based reimbursement.
- Identify ways in which the utilization management process can improve reimbursement when there is no denial process.
- Discuss utilization management in contemporary case management models.

RELIAS | LEARNING

CASE MANAGEMENT: THE 4 BASIC ROLES

EARLY CASE MANAGEMENT WAS INTRODUCED WITH A GOAL OF CONTROLING QUALITY AND COSTS AT THE BEDSIDE

RELIAS LEARNING

RELIAS LEARNING

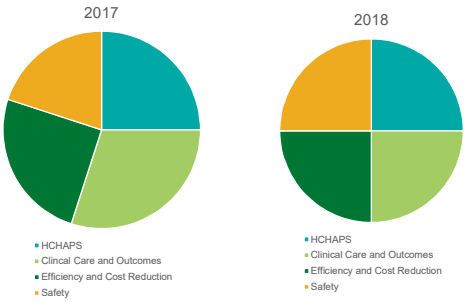
CMS VALUE-BASED REIMBURSEMENT TRANSFORMATION

PASSIVE PAYER → **PRUDENT** PURCHASER

RELIAS LEARNING
RELIAS LEARNING

VALUE-BASED PURCHASING 2017 & 2018

2% of all Medicare Payments at Risk



RELIAS LEARNING

PENALTY ADJUSTMENT

- Applied annually to portion of hospital's payment—no increase after FY2016
- Applied if any of conditions or procedures have a performance worse than national average
- Applies to all Medicare discharges for that year
- 2597 hospitals faced a readmission penalty in 2016
- Penalties assessed on hospitals for readmissions will increase to $528M in 2017, $108M more than in 2016--increase due mostly to more medical conditions being measured

2012	1%
2013	2%
2014	3%
2015	3%
2016	3%

RELIAS | LEARNING

RELIAS | LEARNING

HOSPITAL ACQUIRED CONDITION REDUCTION PROGRAM FY 2017

- Medicare payments reduced by 1% for hospitals with lowest rate of performance
- Domain 1 – Agency for Healthcare Research and Quality Patient Safety Indicator measure: PSI 90 Composite
- Domain 2 – National Healthcare Safety Network Healthcare-Associated Infection measures:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) – colon and hysterectomy
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)
- Separate from value-based purchasing initiative

RELIAS | LEARNING

TOTAL % OF MEDICARE PAYMENTS AT RISK FOR QUALITY OUTCOMES: FY2017

METRIC	% OF MEDICARE PAYMENTS AT RISK
Value-Based Purchasing	2%
Hospital-Acquired Conditions Reduction	1%
Readmissions Reduction	3%
Total % of Medicare payments at Risk	6%

RELIAS | LEARNING

THE BUSINESS OF CASE MANGEMENT

TRANSITIONING FROM TRANDITIONAL UTILIZATION MANAGEMENT TO VALUE-BASED REIUMBURSEMENT UTILIZATION MANAGEMENT

RELIAS | LEARNING

TOP 10 TERMS OF REVENUE CYCLE MANAGEMENT (RevCycle Intelligence: http://revcycleintelligence.com)

- Accountable Care Organization (ACO)
  - Healthcare organization made up of doctors, hospitals and healthcare professionals
  - Share responsibility of providing value-based care to a population of pts
  - Incentivized to provide coordinated care efforts to reduce unnecessary medical care, improved health outcomes for patients and savings for providers
- Bundled Payments
  - Flat pricing structure to cover a full episode of care for pts with certain medical conditions
  - Supposed to encourage a more dynamic relationship among healthcare providers
- Alternative Payment Models
  - A move from fee-for-service and payment for volume to payment for quality of service
  - Include ACOs, bundled payments and reimbursement tied to quality reporting bonuses and penalties

RELIAS | LEARNING
RELIAS | LEARNING

TOP 10 TERMS OF REVENUE CYCLE MANAGEMENT

- Concierge Medicine
  - "Retainer healthcare"
  - Pts pay physicians yearly membership/retainer
  - Physicians able to focus more on preventative care
- MACRA (Medicare Access and CHIP Reauthorization Act of 2015)
  - New model for value-based reimbursement: MIPS (Merit-based Incentive Payments System) for physicians
  - Replacement for Medicare Part B reimbursement
- Medicare Shared Savings Program
  - Providers, hospitals and supplier opportunity to coordinate cost reduction and improve quality of care for Medicare beneficiaries by joining or forming an ACO
  - Allows participation in risk-only track
  - Currently being overhauled to ensure adequacy of metrics and goals

RELIAS | LEARNING
RELIAS | LEARNING

TOP 10 TERMS OF REVENUE CYCLE MANAGEMENT

- MIPS
  - Alternative payment model: physician quality reporting pay-for-performance program
  - Focus on care coordination, patient outcomes and population health
  - Physician scores influence financial bonuses or penalties
- Price Transparency
  - Important with increasingly high deductibles and out-of-pocket copayments
  - Challenging for providers due to multitude of payers and price variations

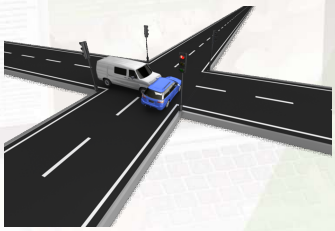
RELIAS | LEARNING
RELIAS | LEARNING

TOP 10 TERMS OF REVENUE CYCLE MANAGEMENT

- Supply Chain Management
  - One of most complex aspects of revenue cycle
  - Collaborators in cost management for supplies often not aligned: doctors, insurance companies, hospitals, other healthcare professionals
  - Conflicting interests can lead to inefficiencies
- Value-Based Reimbursement
  - Any payment directly tied to quality of care and/or patient outcomes
  - Shifts costs of excess or unnecessary care back to providers
  - Financial incentives to stay within spending limits
  - Intended to produce higher quality care without redundancy or inefficiency

RELIAS | LEARNING
RELIAS | LEARNING

A FLAWED DELIVERY-OF-CARE SYSTEM REQUIRES BUSINESS INNOVATION



RELIAS | LEARNING

An important lesson from studies of disruptive innovation

- Hospitals providing much of today's health care cannot, and therefore ought not, be relied upon to transform the cost and accessibility of health care
- Hospitals need to be disrupted—they need to transition to disruptive business models, patient by patient, disease by disease starting at the simplest end of the spectrum of disorders they now serve

"We will do everything for everybody" has never been a viable value proposition for any successful business model that we know of–and yet that's the value proposition managers and directors of general hospitals feel they are obligated to put forth

Clayton Christensen The Innovator's Prescription

RELIAS | LEARNING

CASE MANAGEMENT: A BUSINE$$ WITHIN A BUSINE$$

- Every department can be treated as a unique business, whose job is to produce products and services for customers
- Harnesses entrepreneurial spirit in service of organization's strategies and shareholders' interests
- Empowerment is natural result
- Not outsourcing

Dean Meyer, NDMA Consulting Firm

RELIAS | LEARNING
RELIAS | LEARNING

CURRENT CASE MANAGEMENT ROLES IN UTILIZATION MANAGEMENT

- ED RN Case Manager
- Admissions Case Manager
- Unit Care Manager
- Perioperative Case Manager
- Transfer Center Case Manager
- Social Worker Roles
  - ED Social Worker
  - Complex Discharge Planner
  - Unit Social Worker
- Physician Advisor
- Case Management Leadership

RELIAS | LEARNING
RELIAS | LEARNING

CURRENT CASE MANAGEMENT ROLES IN UTILIZATION MANAGEMENT

- ED RN Case Manager
- Admissions Case Manager
- Unit Care Manager
- Perioperative Case Manager
- Transfer Center Case Manager
- Social Worker Roles
  - ED Social Worker
  - Complex Discharge Planner
  - Unit Social Worker
- Physician Advisor
- Case Management Leadership

WHAT ROLES ARE MISSING??

RELIAS | LEARNING

RELIAS | LEARNING

UTILIZATION REVIEW AND MANAGEMENT: THE DIFFERENCE

A system for review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to a beneficiary

- Utilization review: Passive
- Utilization management: Active and operational
  - Includes proactive procedures to review medical necessity and collaborate with the health care team to ensure care delivered is clearly documented
  - Aligns with the other roles of the case manager: discharge planning, care coordination and resource management
  - Requires critical thinking
  - Includes flexibility related to various payers and their reimbursement structure(s)

RELIAS | LEARNING

RELIAS | LEARNING

UTILIZATION MANAGEMENT PROCESS OCCURS AT THE BEDSIDE, IN EACH GEOGRAPHIC AREA WHERE THE PATIENT RESIDES---------- NOT AT YOUR DESK ON THE COMPUTER!

RELIAS | LEARNING

MEDICAL NECESSITY

Defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care

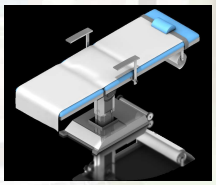
Neither more nor less than what the patient requires at a specific point in time

AMERICAN COLLEGE OF MEDICAL QUALITY (ACMQ)

RELIAS | LEARNING

RELIAS | LEARNING

SEVEN COMPONENTS OF THE MEDICAL NECESSITY PROCESS FOR HEALTH CARE



AMERICAN COLLEGE OF MEDICAL QUALITY

RELIAS | LEARNING

MEDICAL NECESSITY: APPROPRIATE SERVICES AND SUPPLIES

1. Determinations must adhere to standard of care applying to actual direct care and treatment of the patient
2. Must use standard terminology that all health care professionals and entities use in the review process when determining if medical care is appropriate and essential
3. Must reflect efficient and cost-effective application of patient care including, but not limited to, diagnostic testing, therapies (including activity restriction, after-care instructions and prescriptions), disability ratings, rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations, procedures, psychiatric care, levels of hospital care, extended care, long-term care, hospice care and home health care

RELIAS | LEARNING

RELIAS | LEARNING

MEDICAL NECESSITY: APPROPRIATE SERVICES AND SUPPLIES

4. Determinations made in concurrent review should include discussions with attending provider as to current medical condition of patient whenever possible
   - Physician advisor can make positive determination regarding medical necessity without necessarily speaking with treating provider if advisor has enough available information to make appropriate medical decision
   - Physician advisor cannot decide to deny care as not medically necessary without speaking to treating provider--these discussions must be clearly documented
5. Determinations of medical necessity must always be made on case-by-case basis consistent with applicable standard of care and be available for peer review

RELIAS | LEARNING

MEDICAL NECESSITY: APPROPRIATE SERVICES AND SUPPLIES

6. Recommendations approving medical necessity may be made by a non-physician reviewer
   - Negative determinations for the initial review regarding medical necessity must be made by a physician advisor who has clinical training to review the particular clinical problem under review.
   - A physician advisor must not delegate review decisions to a non-physician reviewer
7. Medical review organizations involved in determining medical necessity, shall have uniform, written procedures for appeals of negative determinations that services or supplies are not medically necessary

RELIAS | LEARNING

INTEGRATING ACMQ'S PRINCIPLES IN TO YOUR VALUE-BASED REIMBURSEMENT UM

- No more or no less than patient requires in any healthcare setting
- UM process assists in determining if care in the current setting is appropriate essential, and related to reason to patient is in that setting
- Efficient and cost-effective patient care is the key
- The attending physician must be included in any review where documentation in the record does not support efficient and cost-effective patient care (medical necessity)
  - Is there more documentation the physician can add?
  - Review lab results, consultation reports, and any orders to support conversation with the physician
  - Relate medical necessity to current setting and any alternative payment model related to patient

RELIAS | LEARNING

INTEGRATING ACMQ'S PRINCIPLES IN TO YOUR VALUE-BASED REIMBURSEMENT UM (2)

- Any time physician cannot add anything to record to demonstrate medical necessity, a referral to physician advisor must be made
  - A non-physician (UR nurse or case manager) cannot determine lack of medical necessity
  - Physician advisor must also be aware of patient's alternative payment model (if one exists)
  - Physician advisor should have conversation with attending if medical necessity is determined to not be met
- While medical necessity is determined through criteria, it must also be assessed on a case-by-case basis; any case-by-case basis determinations should be supported by peer review
- Payer contracts should have verbiage regarding medical necessity reviews and their appeal and denial process

RELIAS | LEARNING
RELIAS | LEARNING

UTILIZATION MANAGEMENT HAS A COMPLIANCE COMPONENT

- CMS Condition of Participation
- Inpatient and Outpatient Prospective Systems (IPPS and OPPS)
- National and state agencies
- Hospital accreditation bodies
- Payer contracts
- Your hospital
- Value based reimbursement
  - Medicare spending per beneficiary measure
  - Readmissions
  - Avoidable days/delays
  - Bundled payment and alternative payment models

RELIAS | LEARNING
RELIAS | LEARNING

CMS CONDITION OF PARTICIPATION FOR HOSPITALS (COP)

Rules from CMS by which Medicare and Medicaid enrolled hospitals must abide as a condition of participation in federal health care programs

RELIAS | LEARNING
RELIAS | LEARNING

CoP UM REQUIREMENTS

- All UR activities, including review of medical necessity of hospital admissions and continued stays are fulfilled as described in section 42 CFR Part 482.30
- UR plan

Must have a plan that provides for review of services furnished by institution and by members of medical staff to patients entitled to benefits under Medicare and Medicaid programs

- UR committee

RELIAS | LEARNING

RELIAS | LEARNING

CoP UTILIZATION REVIEW COMMITTEE REQUIREMENT

- Committee of medical staff
  - Can be group outside institution either established by the local medical society and some or all of the hospitals in the locality

    Or
  - Established in a manner approved by CMS
    - If a small hospital and it is "impractical", may be established, as identified above
- Reviews may not be conducted by any individual who
  - Has direct financial interest (for example, an ownership interest) in hospital
  - Was professionally involved in care of patient whose case is being reviewed

RELIAS | LEARNING

RELIAS | LEARNING

CoP UR BILLING PROCESSES

Condition Code 44

- Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and has not been discharged
- Increased payment for hospital with this process (more payment than provider liable)
- Patient must be notified of observation service and be billed for their responsibility
- Requires involvement of UR Committee

RELIAS | LEARNING

RELIAS | LEARNING

CoP UR BILLING PROCESSES

Provider Liable

- Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and has already been discharged
- Less payment for hospital with this process (than with condition code 44)
- Requires involvement of physician advisor

RELIAS | LEARNING

THE 2 MIDNIGHT RULE

- Payment contingent on following 2 midnight rule regulation
- Defined physician documentation
  - Expectation of inpatient length of stay to be greater than 1 midnight
  - Documentation of reason for hospital services for any inpatient order: must support medically reasonable and necessary care
- Authentication of inpatient admission order before patient discharged

THE 2 MIDNIGHT RULE

Reassess any observation service patient after 1 midnight

- If patient will continue to stay and be transitioned to inpatient, documentation required with reason for extended hospital services
- If observation service continue (and this should be rare) coordinate discharge as soon as appropriate

2 MIDNIGHT RULE UPDATE

VULNERABILITIES REMAIN UNDER MEDICARE'S 2-MIDNIGHT HOSPITAL POLICY

By Office of Inspector General December 2016

RELIAS | LEARNING

MEDICARE SPENDING FOR SHORT STAYS

- $2.9 billion paid for inappropriate IP stays (FY 13 and 14)
- Inappropriate billing for nearly 40% of short IP stays
- Continued variation in use of IP and OP stays in FY 2014
  - 3% of all stays were short IP stays: Ranges from 1% to 5% among hospitals
  - 6% of all stays were long OP stays: Ranges from 2% to almost 11%
- Medicare pays more for some short IP stays than for short OP stays, although the stays for similar reasons
- Since introduction of 2 midnight stay policy
  - IP stays decreased 2.8%
  - OP stays increased 8.1%

RELIAS | LEARNING
RELIAS | LEARNING

MOST COMMON REASON FOR SHORT INPATIENT STAYS POTENTIALLY INAPPROPRIATE UNDER 2 MIDNIGHT POLICY FY 2014

MOST COMMON REASON FOR IP STAYS	# SHORT IP STAYS	% SHORT IP STAYS
Irregular heartbeat	16,235	3.8%
Chest pain	14,766	3.5%
Digestive disorders	13,544	3.2%
Loss of blood flow to brain	10,146	2.4%
Coronary stent insertion	9,846	2.3%
Fainting	9,158	2.2%
Nutritional disorders	8,924	2.1%
Irregular heartbeat (medium severity)	8,881	2.1%
Circulatory disorders	8,677	2.0%
Red blood cell disorders	7,752	1.8%

OIG analysis of CMS data 2016

RELIAS | LEARNING
RELIAS | LEARNING

MOST COMMON REASON FOR SHORT OUTPATIENT STAYS FY 2014

MOST COMMON REASON FOR SHORT OP STAYS	# SHORT OP STAYS	% SHORT OP STAYS
Chest pain	356,625	13.2%
Digestive disorders	185,202	6.8%
Fainting	84,596	3.1%
Coronary stent insertion	81,966	3.0%
General signs and symptoms	63,330	2.3%
Injuries to the skin or tissue	58,963	2.2%
Kidney and urinary tract infections	52,817	1.9%
Back problems	50,393	1.9%
Respiratory signs and symptoms	47,232	1.7%
Circulatory disorders	46,448	1.7%

Bolded reasons also on IP stay list—previous slide)

OIG analysis of CMS data, 2016

RELIAS | LEARNING

OFFICE OF INSPECTOR RECOMMENDATIONS TO CMS, BASED ON DECEMBER 2016 REPORT

- Conduct routine analysis of hospital billing
- Target hospitals with high or increasing # short stays for review
- Identify and target for review short IP stays potentially inappropriate under 2 midnight rule policy
- Analyze potential impacts of counting time spent as OP toward 3 night requirement for SNF services (so beneficiaries receiving similar hospital care have similar access to these services)
- Explore methods for protecting beneficiaries with OP stays from paying more than they would have paid as inpatients

RELIAS | LEARNING

LACK OF COMPLIANCE
=
LACK OF REIMBURSEMENT

UTILIZATION MANAGEMENT COLLABORATION PROCESS

- Case management
- Patient Access
  - Identify all existing coverage and benefits
  - Assess accounts for financial need and eligibility
  - Predict propensity to pay
- Compliance
- Finance
- Patient navigator
- Physicians
- UM Committee
- Nursing
- Ancillary service
- Diagnostic-specific coordination
- NCD/LCD coordinator
- Post-acute care providers
  - Hospital-owned
  - Non hospital-owned

RELIAS | LEARNING

RELIAS | LEARNING

IMPLEMENTING THE HYBRID MODEL OF UTILIZATIONMANAGEMENT

RELIAS | LEARNING

HYBRID MODELS OF REIMBURSEMENT

- Diagnosis related groups (DRG): case rate
- Per diem: payment for each day in hospital
- Percent of charges
- Carve-out services: based on contract, usually for high-cost services, such as implants
- Stop loss: Increase in payment after charge threshold met
- Outlier: increase in payment after specific combination threshold met, such as both LOS and charge
- Value-based reimbursement bonuses or penalties
  - Value-based purchasing
  - Readmission reduction
  - Hospital-acquired condition reduction
- Bundled payment bonuses or penalties
- Alternative payment model bonuses or penalties

RELIAS | LEARNING

RELIAS | LEARNING

HYBRID MODELS OF UTILIZATION MANAGEMENT

- Commercial UM
- Medicare UM
  - Traditional Medicare
  - Medicare Advantage
- Medicaid
  - State Medicaid
  - Managed Medicaid
- Other models such as worker's comp
- Bundled payments
- Alternative payment models
  - Hospital
  - Physician

RELIAS | LEARNING

RELIAS | LEARNING

IMPLEMENTING THE CASE MANAGER UTILIZATION MANAGEMENT ROLE IN VALUE-BASED REIMBURSEMENT

RELIAS | LEARNING

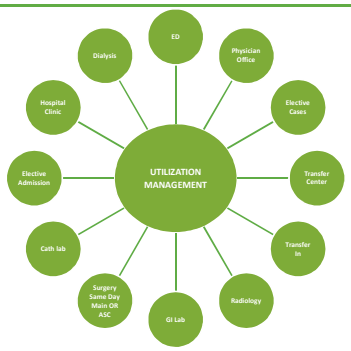
VALUE-BASED REIMBURSEMENT CM STRATEGIES

- Right model
- Right roles
- Right clerical support
- Timely assessment day of admission
- Hardwired processes
- Demonstrated compliance
- Appropriate physician communication when record does not support medical necessity
- Appropriate physician advisor referrals
- Minimal avoidable days
- Identification of patient's reimbursement model
- Appropriate auditing to by leaders to ensure effective UM

RELIAS | LEARNING

RELIAS | LEARNING

UM AND MEDICAL NECESSITY START AT ALL ACCESS POINTS TO YOUR FACILITY



RELIAS | LEARNING

RELIAS | LEARNING

THE RIGHT MODEL FOR VALUE-BASED REIMBURSEMENT

INTEGRATED MODEL VERSUS TRIAD MODEL

YOUR GOAL: NO SILOS

RELIAS | LEARNING

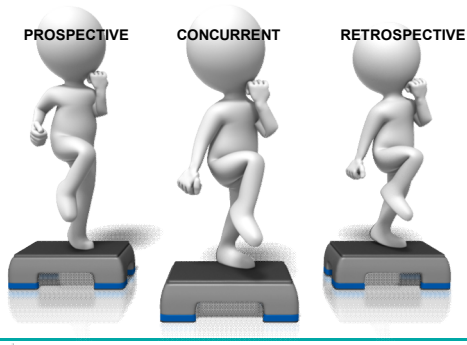
THE RIGHT ROLES FOR VALUE-BASED REIMBURSEMENT UM

- ED RN Case Manager
- Admissions Case Manager
- Observation Case Manager
- Unit Case Manager
- Perioperative Case Manager
- Transfer Center Case Manager
- Social Worker Roles
- ED Social Worker
- Complex Discharge Planner
- Unit Social Worker
- Physician Advisor
- Business Case Manager

RELIAS | LEARNING

RELIAS | LEARNING

THREE TYPES OF UTILIZATION MANAGEMENT



RELIAS | LEARNING
RELIAS | LEARNING

PROSPECTIVE REVIEW: OCCURS BEFORE SERVICES RENDERED

- Perioperative case manager review of scheduled surgical cases
  - Ensure appropriate level of care
  - Validate there are no pre-op days that do not meet medical necessity
  - Identify any alternative payment patient
    - Bundled payment
    - ACO patient
  - Collaborate with National Coverage Determination coordinator to ensure all documentation in record demonstrates appropriateness of specific procedure
- Transfer center case manager review of patients transferred to hospital
  - Appropriate orders for status and level of care
  - Transferred patient is in-network for payer/alternative payment method

RELIAS | LEARNING
RELIAS | LEARNING

CONCURRENT REVIEW: OCCURS WHILE SERVICES BEING RENDERED

- ED Case Manager/Admission Case Manager/Observation Case Manager/Perioperative Case Manager
  - 2 midnight rule followed
  - Readmission appropriately managed
  - Patient placed in appropriate status and level of care
  - Bundled payment or alternative payment model patient identified and appropriate coordinator alerted
- Unit Case Manager
  - Provider's plan for hospital days extends beyond those approved triggers concurrent review
  - DRG reimbursed cases
  - Bundled payment cases
  - Unfunded/underfunded patient strategies
  - Concurrent appeals/denials managed at the bedside

RELIAS | LEARNING
RELIAS | LEARNING

CONCURRENT REVIEW IN THE HYBRID MODEL OF REIMBURSEMENT REQUIRES CONTINUOUS FOCUS AND COLLABORATION

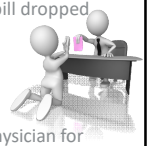
- Creative Solutions
- Persistent
- Don't take no for an answer—without researching options
- Incessant
- Proactive
- Sense of Urgency
- Perserverence
- Determination

RELIAS | LEARNING

RETROSPECTIVE REVIEW: OCCURS AFTER SERVICES HAVE BEEN RENDERED

Appeal Coordinator

- Short stay patient admitted and discharged before medical necessity review: appropriate review before bill dropped
  - Medicare
  - Medicaid
  - Commercial
- Denial issued after patient discharged
- Feedback to appropriate case manager and physician for denials
- Collaboration with physician advisor for any medical record where patient does not meet medical necessity



RELIAS | LEARNING
RELIAS | LEARNING

UTILIZATION MANAGEMENT AND COMPLIANCE ARE PART OF THE PATIENT'S FINANCIAL EXPERIENCE

Keep the patient in loop regarding payer

- Important message
- Advanced beneficiary notice (ABN)
- Hospital issued notice of non-coverage (HINN)
- Benefits—reimbursement for non-covered services
- Observation notice
- Notification of inclusion in specific payment models, such as bundled payment
- Potential denial
- Patient choice
- Discharge limitations

RELIAS | LEARNING
RELIAS | LEARNING

YOUR ROLE, AS CASE MANAGER, IN EFFECTIVE VALUE-BASED REIMBURSEMENT UTILIZATION MANAGEMENT

RELIAS | LEARNING

DENIAL MANAGEMENT

Process of monitoring and managing payer reimbursement from pre-admission to post-discharge

- Includes
- Pre-authorization
- Billing
- Appeals and denial management
  - Concurrent
  - Retrospective
- Appropriate care provided at appropriate level

RELIAS | LEARNING
RELIAS | LEARNING

KEY FUNCTION OF DENIAL MANAGEMENT

Prevent denials whenever possible!

Best defense is a good offense

RELIAS | LEARNING
RELIAS | LEARNING

KEY FUNCTION OF VALUE-BASED REIMBURSEMENT UM

Value-based reimbursement programs often do not have denial processes, but rather financial bonuses or penalties

Prevent gaps in care coordination and avoidable delays/days!

Best defense is a good offense for both traditional denial management and value-based reimbursement UM

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN YOUR CASE MANAGEMENT PROCESS WHERE UM DENIALS OR FINANCIAL PENALTIES CAN OCCUR

- Admission
  - Is patient sick enough to be admitted to the hospital?
  - Is patient receiving treatment at a level requiring admission to the hospital?
  - Will traditional Medicare patient be in the hospital at least 2 midnights?
- Continued stay
  - Is patient receiving treatment at a level that requires the patient to continue stay in hospital?
  - Is patient improving/responding to the treatment?
  - Is that medical necessity documented?
- Discharge: Is patient meeting medical necessity (well enough, as defined by medical necessity criteria) to transfer to next level of care (either in hospital or outside of hospital)?

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE ADMISSION PROCESS WHERE UM DENIALS OR FINANCIAL PENALTIES CAN OCCUR

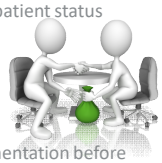
- Assessment of medical necessity
  - Not done on day of admission
  - Not done appropriately throughout the stay
  - Patient admitted and discharged before assessment completed
- Inaccurate level of care or status
  - On admission
  - During stay
- 2 midnight rule required elements and documentation not in record

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE ADMISSION PROCESS WHERE UM DENIALS OR FINANCIAL PENALTIES CAN OCCUR

- Inaccurate payer information by registration
- Inpatient only procedure not placed in inpatient status
- Not recognizing payer and benefit plan
  - Traditional payer
  - Bundled payment
  - Alternative payment



- Not asking physician for additional documentation before starting condition code 44 process
- Not including physician advisor in condition code 44 and provider liable billing

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE CARE COORDINATION AND CONTINUED STAY PROCESSES WHERE DENIALS OR FINANCIAL PENALTIES CAN OCCUR

- Out of network patient not transferred to appropriate facility
  - ED
  - Observation service
  - Inpatient status
- Weekend delays due to skeleton weekend staffing
- Clinical information to payer
  - Late provision of clinical documentation to payer
  - Not collaborating with on-site reviewer or payer medical director
- Not closing out the account after discharge with authorized days for entire stay

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE CARE COORDINATION AND CONTINUED STAY PROCESSES WHERE DENIALS OR FINANCIAL PENALTIES CAN OCCUR

- Not collaborating with physician for additional medical record documentation
- Not utilizing physician advisor during the "sweet spot" of time (when physician advisor could have a meaningful discussion with physician)
  - Concurrent medical necessity
  - Condition code 44
  - Concurrent denials
  - Avoidable delays/days for

- Not requesting a peer to peer discussion with payer medical director
- Not coordinating/facilitating care, treatment and procedure delays

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE CARE COORDINATION AND CONTINUED STAY PROCESSES WHERE DENIALS OR FINANCIAL PENALTIES CAN OCCUR

- ICU OVERUSE
- Studies avoiding ICU admissions for some pts with COPD, exacerbation of heart failure and acute MI
  - Claims studied 2010-2012 (1.5 million claims)
  - 31% of patients admitted to ICU
- Study showed ICU admission for these diagnosis did not improve 30 day survival rate for patients ≥65 years of age
- Costs increased with ICU stay
  - $4,923 more with ICU stay for AMI
  - $2,608 more with ICU stay for heart failure
  - No cost increase with COPD patient having an ICU stay
- Researchers concluded providers could reconsider an ICU admission for certain patients
- May have implications for providers participating in some bundled payment models

Annals of American Thoracic Society Study—11/4/2016

RELIAS | LEARNING

RELIAS | LEARNING

STEPS IN THE DISCHARGE PLANNING PROCESS WHERE DENIALS CAN OCCUR

- Delayed assessment resulting in delayed initiation of discharge planning
- Delay in social worker referral
- Family decision-making process
- Delay in discussing post discharge plans with family

RELIAS | LEARNING

RELIAS | LEARNING

AVOIDING DENIALS AND FINANCIAL PENALTIES

A SENSE OF URGENCY AT EVERY STEP IN THE PROCESS

RELIAS | LEARNING

RELIAS | LEARNING

THE NEW RECOVERY AUDIT PROGRAM

- 5 regions
  - Region 1 – Performant Recovery, Inc.
  - Region 2 – Cotiviti, LLC (Previously Connally)
  - Region 3 – Cotiviti, LLC
  - Region 4 – HMS Federal Solutions
  - Region 5 – Performant Recovery, Inc.
- Regions 1-4: Postpayment review to identify and correct Medicare claims that contain improper payments (overpayments or underpayments) made under Parts A B, for all provider types other than Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health/Hospice
- Region 5 RAC: Postpayment review of all DMEPOS and Home Health/Hospice claims

RELIAS | LEARNING

RELIAS | LEARNING

THE NEW RECOVERY AUDIT PROGRAM STATEMENT OF WORK 2016

- Review claims
  - Improper payments (over and under)
  - High propensity for errors (based on Comprehensive Error Rate Testing and other CMS analysis)
- Review topics must be approved before Recovery Auditor may review
- Support appeals process by provider
- Share with CMS and appropriate MAC all review guidelines and parameters used to identify improper payments
- Collaborate with other CMS contractors and partners to adjust improperly paid claims, support appeals, and avoid duplicative reviews
- Maintain quality customer service center to for timely responses to CMS and provider inquiries

CMS Statement of Work for the Part A/B Medicare Fee-for-service Recovery Audit Program—Regions 1-4

RELIAS | LEARNING

RELIAS | LEARNING

MEDICAL NECESSITY GAP ANALYSIS

MEASURE	CURRENTLY IN PLACE	NEEDS TO BE IMPROVED
2 Midnight Rule process in place and successful		
2 Midnight Rule audit process in place and reported to UM Committee		
UM Committee in place and following Condition of Participation requirements		
ED Case Management in place during appropriate hours		
Access Case Management in place, if appropriate		
Physician advisor process in place and successful		
All case managers understand role of medical necessity and 2 midnight rule expectations		
All records have orders with correct order to admit		
Effective self denial process in place for 2 Midnight Rule		
Condition code 44 process in place per Conditions of Participation		
HINNs issued in compliance with CMS regulations		
Effective denial management process		

RELIAS | LEARNING

RELIAS | LEARNING

MEDICAL NECESSITY'S UTILIZATION MANAGEMENT BALANCE IS TRULY A BALANCE OF FINANCIAL AND CLINICAL

RELIAS|LEARNING
RELIAS|LEARNING

BUT.....WHAT IS THE FUTURE OF UTILIZATION MANAGEMENT—THE NEXT GENERATION?

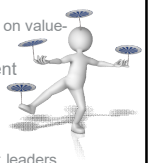
Straddling, Managing, Collaborating, and Surviving Two Payment Systems

RELIAS|LEARNING

UTILIZATION MANAGEMENT'S FUTURE

A NEW CRITICAL ROLE: BUSINESS CASE MANAGER

- Team lead or supervisor role
- Focuses on the business side of case management
  - Becomes super user of Hospital Compare
  - Knowledge expert of case management's impact on value-based reimbursement system
- Manages understanding straddling two payment systems
  - Coordinates education of staff
  - Resource for case management leaders
  - Provides recommendations to case management leaders
  - Develops competencies for staff related to alternative payment models



RELIAS|LEARNING
RELIAS|LEARNING

UTILIZATION MANAGEMENT'S FUTURE

A NEW CRITICAL ROLE: BUSINESS CASE MANAGER

- Interacts with payer contract department
- Develops dashboard related to case management impact on value-based reimbursement
- Reviews avoidable delays/days with follow up feedback and recommended action plan
- Leads coordination of appeals and denials

RELIAS | LEARNING

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

EVOLVING ROLE OF THE UM COMMITTEE WITH VALUE-BASED REIMBURSEMENT

- Consider adding business case manager to membership
- Ensure education
  - Compliance
  - New bundled payment and alternative payment model update
  - Proposed and final regulations related to case management
    - Inpatient Prospective Payment System
    - Outpatient Prospective Payment System
    - Federal and/or state regulations
- Managed care contracting update
- Physician advisor report

RELIAS | LEARNING

RELIAS | LEARNING

THE EVOLVING ROLE OF THE UR COMMITTEE

Dashboard That Includes Value-Based Reimbursement Outcomes

- LOS trends by payer group and payment models
- Trends for Medicare short stays
- Cost/case trends by payer group and payment models
- Medicare spending per beneficiary from hospitalcompare.gov
- Outlier cases (requirement of Conditions of Participation)
- Medical necessity audit results, including 2 midnight rule
- PEPPER reports
- Denial rates by payer group
- Avoidable delays/days

RELIAS | LEARNING

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

- Determining the place for the utilization management role
  - Continued in the case manager role of discharge planning, care coordination, resource management and utilization management
  - Separation of utilization management from the case manager role
- Payer contracts
  - More restrictive contracts with, and without, case management leadership involvement in the payer contract negotiation process for utilization management segments
  - Fewer payer contracts as bundled payment continues to expand
  - Increased risk-based contracts
- Accountable Care Organization (ACO) expansion
  - If you are part of an ACO, care coordination and utilization management expertise is critical
  - If you are not part of an ACO, you must act like an ACO

RELIAS | LEARNING

RELIAS | LEARNING

Aetna placing a great deal of emphasis over the past several years on value-based relationships with providers, with hospitals, health systems, and physicians

Now: About 45% of payments are through some type of value-based relationship

Goal for 2020: 75% of payments in some type of value relationship with only about 25% in traditional fee-for-service reimbursement models

We believe that's the direction that healthcare is heading and the financing of healthcare will result in the providers of care taking more risk, on not only the outcomes but also how care is ultimately delivered to each and every individual. At the end of the day, that rewards quality, it puts the emphasis not on volume but on value, and we think that's very important.

Harold L. Paz, MD, MS, Aetna executive vice president and chief medical officer

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

- Population health emphasis
  - Increased care coordination with next level of care providers
  - Consideration of transition case managers
    - In hospital
    - Post hospitalization
      - Post acute care providers
      - Physicians able to bill for transitional care management from an inpatient setting to a community setting, such as home or assisted living (2013)
      - To bill
        - Communicate with patient or caregiver within 2 business days of inpatient discharge (phone, email or in person)
        - Engage in medical decision making of at least moderate complexity
        - Conduct face-to-face visit within 7 to 14 days of patient discharge, depending on the clinical complexity of patient's condition
      - CMS estimated 2/3 of discharged patients would qualify for this service (2013)
      - Chronic care management: For providers who manage to bill for management of chronic disease patients (2015)
        - Must spend 20 minutes per month on monitoring and/or management of these patients
        - Includes monitoring care plans, reviewing test results, consulting patient's other providers, following up with patient by phone
        - CMS reports that 2/3 of Medicare patients with chronic diseases would be eligible for these services
  - Alignment by case management leadership with next level of care providers

RELIAS | LEARNING

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

- Free standing access to patients, potentially leading to disconnected care of patient
- Continue increase of alternative payment models
- ACA marketplace
  - Potential changes with new administration: American Health Care Act
  - Increase in underfunded patients
  - Potential increase in unfunded patients
  - Increase in IRS auditing of ACA charity care rules for certain hospitals (501(c)(3)—auditing at least every three years

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

- Revenue cycle efficiency
  - Need for improved patient access operations
    - Identifying patient's payer
    - Timely screening of patient's without payer
    - Identifying patient's benefits
    - Identifying initial payer communication requirements for optimal utilization management
    - Enhanced financial counseling role
  - Improved collaboration with case management, patient access, finance and compliance
- Effective physician advisor role
  - Appropriate physician advisor
  - Appropriate number of physician advisors

RELIAS | LEARNING

UTILIZATION MANAGEMENT'S FUTURE

- Enhanced integration of patient care and utilization management technology communication across the health care continuum
- Denials
  - Prevention
  - Management
  - Number of denials today
    - 1 in 5 claims delayed or denied (RelayHealth Financial)
    - 31% of denials originate in the claims process--30-40% of these are due to registration and pre-service related challenges
  - Understand that not all payment models will have denials
- Redirection of variations in clinical care

RELIAS | LEARNING

ONE OF THE BIGGEST CHALLENGES OF THE FUTURE OF UTILIZATION MANAGEMENT…… HYBRID REVENUE CYCLE MANAGEMENT

RELIAS | LEARNING

"Plans are nothing, but planning is everything."

President Dwight D. Eisenhower

RELIAS | LEARNING

RESOURCES

- Conditions of participation: http://www.Cms.Gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.Pdf
- HINNS: http://www.Cms.Gov/medicare/medicare-general-information/BNI/hinns.Html
- Www.Oig.Hhs.Gov
- Www.Justice.Gov
- Condition code 44: https://www.Cms.Gov/regulations-and-guidance/guidance/transmittals/downloads/R1760CP.Pdf
- Medicare claims processing manual: http://www.Cms.Gov/regulations-andguidance/guidance/manuals/downloads/clm104c01.Pdf
- OPPS 2016 final rules: http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf
- Case Management Concepts: www.casemanagementconcepts.com

RELIAS | LEARNING
RELIAS | LEARNING

RESOURCES

- RevCycle Intelligence: http://revcycleintelligence.com
- Appeal Academy: www.appealacademy.com
- RAC Monitor: www.racmonitor.com
- American Health Care Act: https://waysandmeans.house.gov/wp-content/uploads/2017/03/AmericanHealthCareAct_WM.pdf?wpisrc=nl_daily202&wpmm=1

RELIAS | LEARNING

RELIAS | LEARNING

IT'S TIME FOR QUESTIONS

cestacon@aol.com

bevcmc@hotmail.com

www.casemanagementconcepts.com

RELIAS | LEARNING