Winning The Patient Status Battle

Tuesday – December 13, 2016
Noon – 1:30 Pacific / 1:00 – 2:30 Mountain / 2:00 – 3:30 Central / 3:00-4:30 PM Eastern

Connie Perez, President, Adreima
Teresa Torkelson, Director, Adreima
Rhonda Kamenick, Manager, Revenue Recovery, Aurora Healthcare
Connie Perez is currently the President of Adreima. She started with Adreima in 2004 and was the President and CEO until 2012. Before joining Adreima, Connie was Vice President of Patient Care Services at Phoenix Children’s Hospital and spent most of her early career in various nursing leadership and quality roles in Children’s hospitals. She is currently chairing the national “Women Lead HERe” initiative for HFMA at a national level and served as the 2011-12 President of the Arizona chapter of the Healthcare Financial Management Association. She is the 2009 Past Chairman of the Board for the Greater Phoenix Chamber of Commerce Board of Directors. She also served as the 2011-12 Chairman of the Board for Ryan House in Phoenix.
Teresa Torkelson Bio

Teresa Torkelson has been instrumental in the launching and ongoing successful maintaining of Adreima’s Utilization Management programs in several major hospital systems. The programs include full service Utilization Review, Physician Secondary Review and Medicaid specific authorization services. Ms. Torkelson previously held the role of Clinical Manager over Denials Management and RAC. Her expertise and clinical acumen has resulted in exceptional results in increased revenue and decreased denials. Most recently, Ms. Torkelson successfully implemented a new client for Physician Secondary Review going live within 2 weeks. During the last few months, this client has seen a potential of converted and maintained revenue of 2.5 million dollars.
Rhonda Kamenick Bio

Rhonda Kamenick has been with Aurora Healthcare for 11 years and is a Registered Nurse with a Bachelor’s Degree in Nursing from the University of Wisconsin Milwaukee. Her nursing background is in oncology and obstetrics. Previous to working in Revenue Cycle, she worked on implementation and build of the Beacon Oncology application in Epic for Aurora. She has presented at the national Epic User Group multiple times, including on nursing’s expanding role in healthcare finance.

Rhonda Kamenick
Manager, Revenue Recovery
nThrive, an independent patient-to-paymentSM solutions company, is pleased to announce it has closed on an agreement to acquire Adreima, a Downers Grove, Ill.-based provider of patient-centered, clinically-integrated revenue cycle services that help patients find coverage and meet their financial obligations, while partnering with health care providers to optimize revenue cycle functions. Adreima’s solution portfolio further strengthens nThrive’s patient-to-payment roadmap and demonstrates nThrive’s commitment to delivering on its promise to create greater innovation and scale that generates standardized and repeatable clinical, operational and financial performance for health care providers.

Please view our press release for additional information on this exciting acquisition at thrive.com.
The Patient Status Battle

Arguably the most impactful revenue cycle function/challenge hospitals are dealing with today

- Continued confusion around Two Midnight Rule and more recent guidance around physician judgment
- Significant Compliance risk if push too hard
- Significant Revenue/Cash risk don’t push hard enough
- Integration with down-stream coding and billing practices complex and can create risk
- Consequences of inaccurate data/classifications can have long term impact in future contracting, pricing and planning
The Battle Lines

• Managing correct assignment OP/OBS/IP is a 24/7/365 challenge that starts in Scheduling, *rages in the ED* and doesn’t end until account resolution

• Has become a race against the clock to “get it right” when it comes to accurate, timely assignment of/order for patient status
  – *More* UM/CM staff deployed in nursing, physician and clerical roles
  – Utilization/Case Management continue to move focus “up” in an encounter
    ▪ Shifting resources to concurrent review
    ▪ Increased staffing ED
    ▪ Specific OBS plan and assignments
  – Rapid escalation processes in place to resolve “disagreements” between UM criteria-based assessments (MCG/InterQual) and physician assessment
The Battle Lines

• Concurrent payer information requests and required authorizations increasing and increasingly specific throughout an episode of care
  – More dedicated UM/CM and clerical resources to manage
  – “Solutions” such as direct medical record access for payers saves time/resources but does not facilitate the case to be made for continued authorization

• Need to follow all the way through the cycle to understand real impact
  – Still see retrospective denials despite strong concurrent processes and documentation
  – Significant impact on revenue and cash if not coded, billed and paid based on accurate patient status assignment
The Battle Plan

• Requires a comprehensive approach utilizing a systematic process and systemic view

• Pulled together best known methods to facilitate awareness, stimulate thinking and hopefully provide a base of information from which others can work
Discovery and Assessment: Data Analysis and Review

• Volume indicators:
  Past two years trended by month and by day-of-week
  – Census reports for inpatients
  – Length of stay distributions
  – ED visits and Observation days

• Review of denied admissions / days
  – Retrospective level of care and medical necessity
  – Concurrent review requests/results
  – Reconsideration requests

• Review of current practice related to going-forward metrics
  – Number of IP and OBS reviews completed
  – Quality and accuracy of completed reviews
Client Admits Per Day-Historical

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<tr>
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<tr>
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<tr>
<td>Initial reviews</td>
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<td>Avg Adm Friday</td>
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<td><strong>Weekly Average</strong></td>
<td><strong>533</strong></td>
<td><strong>131</strong></td>
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Inpatient: 755
OBS: Obs 176
11
## Monitoring Nurse Productivity

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<th>Nurse</th>
<th>Billable Hours</th>
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<th>IP Reviews/Hr</th>
<th>Expectation</th>
<th>% to Expectation</th>
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### Week 3

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<td><strong>111%</strong></td>
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Design and Validation

• Ensure processes are developed and people are prepared with the knowledge needed to “get it right” when it comes to patient status determination

• Establish metrics and timeframes by which the program will be measured
  – Drives daily staffing/assignments/budget

• Create process flows to facilitate adherence to process and strong communication between what can be “silöed” areas of the organization
  – Documented in UR Service Delivery Guide
Getting it Right: Criteria and Factors Driving Revisiting CMS 2-Midnight Rule

- An Inpatient Admission is defined by the physician’s expectation that a patient will require a hospitalization encompassing 2 midnights.
  - Time is based on the cumulative time spent at the hospital including the time spent in outpatient service….physician should consider the time already spent receiving those services in estimating the patient’s total length of stay.
  - Transferred Patients: The receiving hospital is allowed to take into account the pre-transfer time and care provided at the initial hospital as the clock begins there.

- The physician should order inpatient admission “if he or she expects the length of stay will exceed a 2 midnight benchmark.”
  - Order MUST SPECIFY “Admit to Inpatient” or similar language.
  - ”Admit to ICU” is not an acceptable order.
Getting it Right: Physician Documentation

A reasonable inpatient hospital stay that spans more than 2 midnights will have to show “sufficient documentation….rooted in good medical practice…”

Documentation includes:

- Patient history
- Severity of signs and symptoms
- Co-morbidities
- Current medical needs
- Risk of adverse event
Assumptions and Staffing Plan

• All Observation/Outpatient Bedded patients daily until able to upgrade or discharge

• All Inpatients initial reviews for all payers

• Continued stay reviews/Payer requests for clinical submitted within time frame requested
  − Some payers have very strict time frames (2-4 hours)
  − Otherwise EOB

• UR Team coverage hours 7:00 AM-5:00 PM

• Daily staffing determined by:
  − Number of reviews listed on first run reports in AM
  − Average hourly productivity expectations
  − Expectation to complete 100% of all reviews on first run reports in AM
Considerations for Design

• Focus on areas of Patient Entry
  – ED with extended hours into the evening
  – Surgery/PACU
    o Daily Surgery Schedule to check for “Medicare IP only” procedures
    o Review surgical procedure notes
  – Direct admissions from external facilities

• Assign RN(s) specifically patients in OBS/OPB status
  – Timely review before crossing 2\textsuperscript{nd} midnight
  – Quicker referral to physician advisor for secondary review

• Assign RN(s) specifically to IP concurrent/continued stay
  – Clinical updates to payer
  – Managing concurrent denials from payers
Considerations for Design

• Ensure timely concurrent/continued stay management
  – Clinical and Clerical staff dedicated to endeavor
  – Provide prospective clinical updates to payer
  – Manage concurrent denials from payer

• Maintain payer contract matrix for quick reference
  – See next slide for types of things to include

• Work collaboratively with CBO/Revenue Cycle

• Review quarterly PEPPER report
Payer Matrix

Things to include in payer matrix:

- Payer
- Plan Type
- Plan Name
- Original Contract Date
- Last Update/Renewal Date
- Expiration Date
- Plan Provider Assistance Contact number
- Review Guidelines Used
- Elective/Prior Notification Process
- Emergent Notification Requirements
- Inpatient Notification Requirements
- Observation Notification Requirements
- Concurrent Review Requirements (by status and time frame)
- Readmissions
- Clinical Submission Contact
- Peer to Peer Allowed?
- Appeal Levels and Timelines
- Discharge Notification Required?
- Discharge Contact
- Payment Methodology
Implementation and Transformation

- Key players meet regularly to develop and review program
- Document/manage against a formal Implementation Plan
- Process flows under continual revision with changes documented in Process Guide and shared
- Utilize KPIs to guide and manage program
  - Quality Score 95% or above
  - MCG review completion based on AM report: 100%
  - Productivity with Targets
    - 4 IP per hour
    - 2 OBS or Outpatient Bedded per hour
  - Clinical Denials

20
Review Prioritization

- Observation/Outpatient Bedded
- Initial Inpatient
- Continued Stay (non Medicare) based on payer requirements
- Readmissions
Observation/Outpatient Bedded

- RN’s assigned specifically to this population/Staffing based on number of reviews
- Initial and daily reviews as long as patient remains in an outpatient status
- Medicare/Medicare Advantage 1st priority
- Clinical review/IP Only Procedure/Midas documentation
- Contact attending physician to discuss
  - Possible upgrade if meeting IP
  - Discharge plans if not meeting IP
- Send to PA for secondary review as indicated
- Order entry in EMR
Example Process Flow OBS to IP

1. **Initial UM Reviewer**
   - **Provider agrees to change order?**
     - **Yes** → **Enter TO into EMR** → **Refer to initial placement workflow** → ** Notify PA, via text**
     - **No** → **Text PA and pend in CM System** → **Response?** → **Review of order and determination of authorization requirements** → **Set follow up in CoRCIS and CM System for end of day check to confirm order** → **Order changed?**
       - **Yes** → **Call Care Coordination Manager on call** → **Physician and Level Review referral approved** → **Create CM System referral to Physician and Level Review** → **Refer to continued stay process as indicated**
       - **No** → **Document case progression with final order status. Results from inventory**

2. **Physician Advisor**
   - **Completes secondary review** → **Review with attending** → **Document case notes and results in CM System** → **CM System populates queue when review completed** → **Review case and determine if Physician 2nd Review escalation indicated** → **Completes secondary review**

3. **UM Lead**
   - **Review case and determine if Physician 2nd Review escalation indicated** → **Completes secondary review**

4. **Physician 2nd Level Reviewer**
   - **Complete 2nd level review** → **Contact attending with recommendation and secure order update** → **Update CM System with notes and final determination**
Inpatient

- RN’s assigned specifically to this population/Staffing based on number of reviews
- Initial reviews only for Medicare
- Initial reviews for all other payers and continued stay reviews per payer request
- Initial reviews Medicare/Medicare Advantage 1st priority
- Clinical review/IP Only Procedure/CM system documentation
- Contact attending physician to discuss
  - Possible downgrade if not meeting IP
  - Condition Code 44 process if indicated
- Send to PA for secondary review as indicated and follow up accordingly
- Order entry in EMR
Example Flow IP to OBS
Example Flow Condition Code 44

Initial UM Reviewer
- Order change from IP to OBS on Medicare patient is indicated
  - Update Midas for condition code 44 flag
  - Refer to conditioned stay review process

Physician Advisor
- Documentation from UR committee of order appropriateness per guidelines

UM Lead
- Coordinate patient documentation
  - All patient documentation present prior to discharge?
    - Yes
      - Set follow up in CM System for end of day check to confirm order
    - No
      - Set follow up in Midas for end of day check to confirm order

Revenue Cycle
- OBS hours captured in Epic after OBS order entered
  - Bill outpatient claim with observation services
  - Adjust account per process
Staffing and Workforce Strategies

• UR Manager
• Training and Development Coordinator
• Full time RN’s working 10 hour shifts---may be on-site or remote---for core staffing
• PRN RN’s to help fill weekends, holidays and PTO---increases flexibility
• “Clinical” Coordinator---dedicated clerical resource to coordinate clinical payer requests
• Physician Advisor---key role
• Physician Second Level Review
Physician Advisor Role

The purpose for Physician Advisor (PA) and secondary review is to render a billing status recommendation based on supporting clinical documentation and medical best practice beyond nurse review guidelines (MCG; InterQual).

- Referrals are sent to a Physician Advisor (PA) when:
  - RN criteria review does not meet current status of patient
  - Attending physician disagrees with RN status review
  - Other situations as documented in hospital UM Committee Policy

- Physician Advisor can be internal or external (vendor)

- The PA reviews the case, makes a status recommendation and documents with all supporting information to validate.

- The PA may also speak directly with the attending physician to discuss if limited clinical information in EMR.
UR Manager Role: “Air Traffic Controller”

- MCG and InterQual certified with strong expertise in Utilization Management
- Needs excellent communication skills and PATIENCE
- Runs AM and PM reports to identify cases requiring review and assigns to RN’s
- Ongoing communication with Client Care Coordination Manager/Client PA/RN’s
- Conducts daily midday “huddle” call with Care Coordination Manager & provides documented updates to the OBS/OPB cases as needed
- Creates/maintains work schedule and communicates daily staffing
- Tracks daily productivity
- Conducts team member performance reviews
Training and Development Coordinator

- MCG and InterQual Certified
- Education and Onboarding of new RN’s
- Monthly QA reviews
- Group training
- Individual training as needed
- Ongoing staff education and training
Nurse Reviewer

- May work remotely from home with access to all necessary systems
- Performs MCG/InterQual reviews CM system and uses EMR documentation review/order entry
- Contacts attending physicians directly to discuss cases
- Contacts Physician Advisor for physician secondary review and follows up accordingly
- Documents review and actions associated with each case in Case Management system
- Supplies UR Manager with final documented “report off” on cases at end of shift
- Responds to payer concurrent denials
- Directs Clinical Coordinator to submit clinical per payer request
- Participates in ongoing and required training
Clinical Coordinator

• Runs payer requests for clinical reports in Case Management system

• Submits clinicals as set up through EMR or other method

• Communicates to RN when concurrent denial received

• Monitors timeframes and ensures reviews are received within contracted timeframes

• Other clerical functions as needed
Case Study
Aurora Health Care

• Not-for-profit integrated system
• 30 counties, 90 communities
• 15 hospitals
• 150 + clinics
• 70 pharmacies
• Largest homecare organization in Wisconsin
• 31,000 employees; 1,700 employed physicians
• $4.7 billion in annual gross revenue (2015)
• 1.2 million unique patients
Aurora Health Care

- 70 Pharmacy locations
- 15 Hospitals
- 159 Clinics
- Prescriptions filled (millions)
  - 2014: 1.821
  - 2015: 1.832
- Visits (millions)
  - 2014: 3.478
  - 2015: 3.566
- Inpatient Days (thousands)
  - 2014: 324
  - 2015: 330
- Home care
- Home Visits (thousands)
  - 2014: 206
  - 2015: 223
- Labs
- Tests Performed (millions)
  - 2014: 17.038
  - 2015: 17.580

Source: Aurora Health Care  y-t-d September
Revenue Cycle at a Glance
Background and History

- Started in 2015: 4 employee’s doing RAC/Audit and outpatient Medicare appeals.
- Hired additional outpatient appeal nurse to do commercial medical necessity appeals in mid-2015.
- Added 4 Denial Case Managers and account assistant in January 2016.
- Account assistant and new outpatient recovery nurse in late 2016.
- Now a team of 12 (from 5 a year ago)
Denial Case Management (Before)

• Previous to centralizing Denial Case Management there was varying models across the Aurora system

• Metro hospitals (including our 600+ bed flagship) had dedicated Denial Case Managers who worked for the Clinical Director at the hospital.

• At outlying hospitals, some had part time Utilization Management also doing appeals and denials, while most of the facilities had their floor Case Managers doing denials and appeals whenever they could fit it in with their patient load.

• Use of a Physician Advisory Service to help status patient’s at the bedside.
  – Large amount of clerical work, such as uploading documentation and denial letters included with managing this process

• Little awareness on what was actually getting paid as inpatient or on what the outcome’s of physician advisory services were.

• Missing deadlines for appeals, or not appealing appropriately due to time constraints and patient load.

• Inability to see larger system-wide trends.
Denial Case Management (After)

• Denial Case Managers working at the Metro hospitals were brought to Revenue Recovery under the Revenue Cycle umbrella January 1st, 2016.

• Moved from getting cases via individual email to using Epic WQ’s and having a centralized email box to communicate with business office.

• Hired additional Case Manager and slowly brought on outlying hospitals who were handling their own denials.

• Hired a patient account assistant to manage the clerical volume of work for the Physician Advisory Service that was previously being done by Nurse Case Managers.

• Last hospital went live in September, 2016. All 14 Medical Facilities status denials are managed by Revenue Recovery.

• This allows for a much bigger picture, and the ability to look at things from a different lens.
Physician Advisory Service

• While Aurora continues to use our PAS, it is being looked at in a different light, and analyzed to a much greater level.
• Prior to centralization, things were sent to the PAS at times because the floor CM’s knew they were not going to have time to work the case when it denied. Since there are now dedicated people to do this, that decreased sending cases ‘just because’, that did not fit the criteria set forth for sending to PAS.
• On the clinical side it was looked at from a perspective of: the PAS maintained x amount of stays as Inpatient, or turned x amount of stays from OBS to Inpatient. What was not looked at was what are the outcomes of the cases that they turn from OBS to IP? Do they deny? And if they deny, how many denials are they overturning on appeal?
• No one was following up with the PAS when they were filing appeals, therefore they were holding cases often until near deadlines for appeal. This left valuable dollars sitting in A/R. With little disagreement, they changed to a 45 day turnaround when asked.
• A recent finding, was that some hospitals were sending to PAS post-discharge cases that were ‘grey’ (so they had not been statused while the patient was here). After analysis by Revenue Recovery it was found that 100% of the time, if the patient was statused as OBS in these post-discharge reviews, the PAS was maintaining OBS. Hence, we are no longer sending any OBS patients post-discharge to the PAS.
Denial Prevention (Phase 2)

- Another large advantage, and maybe even the biggest one, was the ability to give feedback to the hospitals on what trends the Denial Case Managers are seeing on the back end, and helping to **PREVENT** denials in the first place.
- This is much harder than it sounds!
- Waited until all 14 hospitals were live to give this level of feedback.
- Meet with System Case Management on a monthly basis, including Hospital Case Management Manager and Director of System Case Management
Denial Prevention (Phase 2) con’t

• At this monthly meeting, we bring two real case studies from the last month to the team, with a focus on cases that are rebilled without being appealed.
  – Each of the Denial Case Managers sends a case study of what they feel has been THEIR biggest trend this past month to review, and select the two most important trends to take back to the system which could have the biggest impact for the facility.

• Each case study is assigned a code (001, 002 etc.). When documenting the rebill reason, the trending code is applied (as applicable).

• This is a running list that will expand over time allowing the managers at the sites to run reports out of the Case Management systems and determine how many of their cases are rebilled for those reasons, and gives opportunity to educate their teams.
One Year In

• As expected, there have been bumps in the road.
• Communication is a key piece. Example: Case Managers at a site were not sending clinicals because “the people on the back end will clean it up!”
• Has vastly changed how the clinical area of Case Management looks at denials.
• They no longer look at it as just days, but can equate it into the dollars worth of impact, including on A/R.
• Decreasing cost of external PAS when sending does not make good financial sense (Although the PAS is still a key piece in our Case Management toolbox, we want to use them appropriately and efficiently)
• Helping to control A/R, by making wise decisions on what to appeal or what to rebill as an outpatient.
Questions?
To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT69

URL: http://www hfma org/awc/evaluation.htm

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