27th Annual Revenue Cycle and Finance Conference

Building Beyond: Leading the Future of Revenue & Finance

CARE MANAGEMENT AND FINANCE – BRIDGING THE GAP

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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

TODAY'S REALITY

Hospitals overflowing with patients

Burnout remains 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

Uncertainty in DC

US health care system with fragmentation and mega-consolidation at the same time

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

Most hospitals are:

Fighting to stay in business

Trying to provide state of the art medical care

Aiming to meet the Quintuple Aim

THE CHALLENGES AT BOSTON MEDICAL CENTER

Long length of stays, Avoidable days, Frequent readmissions

Drivers:

Social determinants of health

Unhoused, low health literacy, limited income, social support, food insecurity

Limited LTAC facility beds for most complex patients

Immigration barriers

Prior authorization delays/denials

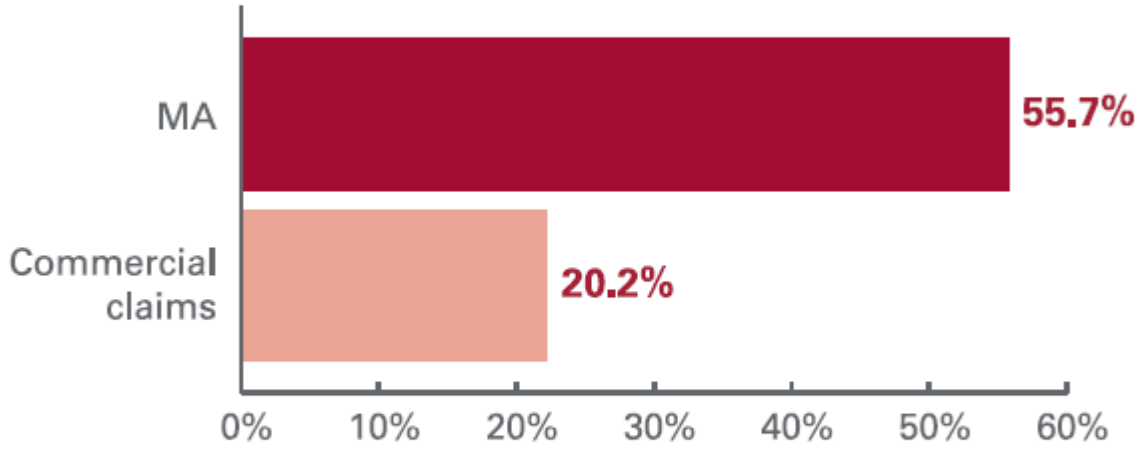
Secondary insurance/Long term care

Capacity for decision making

HOW WE VIEW THE QUINTUPLE AIM

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 reinbursement challenges 2023.*

AETNA- ARE YOU SERIOUS?

Effective November 15, 2025, we'll adopt a new reimbursement approach for hospital stays of 1+ midnight in cases where a member is urgently or emergently admitted to a hospital and the provider has submitted an inpatient order.

- We'll approve the inpatient stay without a medical necessity review and pay the claim at a lower level of severity rate that's comparable to your rate for observation services.**
- If the inpatient stay meets MCG (Aetna Supplemental Guidelines for inpatient admissions), we'll pay the claim at your inpatient rate in accordance with the hospital agreement.

RELATIONSHIPS WITH OUR PAYERS

Forum for collaboration and communication with payers

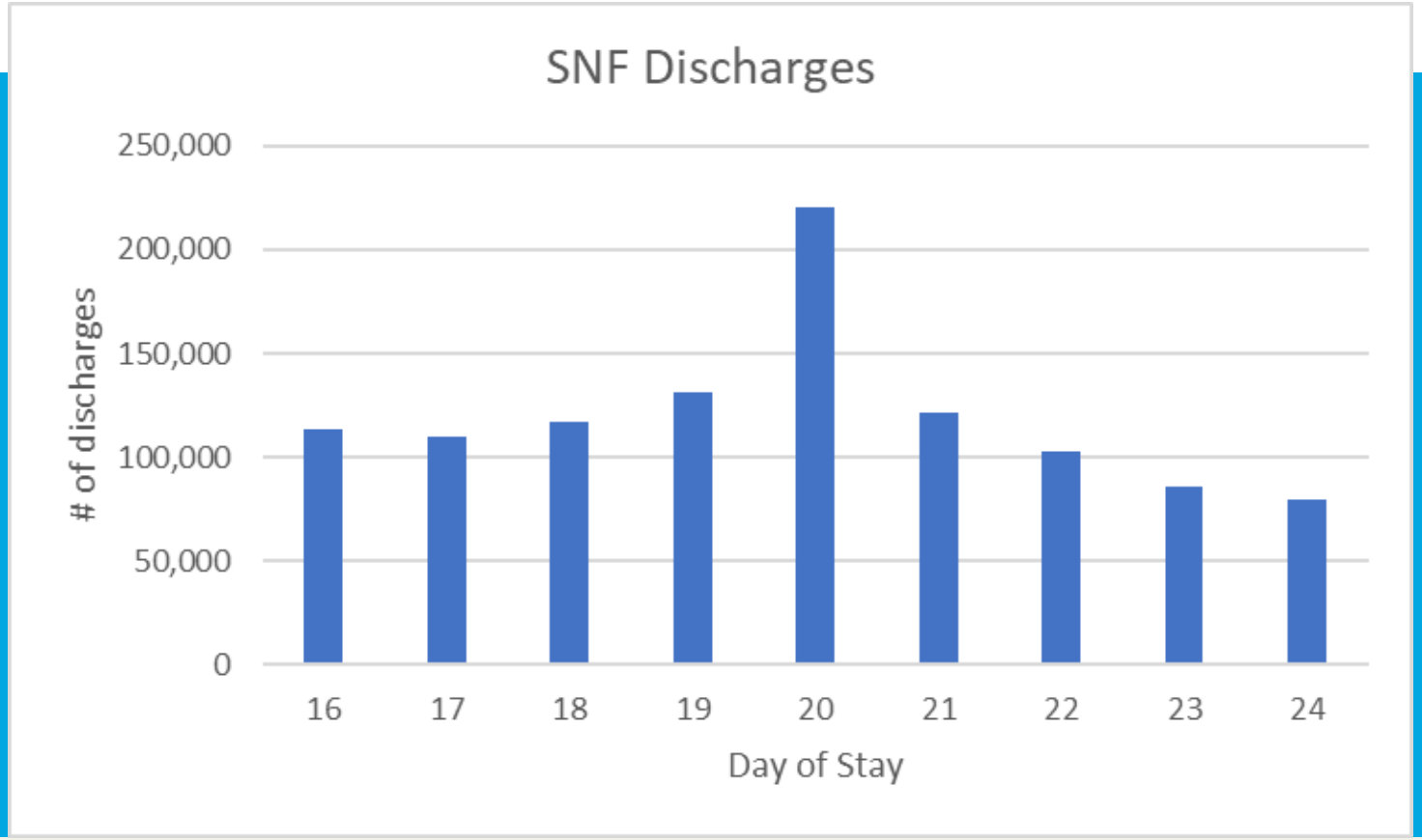
JOCs (Joint Operating Committees) for high denial payers in an attempt to address and resolve contractual and relational issues

Case Management input when negotiating payer contracts

Collaborate with Payer CMs in developing an aftercare plan for challenging patient discharges

Case Example – Readmissions and the Obligations of the Payers

THE FEW RUIN IT FOR THE REST
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

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

WHAT CARE SHOULD SHE GET?

Inpatient admission

Neurologic evaluation

Blood pressure management

Frequent vital sign monitoring

Manage coagulation

Potential neurosurgery consult

Swallow, PT, OT evaluations

Medication review

Social work consult

Discharge to appropriate level of care

IRF (Acute Rehab), Subacute rehab, home health

DME

Community support – meals, home health aid, transportation, home modifications

WHAT'S THE ROLE OF CASE MANAGEMENT?

Confirm payer

Notice of Admission

Level of care

Disposition

Post acute insurance auth (P2P, Appeal)

Healthcare proxy

DME

Community resources

Discharge on day medically ready!

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
  - For patients with minor conditions, will a bit more ED time prevent an admission?

EASIER WAY TO IMPROVE PRESS-GANEY SCORES

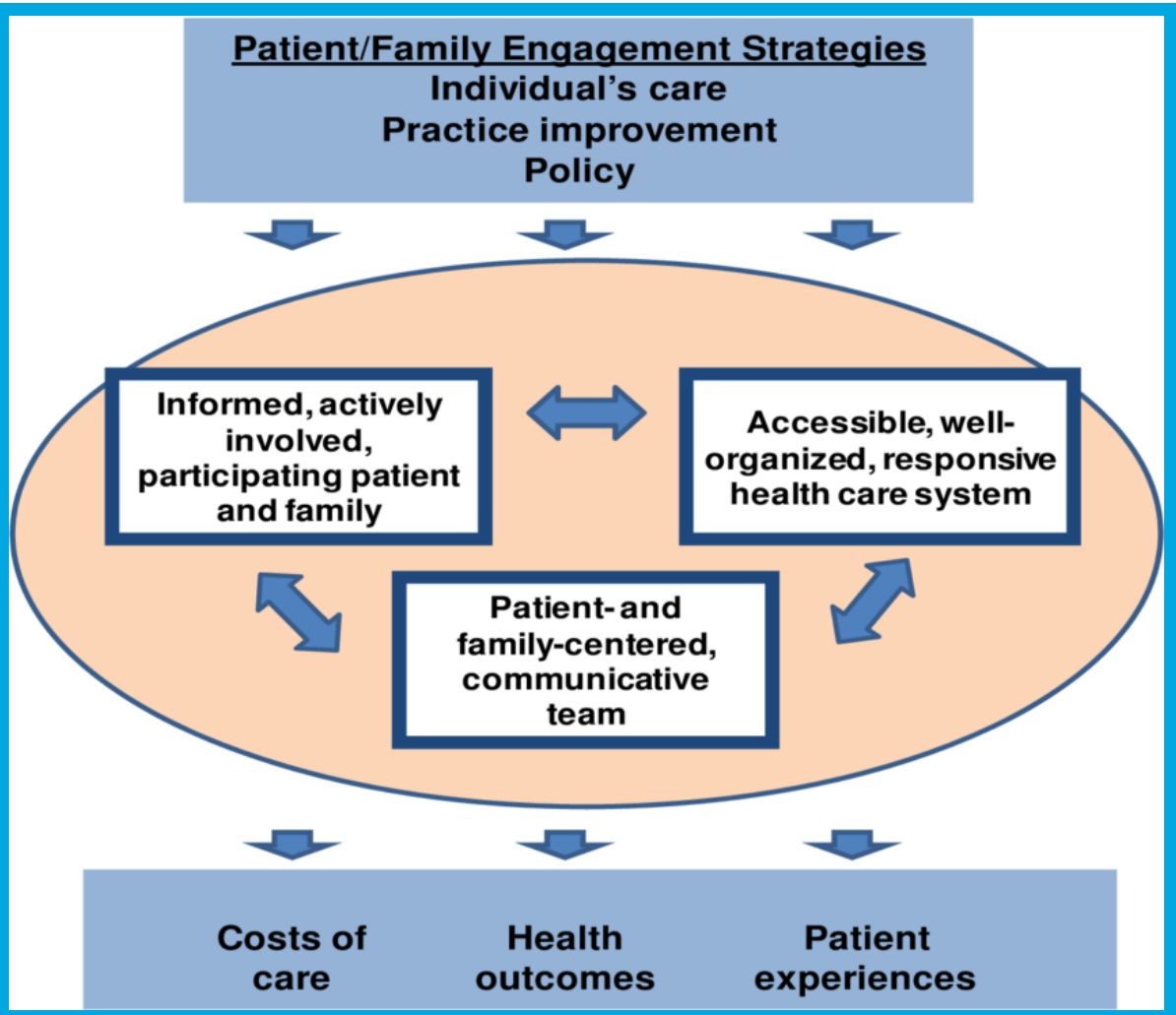
The Influence of an Unexpected Symbolic Gift on Postoperative Arthroplasty Patients' Press Ganey Scores

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

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

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

PATIENT SATISFACTION V ENGAGEMENT



"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 , 3 day waiver
  - Acute rehab; Medical respite; Respite care; Psych hospital
  - Family; Home; Home health services

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

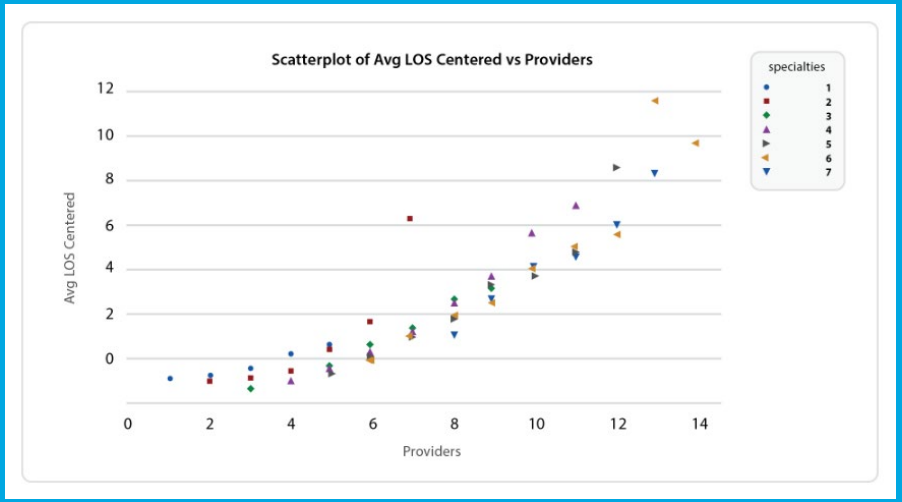
HOSPITAL CARE – WHAT CARE IN WHAT SETTING?

Mrs. Smith arrives at ICU

Admitted to Hospitalist on call

Stroke care plan initiated

Consultations with Neurosurgery, Neurology, Cardiology



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

CRUCIAL ROLE OF UR STAFF

Notify payer if applicable – everyone except Medicare and standard Medicaid

Hospitals open 24/7 but insurers open 10/5 M-F

Miss notification- technical denial, can't appeal

Prospective Review - Level prior to the Admission status order for accurate and timely start of care and to avoid confusion for Medicare patients requiring Medicare notices related to level of care (MOON, IMM, Code 44, MCSN).

Allows for collaboration with admitting provider and documentation standards for determining level of care.

Timely reviews crucial for Observation statuses. Flip to Inpatient (when appropriate) within specific payment policy timeframes (which can differ from payer to payer), otherwise vulnerable to a late notification denial

Ongoing communication with PAS Precert team when upgrading or downgrading an order to ensure NOA is provided to payer to avoid a late notification denial

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

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 – "we are a teaching hospital so I have to teach how to work up anemia"

- Recruit your RNs as "spies" – they know what's necessary
- Have your physician advisors as resource

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

WHAT IS DONE IN THE HOSPITAL?

New treatments and technology abounds

Do you consider these factors?

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

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

WHERE DOES MRS. SMITH BELONG?

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

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?

LENGTH OF STAY – WHO WATCHES? WHO INTERVENES?

"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?"

Multidisciplinary rounds – Review Inpatient vs Obs status, Medical readiness, Dispo, Clinical milestones, barriers to discharge….everyday!

Continued stay reviews for patient throughput, even though already at an IP LOC. Peer to Peer discussions when documentation is no longer supporting IP LOC.

Proactively apply non-covered span codes (Occurrence Span Code 74) for Medicare patients with DC barriers, but medically cleared for DC

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
- Vizient/Premier have better data but use carefully

Medicare LOS calculations are only inpatient days!

- Be sure you use GMLOS correctly
- Can also affect transfer DRG payments

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

CLEAN UP ON MED/SURG UNIT

Mrs. Smith 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

criteria review shows did not meet CMS requirements

MA plan took 72 hours to approve SNF

Contracted SNF was 2 star, family refused transfer

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

CONTRACTING TAKE AWAYS

Hide the rates but let lots of people read it!

No changes via website- must be in writing and signed by you

ED E&M visit codes will not be adjusted by payer

No bundling charges unless it is in contract

Prior auth means pay the claim unless valid fraud

Readmissions paid in full unless hospital at fault

Additional per diem to be paid for every day awaiting approval for care

Set limit on record request volume

Two Midnight rule for all patients

Clinical validation definitions must adhere to professional society guidelines

SUMMARY

Case managers want to provide efficient care

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

Doctors want…well, we are not sure…

Understanding each other's struggles benefits both

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

hfma
massachusetts-rhode island chapter

THANK YOU!

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