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Clinically Integrated Revenue Cycle – Understanding the Challenges

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R1 RCM

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Presented By

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Dr. Ronald Hirsch was a general internist and HIV specialist and practiced in Elgin, IL. He was Medical Director of Case Management at Sherman Hospital in Elgin, IL from 2006 to 2012, and also served on the Medical Executive Committee.

He is certified in Revenue Integrity by the National Association of Healthcare Revenue Integrity, and on the Advisory Board of NAHRI and the American College of Physician Advisors. He is on the editorial board of RACmonitor.com. He is the author of Hospital Utilization Review, now available on Amazon. In 1996, he was a guest on the Jerry Springer show.

Learning Outcomes

- Introduction of the concept of formal clinically and clinician integrated revenue cycle
- Examine the roles of the Physician leaders in key areas of revenue cycle and healthcare finance
- Concept of true shared governance

In The Good 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 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 beyond belief

The Epic Battle

What we see from Payers:
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

What they claim we are doing:
"Finding" more inpatient admissions
Leading doctors to higher paid diagnoses
Adding high margin services and reducing low margin care

The Latest Payer "Policies"

Aetna – level of severity payment policy

Anthem – reduced hospital payment for out of network providers

Humana – adds Observation "readmissions" as non-payable

Many payers – "Auto-downgrade" of E&M codes

Medicare Elimination of Inpatient Only List

637 surgeries to be added to list as of 1-1-27

Two Midnight Rule to apply to surgeries not on list

Payment differential could be significant – DRG v. C-APC

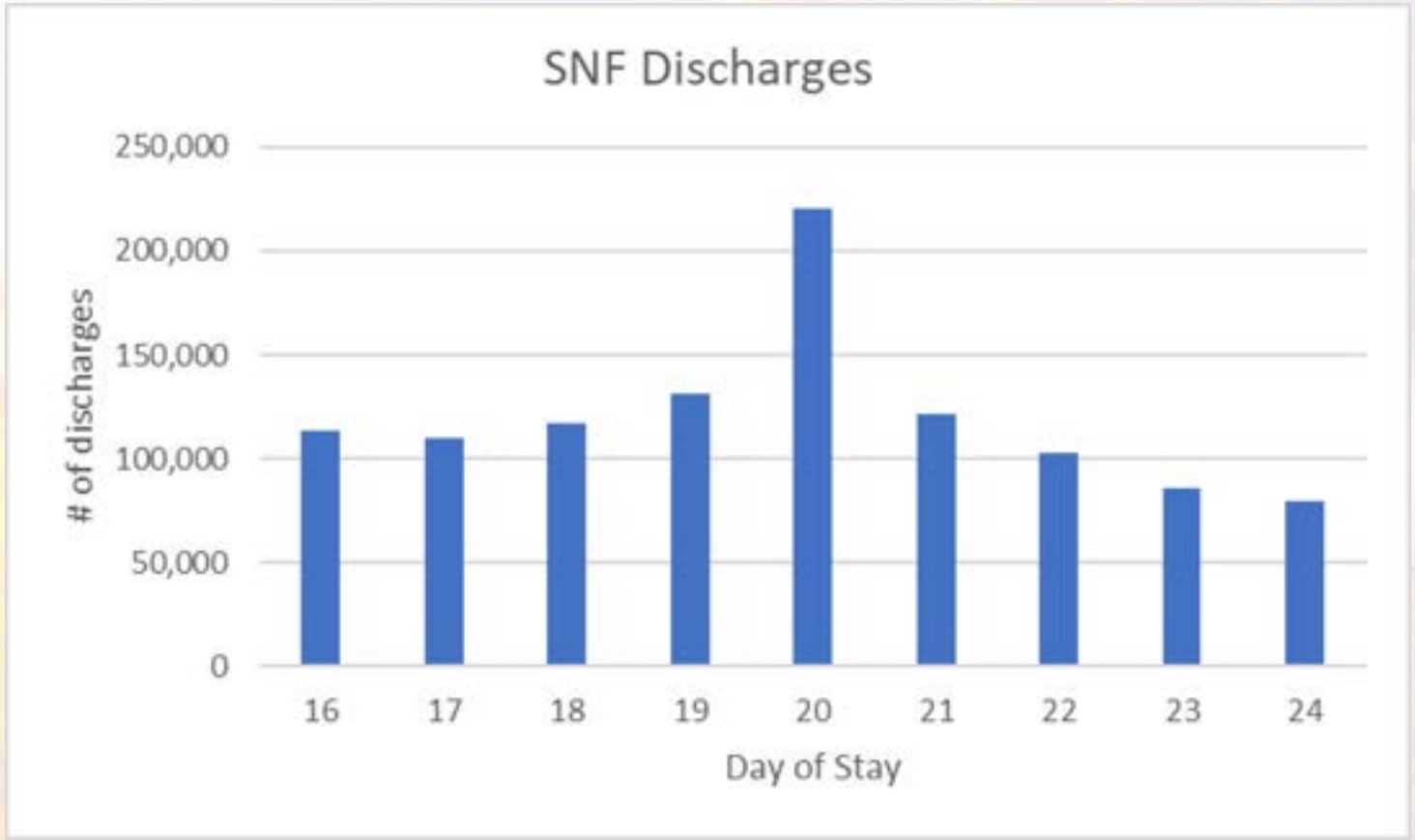
- No IME money
- Significantly lower payment

Providers are not Without Fault

Suburban Chicago Physician Sentenced to Ten Years in Prison for Health Care Fraud

From 2018 to 2022, Ghosh submitted and caused her employees to submit fraudulent claims to Medicaid, TRICARE, and numerous other insurers for procedures and services that were not medically necessary, including endometrial ablations and biopsies, ultrasounds, vaccinations, laboratory blood tests, and tests for sexually transmitted diseases. Some of the procedures were performed without patient consent. Ghosh also fraudulently overstated the length and complexity of in-office and telemedicine visits and submitted claims using billing codes for which the visits did not qualify in order to seek higher reimbursement rates. Ghosh prepared false patient medical records to support the fraudulent reimbursement claims.

Part A SNF Discharges – Random???



LTACH Length of Stay – Random???

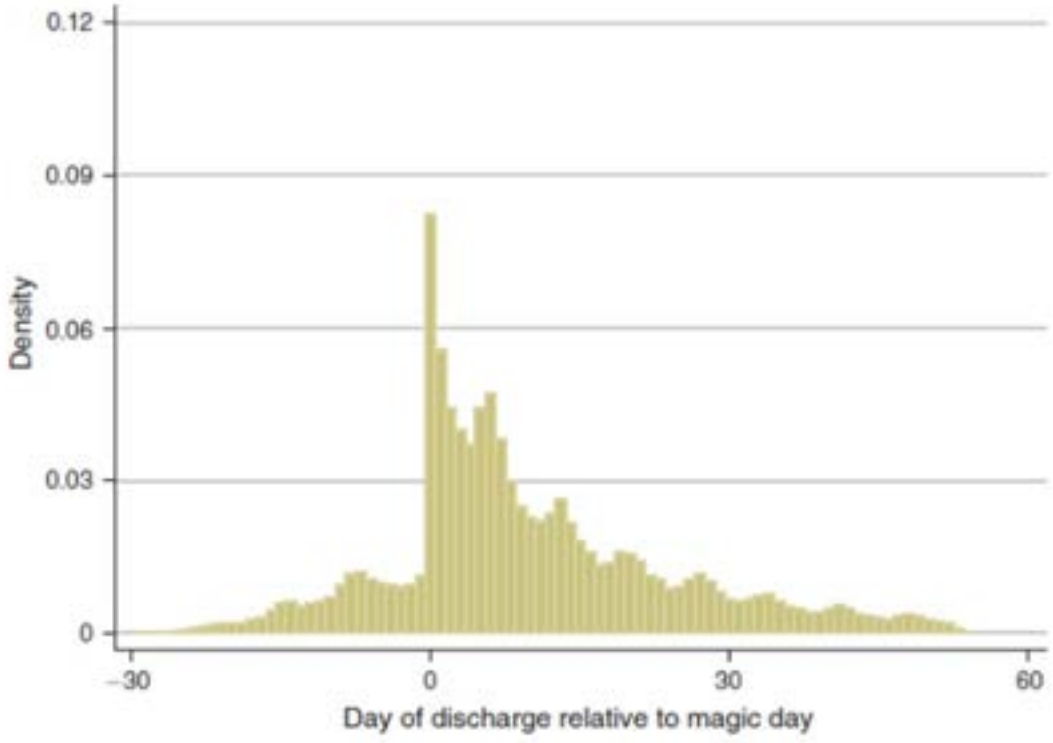


FIGURE 2. DISTRIBUTION OF LENGTH OF STAY RELATIVE TO MAGIC DAY, FY 2004–2013

Where is there Revenue is at Risk?

- Ambulatory Services
  - Physician Practices
    - E&M guideline changes not disseminated to docs
  - Ambulatory Surgery Centers
    - Shifting high margin care to ASC
      - 637 surgeries to be added to ASC list in 2027
  - Infusion Clinic/Oncology Clinic
    - New drug costs, new indications, complex payment
      - Audits focusing on drug choice, sequencing, clinical monitoring
  - Advanced Imaging
    - Scan interval, diagnostic v screening

Medical Costs are not Going Down

Americans think death "optional", says AstraZeneca CEO

By **Reuters**

August 9, 2007 4:10 PM CDT · Updated 1 min ago

"Americans have a funny approach to this -- we think death is optional," joked Brennan.

"We treat an 87-year-old person with pancreatic cancer the same way we treat an 18-year-old with pancreatic cancer. That's not the case outside this country. It's very different," said Brennan, who took over the helm at AstraZeneca at the beginning of this year.

"That's an aspect of this market that's very, very important that we need to maintain," he said. "I think the system in the United States, having toured the world, is great."

Is Site Neutrality Fair?

Patient characteristics	HID	HOPD	ASC	*P* value
	N = 619,070	N = 51,672	N = 7324	
Age	65.91 (10.69)	64.94 (9.80)	61.43 (8.39)	<.001
Sex				<.001
Male	243,590 (39.3%)	23,117 (44.7%)	3572 (48.8%)	
Female	375,480 (60.7%)	28,555 (55.3%)	3752 (51.2%)	
Race and ethnicity				<.001
Non-Hispanic Black	58,793 (9.5%)	2944 (5.7%)	128 (1.7%)	
Hispanic	32,400 (5.2%)	1780 (3.4%)	45 (0.6%)	
Non-Hispanic White	466,525 (75.4%)	43,390 (84.0%)	5236 (71.5%)	
Other	61,352 (9.9%)	3558 (6.9%)	1915 (26.1%)	
Insurance				<.001
Private	212,682 (34.4%)	20,450 (39.6%)	4988 (68.1%)	
Medicare	324,220 (52.4%)	24,756 (47.9%)	1985 (27.1%)	
Medicaid	43,139 (7.0%)	3249 (6.3%)	56 (0.8%)	
Worker's Compensation	27,687 (4.5%)	3200 (6.2%)	293 (4.0%)	
Other	11,342 (1.8%)	17 (0.0%)	2 (0.0%)	
Procedure				<.001
TKR	361,564 (58.4%)	32,160 (62.2%)	3613 (49.3%)	
THR	257,506 (41.6%)	19,512 (37.8%)	3711 (50.7%)	
Comorbidity score				<.001
0	78,738 (12.7%)	11,812 (22.9%)	6780 (92.6%)	
1	154,637 (25.0%)	15,146 (29.3%)	328 (4.5%)	
2 or more	385,695 (62.3%)	24,714 (47.8%)	216 (2.9%)	

https://doi.org/10.1016/j.artd.2025.101695

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

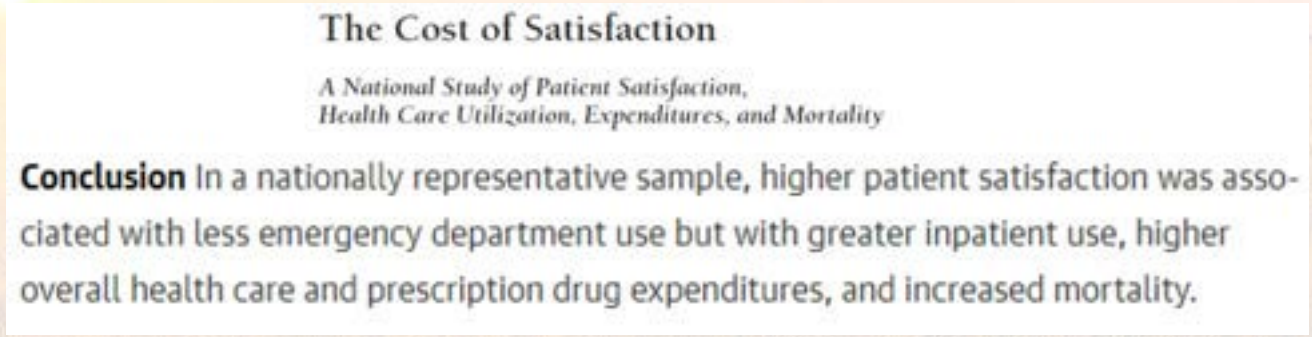
ED doc sees patient, CT scan with small hemorrhage

(eliminates performing cool stuff to remove blockage)

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?
- 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.

"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

Meeting Regulations

https://www.pexels.com/photo/doctors-and-nurses-in-a-hospital-6129507/

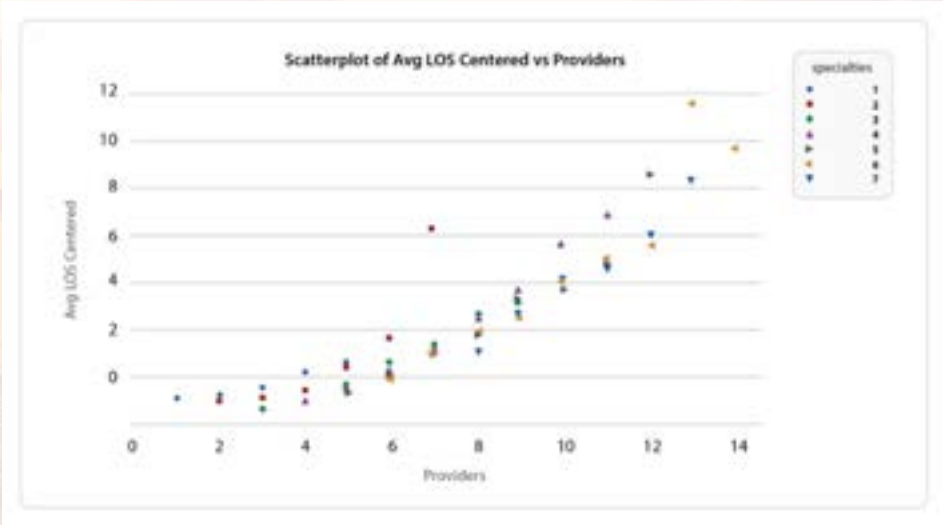
Mrs. Smith is Admitted

Patient arrives at ICU

Admitted to Hospitalist on call

Stroke care plan initiated

Consultations with Neurosurgery, Neurology, Cardiology



When Hospital Care is Needed

UR must screen for proper admission status

- First level review with MCG/IQ
- Second level review with Physician Advisor/Physician Advisory Service
- AI-assisted determinations in the near future

Notify payer for approval

- Hospitals open 24/7 but insurers open 10/5
- Miss notification- technical denial, can't appeal

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?

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!

- Meets IQ IN but goes home after one day?
  - They will try to deny- did not meet 2 MN Rule
- Fails IQ IN but requires over 2 MN?
  - They will try to deny- did not pass "criteria"

What to Do with Convenience?

Quantify and Qualify
- How many convenience days?
- Why did they happen?
  - Patient factors, physician factors, hospital factors, payer factors
  - Outpt - HCPCS A9270, rev code 0760 for “custodial care”
  - Inpt – span codes

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?

As You Look at your KPIs

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.

More inpatients will likely mean a lower CMI!

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

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

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 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?

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?"

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

MCG Care Guidelines- Goal LOS

- assumes optimal recovery, decision making, and care

The right LOS is when very day is medically necessary and there are no delays in care

Post-Discharge Issues

Pharmacy Benefit Managers, Medicare D Plan

- Formulary restrictions, step therapy
- Prior authorizations – who will do it?

Follow up testing issues

- Who orders test?
- Who follows up on results?- “Not my patient” syndrome

Readmissions

Medicare- no pay if same day, same diagnosis

All other readmissions pay a second DRG!

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."

Surgery- What Status?

Medicare/MA plans - Inpatient Only List for now…

Commercial insurers - whatever they want

It’s not about the status, it’s about the payment!

Sort out status prior to surgery and get the right order

Don’t give away surgery for lack of three words

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

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

The physician advisor can be your most valuable doctor

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

Thank you. Questions?

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Thank you.

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