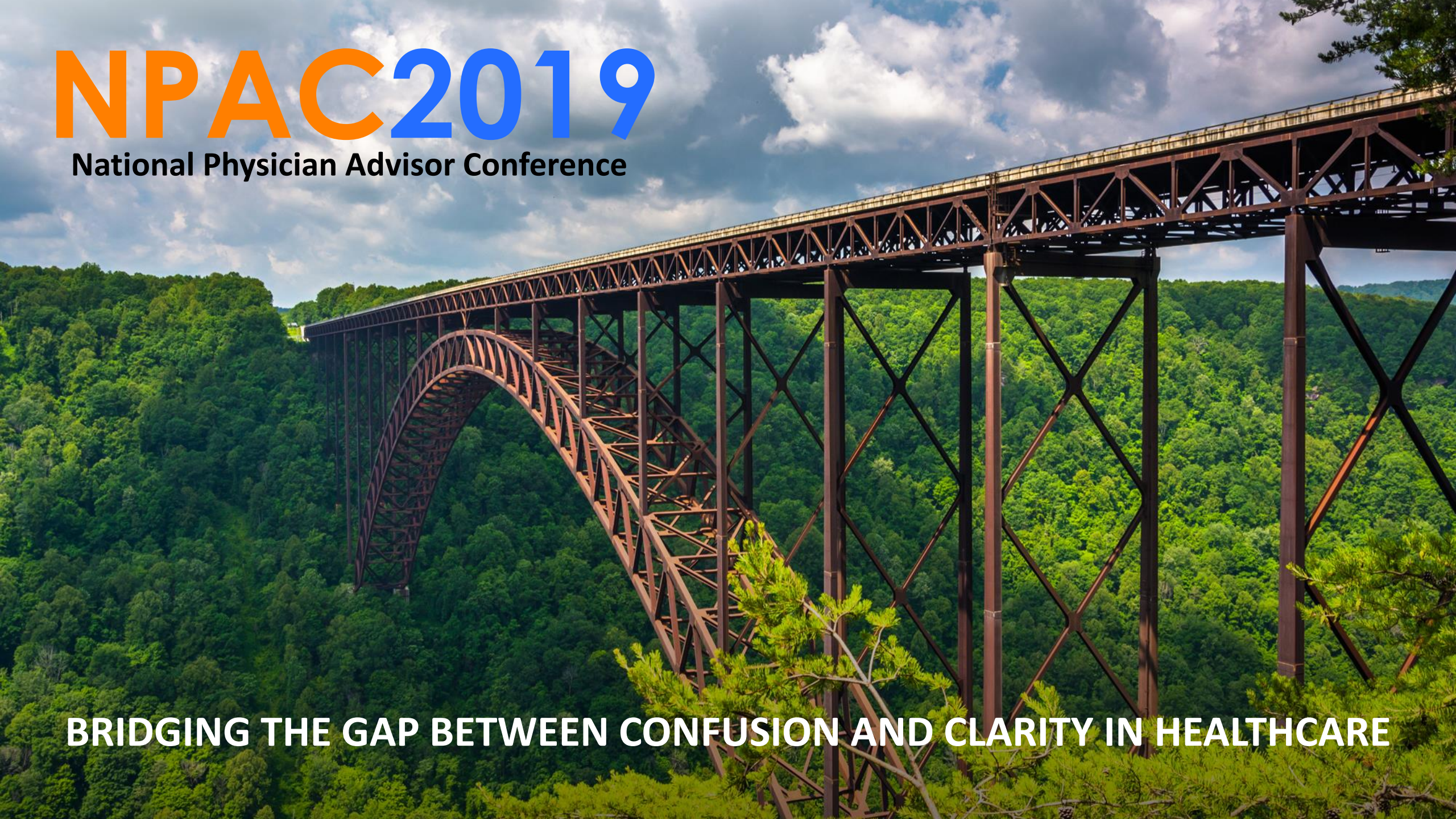
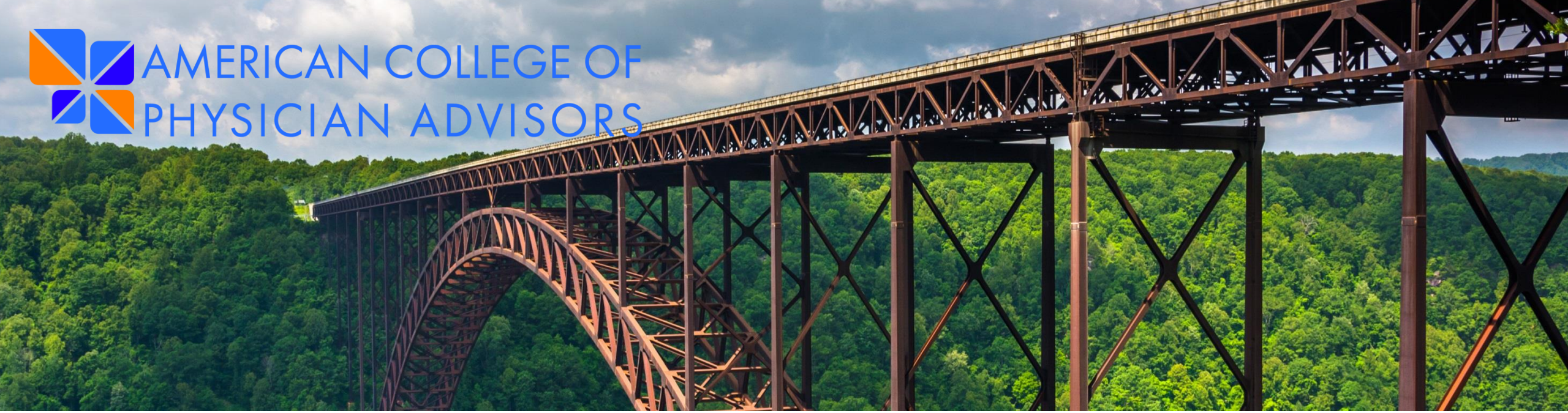

NPAC2019
National Physician Advisor Conference
BRIDGING THE GAP BETWEEN CONFUSION AND CLARITY IN HEALTHCARE



The Physician Advisor As Revenue Integrity Bridge

March 13, 2019 - Atlanta, Georgia

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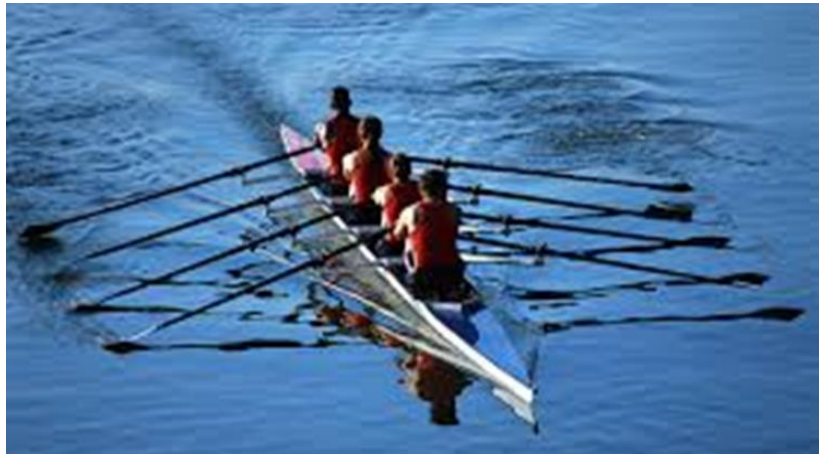
Agenda

- Physician Advisor and Revenue Integrity-What's That Look Like?
- Industry Trends: Medicare Advantage Plans
- Legal Considerations and Strategies
- Discussion

Uncharted Waters

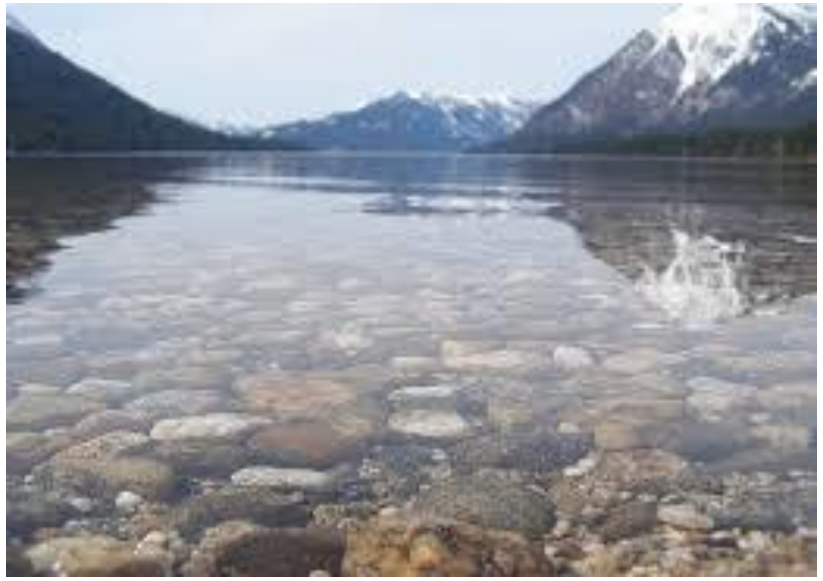
- The same maps/the same ways of doing things…will not get us where we want to go
- Shift from fee for service to value-based care requires considerable collaboration
- Revenue integrity is a strategic priority

Physician Collaboration



- Physicians control most testing and treatment decisions
- Physician documentation sinks or swims medical necessity and quality initiatives
- Physicians are key to value based work whether it is addressing costs, improving quality, coordinating care, improving population health

How Much of Each of Us is Available?

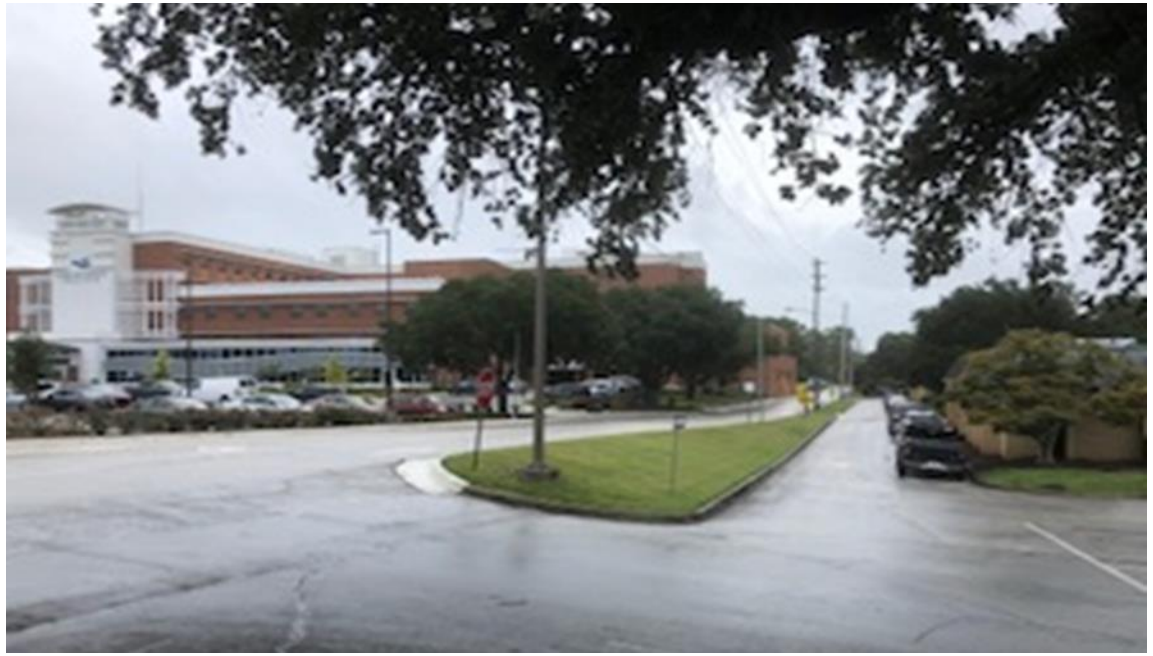


High activity is not necessarily a sign of productive and effective work. May have to shift to "deep work" in order to achieve strategically significant impactful results for our organizations.

Very Difficult to Do It All

- Intimate understanding of the clinical work and the unique stresses
- Passion/ true knowledge for revenue integrity
- Can operate outside silos to a certain degree
- Call a spade a spade
- Walk the Walk
- “One of us instead of one of them?” YES and YES

RAC DISCUSSION → Denials Dept. → UR Physician Advisor → REVENUE



New Version of the Breed

- Bring an expanded perspective to the revenue cycle, to revenue integrity in general
- Bring the regulatory issues to billing and compliance
- Make it clear that no initiative does not touch the physicians- strategize to preempt the pushback
- Teach administrators clinical realities
- Embrace revenue integrity work

NAHRI

"The basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that are able to withstand audits at any point in time."

https://nahri.org/membership/ethics

Revenue Integrity

INTEGRITY

1. Firm adherence to a strict code of moral, ethical or artistic value, incorruptibility
2. an unimpaired condition,
3. the quality of being complete or whole.

Original Latin integritas, from integer 'intact,whole'.

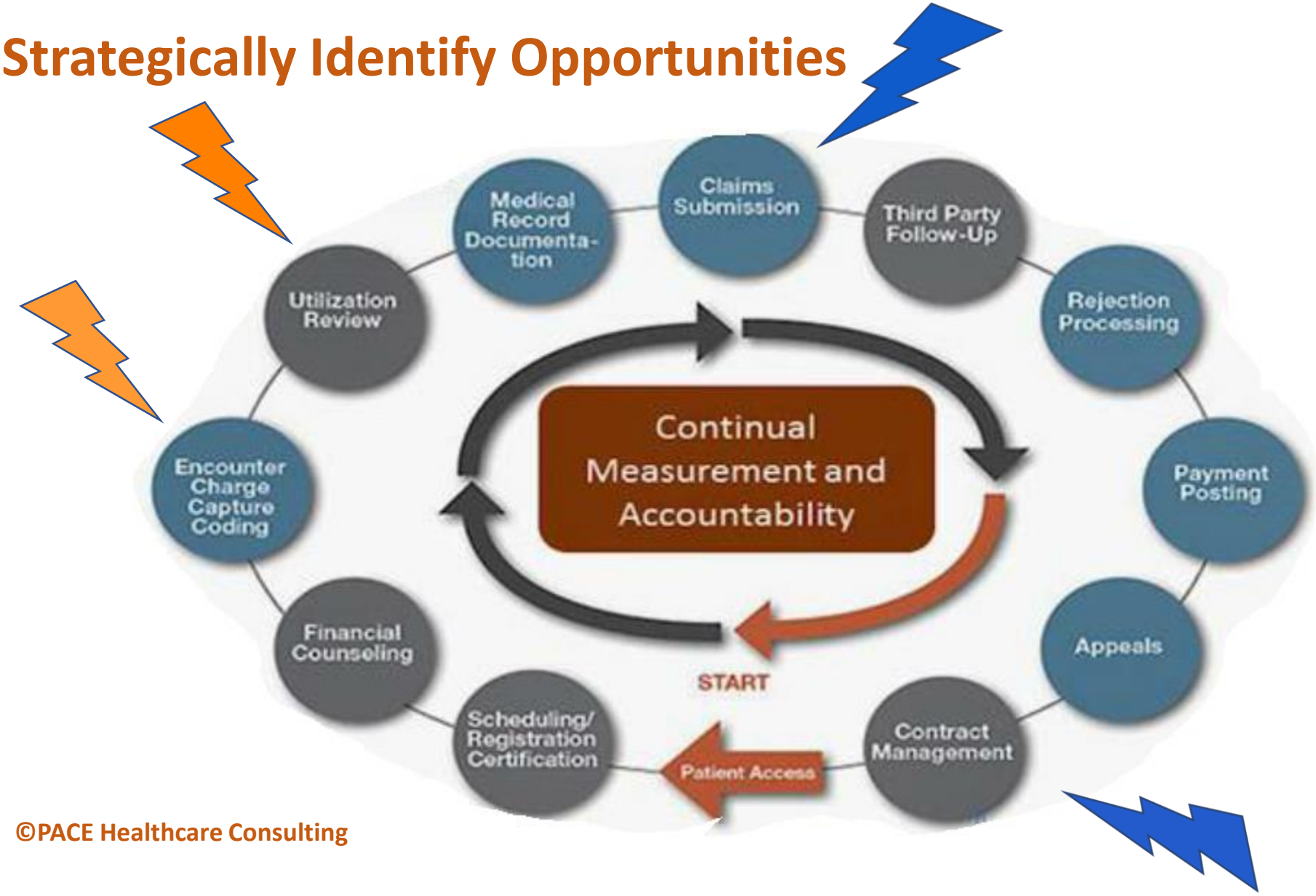
Value is cost, quality….it's also patient safety, accessibility, resource utilization, market share, greater good

It is a constant task to help the medical staff understand the concept of value

Exploding Need

- Roles within the PA profession will continue to evolve
- Non-intimidating, but not a wall flower
- Collaborative, but can move forward and progress
- Expertise on regulatory landscape
- Understands group leadership
- C-suite backing (C-suite is going to come get you)
- Utility of dyads

Strategically Identify Opportunities



Inch Wide, Mile Deep Work for more results

- Billing Education and Compliance
- Early Revenue Cycle-Registration, pre-authorization work, outside lab and imaging orders, scheduling
- Value Analysis in concert with supply chain/materials management
- Administrative oversight of CDI program
- Denials/Appeals work
  - Beyond writing appeals
  - Network building with payers
  - Strategizing on denials prevention
  - Contracting

Industry Trends

- Increase in MA Audits
  - Coding Standards
  - Admission (2 MN)

Industry Trends

- 2 Midnight Rule: MA Plans Do Not Follow
  - Or do they?
  - Review their Manuals, guidance

MA Plans: Legal Standards

- Medicare Managed Care Manual, Chapter 11, § 100.1
    - MA plans must comply with coverage determinations, grievances, and appeals

MA Plans: Legal Standards

- 42 C.F.R. § 422.101
  - MA plans must comply with National Coverage Determinations
  - Must comply with general coverage guidelines in original Medicare
  - Must follow MAC coverage determinations

MA Plans: Legal Standards

- Can supplement coverage, but, **at minimum**, must cover equal to A/B
  - If 2 MN covers, why not MA?
  - *See*, Section 1852 of Social Security Act

Industry Trends

- Unpublished "standards"
  - QIO Appeals
  - Beneficiary involvement
    - Appointment
      - Caution: Hospital Conditions of Participation

Industry Trends

- QIO Decisions
  - Reversals
  - If a trend, "re-education" of MA
- CMS "Involvement" if not contracted

Industry Trends

- Enforcement Initiatives against MA Plans
  - False Claims Act Cases
    - * Hint: Does CMS Know Downcoding Occurred?

Payer Tactics - In-Network Providers

- Contract Negotiations
  - Agreements for Private and MA plans for Hospitals and Physicians
  - Payers do not send decision-makers for negotiations
  - Hospital negotiations by business teams
    - i.e., we don't want lawyers

Payer Tactics – In-Network Providers

- 11th Hour Negotiations
- Media Blitz to "blame" provider
- Extensions – at current rates
- Complex formulas for quality, with no dispute resolution
- Negotiation of Rates walled off from policy considerations

Payer Tactics – In-Network Providers

- Incorporate Manual Provisions that can be modified **at any time**
- Use of vague "medical necessity" standard that defaults to their opinion
- Broad Confidentiality provisions

Payer Tactics – Cost Reduction Measures

- Aggressive UM/Clinical Care Policy Changes
  - MN depends on site of service
  - Strict interpretation of MN
    - Suggestion: Be wary of MN "in payer's opinion" language

Reimbursement Denials

- Coding Review Post-Payment:
  - Coding Reviews that become medical necessity denials
  - For previously "approved" claims
- Unclear appeals "process"
  - Suggestion: FCA Cases for failure to report downcoding

Provider Tactics and Counter-Measures

- Appeals
    - Use "Medicare Standards" against payers

Provider Tactics

- Arbitration under American Arbitration Association
- Commercial Arbitration Rules
  - Contract Dispute
- Healthcare Payer Provider Rules
  - Single Case For All Reimbursement-Related Claims

Healthcare Payer Provider Rules

- Use of One Arbitrator, Regardless of Number of Claims and/or counterclaims
  - *Consider*: Calculations of Quality Metric Payments?

- For Claims Appeals
  - *Consider*: Finality of Appeals Process Agreement Prior to Arbitration
  - Fees: Depend on $$ at Stake

Healthcare Payer Provider Rules

- Multiple Tracks
  - Desk/ Telephonic Arbitration
  - Regular Track
  - Complex Track
    - Flexibility in proceedings if agreed upon by parties prior to arbitrator appointment

Healthcare Payer Provider Rules

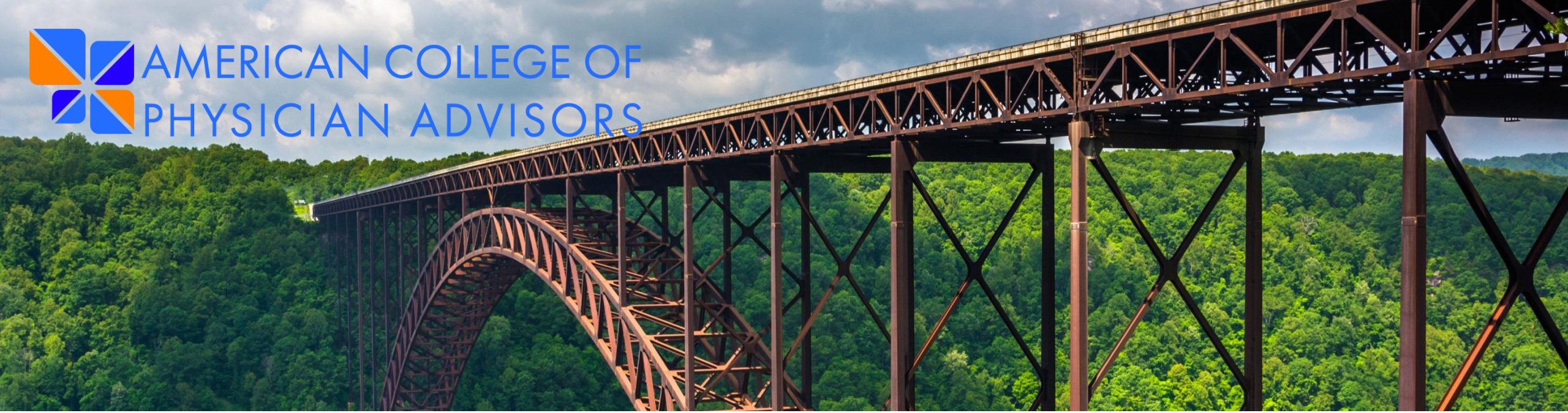
- Selection of One Arbitrator
  - Challenges
- Mandatory Preliminary Conference
- Strict Limits In Discovery / Depositions

Healthcare Payer Provider Rules

- Tactics
  - Delay, Delay, Delay
  - Onerous Discovery/ Expert Depositions
  - Inability to Access Decision-Makers
  - Renegotiate Contract

Healthcare Payer Provider Rules

- Tactics
  - Medical Necessity "in our opinion" per contract
  - Promise to "Fix" In Future
  - Record of Appeals Below



Go Forth and Prosper!

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