Bringing Concurrent Case Management Principles to Financial Utilization Review: Innovations in Commercial Denial Avoidance

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Note: This presentation discusses work done at a non-MHHS site
Summary

• Session 7C – Breakout Session C
• 7C – Bringing Concurrent Case Management Principles to Financial Utilization Review: Innovations in Commercial Denial Avoidance

• Abstract: This presentation aims to (1) review the various solutions to denial of reimbursement, (2) explain the pros and cons of the proposed solutions, and (3) explain how one prospective solution may offer a return in reduced denials and improved payer-provider-facility relations. Specifically, the speaker will examine how one organization addressed the challenge of financial denials, their impact of clinical processes and the revenue cycle, as well as the impact on patients and payers, through a non-adversarial approach ideal for systems that have not fully integrated payer and provider functions.

• Learning Objectives
• 1. Recognize alternative approaches to financial case management and denial management
• 2. Consider the pros and cons of a concurrent approach to denial avoidance
• 3. Begin to develop tools and documentation to support the process
Background*

Setting: 950 bed academic-community hospital

Payer mix: majority Medicare (largest Medicare provider on West Coast), sizeable commercial case mix, approximately 15% Medicaid and unfunded

Key programs: large commercial and Medicare procedural programs such as heart transplant, neurosurgery, and orthopedics

Key factor: System is not integrated

* This is not a Memorial Hermann hospital
### Unit-Based Service

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<th>MD</th>
<th>RN</th>
<th>LCSW</th>
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<tr>
<td>Patient Classification</td>
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<td>Utilization Review</td>
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<td>Clinical case management</td>
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| Patient load per FTE           | 30-40 RN | 20-30 CSW |
| Degree/education/training      | 1:15     |
| Combined load of dyad/triad    | (RN+CSW) |

- MD: Medical Doctor
- RN: Registered Nurse
- LCSW: Licensed Clinical Social Worker
## Overview of Department

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<th>CM Dept</th>
<th>CM MD Service</th>
<th>Case Manager (RN)</th>
<th>Social Worker (CSW)</th>
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**Patient Classification**
- Emergency department review for initial patient class
- Admission review for Patient Classification (Medicare)
- Case finding for missed classification
- Condition Code 44
- Medicare appeals
- Procedural review (operative)

**Utilization Review**
- Utilization reviews for commercial plans
- Coordinate requests for reviews
- Insurance authorization for additional resources/meds

**MediCal functions**
- Review of out-of-network MediCal
Hidden Cost of Commercial UR

• On the provider side alone more than 5% of case manager personnel were directly involved in appeals (at the RN and MD level).
• In addition, a significant portion of routine case manager daily time was allocated to mitigate or prevent denials.
• When commercial information was missing, late or contested by the plan, there was no medical director escalation process.
• When a chart was completed, contested cases were then bundled and litigated.
Litigation, Hospital Wins 90-95%
Litigation, Plan Loses 90-95%
Litigation, Healthcare Loss of 10%
Litigation Losses Raise Costs

**Healthcare Provider / Patient**
- A/R days increase
- When you win, you lose
- Funds leave the “healthcare” system
- Attorneys, courts, administrative and clerical staff receive 10% of patient-care dollars
- Litigation costs reflected in pricing and charges

**Payer / Subscriber**
- Payer raises rates
- Passes inefficiencies to other areas
- Payer increases scrutiny
- Payer-provider relations suffer
- Contracts either steer, tier or narrow providers
- Zero sum game
- Prisoners dilemma
  - Potentially signaling increased costs on both sides because of the threat of litigation
The Problem

• In March, 2014, we needed to address the 5-10% margin that denied cases may incur to both payer and provider/health system.

• Moreover, despite payback of interest rate after winning a case, the relatively low returns of those disputed fees have a negative impact on a business with thriving business lines.

• For other businesses, the short term cash shortages could force more expensive costs of capital to maintain operations.

• Compared to the industry standard of hospital accounts receivable (45 days), denied cases may extend years.
Opportunities Working Together

• Coding Opportunity
  – For each dollar in risk coding opportunity identified approximately 1/3 lay in commercial cases

• Coordination Opportunity
  – On commercial cases we identified the opportunity to improve transitions of care and link to payer-based ambulatory programs

• Length of Stay Opportunity
  – While Medicare LOS had dropped markedly with improvement in private and faculty hospitalist programs, commercial LOS still had a LOS opportunity of approximately 1/3 of a day

• End of life / transitions
  – Several payers identified palliative and hospice opportunities but were uncomfortable broaching those issues with clinicians

• Unnecessary testing
  – Very high rates of major radiologic tests were being ordered in the inpatient setting
Two Approaches

**Accountable Care**

- Under “accountable care” payers and providers agree to terms on reporting and then, assuming some or all of the risk, a provider/health system delivers care to meet targets.
- High level interval meetings allow calibration of resources and programs, collaborations, and contracts regularly. Commercial plans are even less frequent and largely rely on contracting cycles of years.

**Traditional Commercial**

- Traditional commercial plans are typically transactional. Payers allocate case managers to watch transactions that in turn providers/health systems themselves audit.
- Payers are looking for deviations from their benefits and guidelines, and reactively providers/health systems try to respond to denials, seek ways to appeal denials, and seek more current standards to overturn outdated payer guidelines.
We proposed something decidedly “ground level”

- Few patients were organized in ACOs.
- Were there models for conflict management around cases?
- We turned to developing clinical case management models
- Could we implement a concurrent process to preempt conflict and realize the opportunities discussed?
Concurrent Clinical CM with MDs

Managing to Expected Length of Stay: Developing a Model for Integrated Physician Advisors and Progression of Care

Dani Hackner MD
Concurrent Clinical UR with MDs

Managing Medical Necessity Documentation and Appropriateness of Level of Care

CM and Payer/Plan

Medical Directors meet weekly
Virtually round
Discuss patient-level detail

Physician Outreach

MD Outreach (Calls, visits, meetings)

Immediately Determine Anticipated Discharge Date and Manage To Protocolize, Overcome Barriers

Manage to ELOS

Info present and no barriers

Non-MD Systems Issues

Routine Progression of Care

Routine Multidisciplinary Care

New Barriers Encountered

No

Routine F/U

Refer for Systems Change

Systems Review
Solution: Concurrent Rounds on Financial Case Management

Information Gap
• In speaking with RN case managers on both the payer side and provider/health system side, one of the leading problems with denial management is the information gap between payer nurses, hospital nurses, and payer medical directors certifying days.

Weekend/Holiday Communication
• With shortages of staff on both sides, the most glaring shortfalls occur over long weekends and holidays, when a backlog of cases, lack of on-site case managers, or staff coverage result in poor communication.

Physician Communication
• To address this information shortfall, we set up direct rounding of medical directors from payer plans and health system case management
Concurrent Goal

• Goal: Gaps in information, documentation, or care could be solved in real time.

• A Clinical Discussion: Payer and provider medical directors trouble-shoot cases, address information gaps, and assure timely certification.

• For agreed opportunities, both medical directors (1) double efforts to transition cases to less costly levels of care or contracted provider groups, (2) trigger appropriate questions directly to clinicians (e.g. palliation) and (3) work to avoiding unnecessary patient costs.
6 Month Program Sequence

• Began with one payer (Aetna)
• Trialed for 1 month
• Rolled in 2\textsuperscript{nd} payer (Blue Cross) medical director
• Added 3\textsuperscript{rd} (United HealthCare), involved their nurse too
• Added 4\textsuperscript{th} (Blue Shield), involved their contracted hospitalist and nurse
• Added benefit: continuity bridged transitions of plan medical directors
Sample Concerns of Payers (not identified by name)

- Payer A. Concerned about infrequent outliers and weekend utilization. Frequent gaps in information due to stretched payer RN reviewer.
- Payer B. Concerned about surgical patients, transitions to inpatient rehabilitation.
- Payer C. Concerned about delayed palliation and narrow network.
- Payer D. Concerned about readmissions and outpatient workups in the inpatient setting.
Sample Patient List

- 52 commercial patients
- All patients > 7 days discussed
- 13 cases discussed over 30-45 minutes
- Interventions:
  - Certifications of cases previously missing medical necessity documentation
  - Exclusion of global payment cases (e.g. transplant)
  - Expediting transitions to lower levels by hospital medical director
  - 3-way communication with physicians (plan-CMMD-attending)
“John Doe”
- Hospital day 7. Readmitted after CABG. Multiple medical problems now readmitted following opiate and acetaminophen overdose. Found to have depressive disorder. Sitter assigned. PET team evaluated for inpatient psych transfer. Mobility and medical function is limited so unsafe for inpatient psych. SNFs unable to accept due to danger to self. Conclusion: no safe discharge. Payer certifies stay. Aggressive efforts on part of clinical team to address clinical condition to transfer.
Sample Patients

“Jane Smith”
“Jack Brown”

- Hospital day 7. Sepsis with multi-organ failure. Chronic respiratory insufficiency. Clinically doing poorly but hemodynamically stable. Clinically unlikely to extubated within 7 days.

- CMMD: discusses Long Term Acute hospital transfer with ICU team and timing of tracheostomy.

- Payer MD: agrees with LTAC, asks if palliative service considered, and certifies. CMMD follows up on palliative question with team.
Results, Cases Reviewed Collaboratively

Total Reviewed

Week 1  Week 5  Week 9  Week 15  Week 20  Week 24
Results, Process and Documentation

• Process / electronic systems
  – Developed workflow for worklists in EPIC
  – Trained CMMD in EPIC billing system use

• Documentation
  – Developed a template for EPIC financial notes for Medical Director
  – Notes visible to billing and audit department

• Payer worklists
  – Developed or applied existing worklists for each participating payer
Outcomes

50-100 cases per week
- On review, CMMD and Payer MD agreed on 2 concurrent denials in cases and did not pursue appeals/contest.
- No remaining cases resulted in concurrent denials during this period with concurrent rounding
- On one case, CMMD initiated discussions with Payer MD to process denial and involved attending who transitioned case to lower level before denial
Critiques and Questions

• Didn’t you reduce days/charges for contracts with a per diem?
  – Yes. This was a strategic initiative which allowed greater collaboration and efficiency and was the right approach for the patient. During this period one of the payer’s had tiered the hospital to a lower bracket. That changed in 2015 with greater trust on both sides in being able to deliver better value.

• What about contracts structured around DRGs? What incentive does the plan have to concurrently round?
  – There is still opportunity on transitions of care, readmissions, and selection of appropriate services/physicians. Issues like appropriate selection of LTAC which can be very costly or much more effective than an overly long short term admission can still be improved.
Potential Critiques

• Isn’t a global payment / full risk option a better approach?
  – It may be the way of the future, but what do you do in the interim? The answer is that you need to promote a collaborative approach. With collaboration, there is little reason to give patient dollars away to attorneys.

• With full risk, does concurrent rounding on financial case management go away?
  – You still need concurrent rounding. You still need to account for outliers and deviations. Instead, now the documentation and reporting arising out of strong concurrent process will drive your contracts.
Potential Critiques

• Can’t this all be handled by case managers and supervisors?
  – Effective case managers can handle the vast majority of cases. However, there is a role in physician communication and resolving documentation ambiguity, mitigating down-the-line denials contests. Finally, MD-MD intervention results from many of the medical director rounds. The payer medical director is at a distinct disadvantage versus the embedded CMMD.

• Can you bring the payer medical directors onsite to do rounding themselves?
  – Yes. However, as one payer transitioned, we found ourselves virtually rounding with a medical director 350 miles away. In another case, the plan medical director had conflict with attending physicians. In some cases, the local CMMD is a better partner or conduit of utilization messages.
Potential Critiques

• Is there a risk that a payer or local medical director gets into clinical management?
  – The attending physician always needs to be the person answering the questions posed by the medical director. It is not the role of the CMMD or plan medical director to direct care.

• Are health plans getting into the area of appropriateness?
  – Yes. Choosing Wisely has been endorsed by some plans. Others have begun to try to question diagnoses on charts based on documented clinical indicators. It is essential that health care providers keep an eye on “inappropriate” attempts at determining appropriateness or affecting coding. Therefore, concurrent rounding requires considerable care and oversight.
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Thank you

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- Betty Johnson, RN, Health System Manager, Utilization Management, Cedars-Sinai Health System
- Gretchen Case MPH, CPC, Managing Partner, The Wilshire Group Associates
- Hank Smither, CPA, Managing Partner, The Wilshire Group Associates