

# Crossing the Clinic Divide . . . Hospital and Physician Collaboration for Optimum Reimbursement

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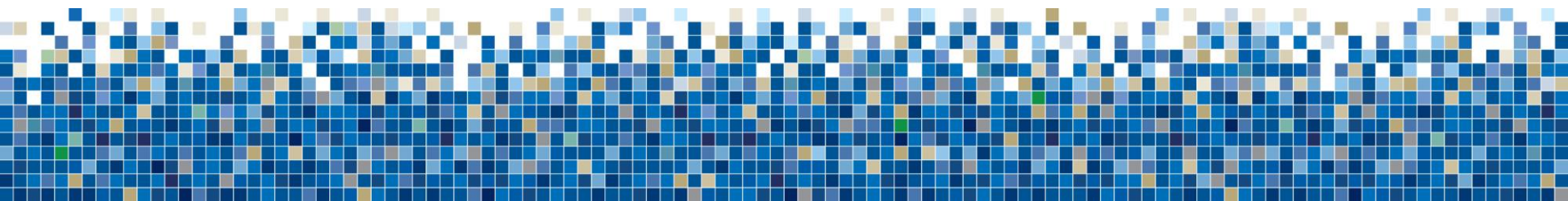
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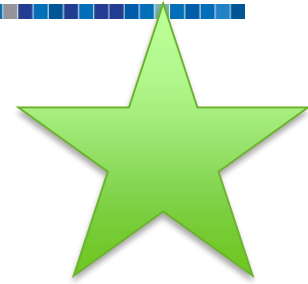
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# Agenda – Patient Care and Payments



- **“Pay-for-Performance” and Value-based Purchasing**
  - Patient “setting” = Inpatient, Outpatient or Observation patient care
  - Payer specificity requires understanding
  - Let’s quickly review ALL of the clinical outcomes that can affect hospital reimbursement
- How does the *Affordable Care Act* define “Quality”?
- **2015 on-going Change = Patient outcomes drive reimbursement**
  - Planned and consistently obtained results from care plans / protocols
- **Patient Care (Clinical) and Revenue Cycle (Financial) – Impact on Clinic performance collaboration** – HCAHPS, Prior Approvals, Pre-certs, medical necessity, bundled / packaged services
- **Preparation and actions to consider for effective reimbursement based on proven quality of patient care!**
- ***How will our Clinics / Hospital continue current / needed cash flow?***

# Collaboration of Physician and Hospital Staff

According to CMS, the answer for rising patient care costs requires . . .

- Greater efficiency in the delivery of “needed” care by providers – **medical necessity guidelines requiring medical “outcomes” expanded to address payment**
- Strong financial incentives for providers to slow cost growth through **improvements in productivity and efficiency**
- High-quality care that meets the patient’s immediate and future health needs across a *continuum of care* – not simply episodic!
- **All of the “new” reimbursement models utilized by CMS require financial and clinical collaboration:**
  - Clinic (Provider-based vs. MPFS); APCs = Comprehensive (packaged services); Outpatient Surgery; Oncology Services; MS-DRGs
  - Present-on-admission (POA) Indicators for HACs and resulting payment
  - Quality reporting to ensure optimum annual Medicare payment increase
  - Re-admissions reductions in payment or “bundling”

# Collaboration of Physician and Hospital Staff

## Pay-for-Performance – Result of clinical “outcomes”

- **60% of cardiac cath** “may be” unnecessary
  - 400,000 patients from the American College of Cardiology National Cardiovascular Data Registry
  - **37% of patients had no blockages** (caths performed based on irregular heart beats or abnormal findings from lower level diagnostic testing. No hx of heart disease!)
  - *New England Journal of Medicine*, March 2014
- **40% of repeat Laboratory tests for the same patient on the same date of service already have current test results in the patient’s medical record**
  - Problematic are tests performed in the Clinic or ER, but repeated a few hours later when the patient reaches Observation or patient care floor
  - Tests performed by the hospital Lab upon request from the physician’s office within the past three to seven days
- **40% of Medicare patient re-admissions may be avoidable**

# Changing Care Paradigms

## Traditional focus

Immediate Clinical needs

Patients are the recipients of care and the focus of the care team

Variety of different teams

## Transformational Focus

On-going, comprehensive needs of the whole person

Patients and family members are essential and active members of the care team who are educated on meeting individual care needs

Cross “continuum of care” Team with a focus on the patient’s medical experience over time



# Collaboration of Physician and Hospital Staff

**Pay-for-Performance –  
Result of clinical patient “outcomes”**

**Let’s take a short quiz on current physician and  
hospital practices before we begin our discussion!**

# Collaboration of Physician and Hospital Staff

## Operational practices:

- What four (4) Healthcare Reform **initiatives related to clinical patient care** may be **lowering your payments** for 2019 – *that began in 2014?*
- Can your hospital Physician and Hospital **team** produce a **positive affect** on all four of these?
- What long-term **reimbursement methodologies** should your facility address every month?
- Rate your **“patient care management”** (CM, UR, DC Planning, CDI) program on a 1 (poor) to 5 (excellent) scale.
  - Name two strengths and two weaknesses
  - What role do your physicians play in PCM?
- What total **\$\$ amount was written-off** at your facility last month (and YTD) due to **“wrong setting”** (patient status), **“not medically necessary,”** or **“unauthorized”**?



# Changing Medicare Reimbursement Payment Reform for Hospitals

Fiscal Year	Value Based Purchasing	Hospital Readmission Reduction Program	Hospital Acquired Conditions (POAs)	Total
2013	1.00%	1.00%	0	2.00%
2014	1.25%	2.00%	0	3.25%
2015	1.50%	3.00%	1.00%	5.50%
2016	1.75%	3.00%	1.00%	5.75%
2017-18	2.00%	3.00%	1.00%	6.00%
<b>2019</b>	<b>2.00%</b>	<b>3.00%</b>	<b>1.00%</b>	<b>6.00%</b>

Alexander, K., LHA Legislative & regulatory Update. LA Assn for Healthcare Quality Annual Education Conference, April 2019





# Here is where Clinical Care Affects Payment!

- What is the one Department that can increase physician and patient satisfaction – and payment for all payors on a daily basis?
- Care driven (ordered and delivered) by physicians / providers
- Physician interaction with hospital care “managers”?



## • *Patient Care Management*

• Case Management



**Patient Status**

• Utilization Review



**Authorizations**

• Discharge Planning



**Approved days**

• Clinical Docum. Review



**Patient Acuity /  
Intensity of Services**

# Clinic and Hospital Cultural Change



# Physicians and Hospital (System) Collaboration?

- **Requires more than “Yes, we need to work together!”**
  - **2015: 42% of hospitals reported that 10% or more of their revenue stemmed from value-based contracts!**
  - **Another 22% expected 50% or more by the close of 2017!**

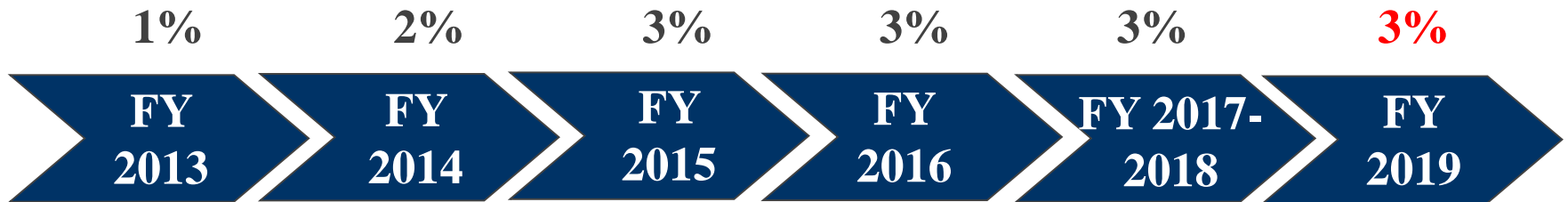
- *Lip service no longer will yield results!*
- **Hospital leadership and physicians must agree the past – is the past.**
- **Reframe the reimbursement challenge to align patient, physician and hospital interests. *Equalize each party’s importance.***
- **Create NEW vision – what does success look like for all parties?**
- **Identify specific improvement through collaboration opportunities – co-management opportunities of clinical and operational standards and procedures.**
  - **Quality of Care, Technology, Financial, Clinic and Hospital Operational Governance, Research, Payor Contracting**
- **Agree and adopt a small number of initial projects for early success.**
  - **Resolve past grievances, agree on goals, establish metrics, evaluate performance, re-align procedures, reward accomplishments.**
- **Repeat for higher value and longer term goals.**

# Hospital Re-admission Reduction Program

- The HRRP is a **reimbursement penalty** approach for general acute care hospitals that have readmissions deemed “excessive” by CMS
  - Began fiscal year 2013 (October 1, 2012)
  - Reduction was capped at 1% in 2013, at 2% in 2014 and **3%** in 2015 and beyond
  - **Reductions apply to total MS-DRG reimbursement**
    - But re-admissions deemed excess are determined using three (3) specific conditions endorsed by the National Quality Foundation (NQF)
      - Acute Myocardial Infarction (AMI)
      - Heart Failure
      - Pneumonia
    - Added
      - Elective Total Hip and / or Knee Arthroplasty (THA / TKA)
      - Coronary Artery Bypass Graph (CABG) Surgeries
      - Chronic Lung Disease (COPD)

# Hospital Readmissions Reduction Program

- Hospital-specific payment adjustment factors were applied to inpatient claims beginning Oct 1, 2012.



- For FY 2019 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during 3 year period
- **AMI, HF, PN, COPD, and THA / TKA (Hip/Knee) and CABG**
- **Not “budget neutral.”** Hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0% for 2019.

# HRRP: Expansion of Applicable Conditions

- For 2019, CMS estimated 2,610 hospitals (out of 3,300) will incur payment reduction of an estimated \$566 M.
- Expand applicable conditions to **include Coronary Artery Bypass Graft (CABG) for FY 2017** (finalized in FY 2015 IPPS rule)
- **FY 2018 changed** payment to include patients through “co-hart” diagnoses with:
  - Aspiration pneumonia
  - Principal diagnosis of sepsis or respiratory failure, and a secondary diagnosis of pneumonia present on admission
- **Impact of expanding definition: major increase to number of cases (about 65%) and the number of hospitals meeting the minimum number of cases for this measure**

# Re-admission Factors

## Why are patients re-admitted?

- 69% were **non-compliant with meds**
- 51% **lacked knowledge of how to use therapy devices** (from inhalers to back braces to over-the-door exercisers)
- 45% inadequate knowledge of **why medication should be taken**
- 42% **unable to self-manage care** (increased symptoms and/or exacerbation of condition untreated)
- 37% had **no follow-up visit with Physician or admitting specialist!**
- 31% **developed infection post discharge**

AARC webcast: “Hospital to Home – Efforts at Reducing Hospital Readmissions”. Greg Spratt BS, RRT; Kimberly Wiles BS, RRT; Becky Anderson RRT.

## New approach for client health system in January 2017:

- Hospital collaborated with Primary Care or Specialty Clinic to set patient appointments within 3 days of discharge for chronic conditions (diabetes, CHF, COPD, Cardiac)
- Clinic visit report shared with hospital UR team to validate patient care
- UR telephoned patient weekly to record patient progress / condition
- UR communicated with Clinic if visit warranted

# Hospital “Pay for Performance” Quality Programs Updates





# Collaboration of Physician and Hospital Staff

## How do you incorporate PAS process improvement?

### **Patient Access – Why the final bill does not originate in the billing office!**

- **Opportunity vs. Reality**
  - “Know” the facility’s Physician and Hospital strengths and weaknesses in the areas of registration and surgery scheduling
- **Pre-registration is a “must” for accurate reimbursement**
- **Insurance verification builds up speed for quicker payment**
- **Scheduling “stops” that may slow down the billing process**
- **OR – Registration collaboration essential!**
  - **Centralized vs. Decentralized scheduling = your analysis!**
  - **“Authorizations” and/or “Prior Approvals” = the elephant in the room no one wants to discuss!**

# Collaboration of Physician and Hospital Staff

## How do you incorporate PAS process improvement?

### **Patient Access – Why the final bill does not originate in the billing office!**

- **Clinic staff and Patient Care Management involvement ensures quality care and earns \$\$**
  - Paid correctly for **patient status** the first time!
- **Manage physician office relationships for appropriate level of care that results in compliant reimbursement**
  - Agree on population health management per Clinic specialty or location – medical homes
  - Trend ED ordering practices to ensure medical necessity
  - Stop “not medically necessary” write-offs!
- **Outpatient is not Inpatient – Why the difference means \$\$**
  - LOS – dollars are lost when patients stay exceeds GMLOS payment
  - RAC reviews

# Collaboration of Physician and Hospital Staff

## Patient Access and Patient Care Management

- Evaluate each and every access point to flow-chart how patients are *brought into the hospital to receive services*; and set goals for planned improvement in data gathering and decision-making
  - **POS cash collections!**
  - Pay particular attention to **ED admissions**
    - Assign physician / CM teams for collaboration
    - “When” is the best time to collect co-pays, deductibles?
  - Establish accountability for medical necessity and the Medicare “required” ABN (Registrar) or HINN (Case Manager) procedures
  - Institute required **financial counseling sessions** with all beneficiaries for scheduled services.

# Collaboration of Physician and Hospital Staff

## Patient Access and Patient Care Management

Successful collaboration =

- **Oncology Center:** patients being admitted due to adverse symptoms, staying overnight, primarily nausea related care / treatment plan.
- **Services did not meet inpatient criteria, considerable write-offs.**
- **Upon physician and hospital agreement, 4 beds established in Center for Observation. Nurses received additional training on monitoring symptoms, and physicians approved outpatient protocols for up to 8 hours of outpatient care.**
- **If unable to be discharged after 7.5 hours of Obs, patient re-evaluated for inpatient admission and new order written.**
- **Medicare's Two Midnight Rule often supports admission.**

# Collaboration of Physician and Hospital Staff

## Patient Access and Patient Care Management

**Successful collaboration =**

- **Center nurses and two nurses from the hospital UR team huddle each morning to discuss patient schedule and any medical problems from patient telephone calls or the prior day's treatments.**
- **May also involve UR follow-up team to contact patient between appointments for “condition checks” – general medical stability and readiness for next planned treatment.**
- **Has improved patient satisfaction and allowed for a more controlled flow of patients and care.**
- **Has improved reimbursement.**

# Patient Access and Patient Care Management

## Other PAS improvement procedures:

- **Utilize “compliance” review software for outpatient services**
  - Establish reliable source in Clinics for updated diagnoses.
- **Involve Patient Care Management in “medical setting” (Inpatient, Outpatient and Observation) decision making**
  - Hip replacement CAN be outpatient; depending on patient condition – does not HAVE TO BE outpatient
  - Cardiology and Neurology outpatient services
- **Require Patient Care Manager review for Medicare inpatients within the shortest time frame your facility can manage**
- **Assign responsibility for Observation number of hours!**
- **Perform a monthly “Admissions” accuracy review**
  - What percentage of patients were lowered to Obs?
  - Graph discharge data for patients over or under the average LOS – Understand Case Mix Index (acuity vs. LOS)
- **Hire the best registrars you can find – and train, train, train**
  - “QA” each registrar’s accuracy each week and post percentage results

# Collaboration of Physician and Hospital Staff

Medicare's Advance Beneficiary Notice (ABN) for outpatients and Hospital Issued Notice of Non-coverage (HINN) for inpatients –

## **Incorporate Patient Care Management process improvement!**

- Centralized vs. decentralized “coverage” responsibility
- Ensure “accountability” for ABN and HINN process
  - **Written procedure incorporating medical staff, financial staff, and clinical staff responsibilities**
  - **Clinic responsibility for medically-necessary ICD-10 diagnosis**
  - Hospitalists can assist with HINNs
- Why ABN's and HINN's are a necessary “quality of care” determination
  - Physician education and collaboration should be initial goal
  - ABN – Registrar with care management resource
  - HINN – Patient Care Manager – established relationship with the hospital's physicians to promote quality

# Collaboration of Physician and Hospital Staff

**Medicare's Advance Beneficiary Notice (ABN) for outpatients and Hospital Issued Notice of Non-coverage (HINN) for inpatients**

## **Incorporating Patient Care Management process improvement**

- Is your facility providing “bed and breakfast” services?

## **Observation after OP Surgery – Non-covered by Medicare**

- Do not allow physician “scheduled” Observation after same day or OP surgical procedure
- Must have physician documented “complication” of the OP surgery to qualify for Observation – even then, it is not reimbursed!
  - Nausea and vomiting generally not a complication.

## **Inpatients – Chest pain unsubstantiated by Lab (cardiac enzyme) findings or EKG**

- Recommend Observation status (or establish protocol) to physician for first 24 hours



# Collaboration of Physician and Hospital Staff

## Medical Necessity Denials

### Local Coverage Determinations (LCD's) and National Coverage Determinations (NCD's)

- **Confusing alternative decisions that control payment**
- **Payment depends completely on compliance with applicable PAYOR policies, 100% of the time!**
- **ICD-10 has complicated coverage determination!**
  - **Physician and Coder on same wording?**
- **Physician order vs. Payor contracted “medical necessity” guidelines vs. Hospital determination of medical necessity**
- **Medicaid often stipulates “setting” – emergent vs. routine care in Clinic; OP vs. IP stay; OP vs. IP surgery or Chemotherapy / Radiation**
- **Ensure electronic order entry document or template allows for complete description of medical complaint (diagnosis)**

# Collaboration of Physician and Hospital Staff

## **Incorporation of Process Improvement by Payor!**

January 2019 – *ideal time for physician education*

Payment depends on specificity requirements by payor

- Medicare = traditional and Advantage plans *are different!*
- Medicaid = traditional and HMOs / CMOs
- Commercial = variety of billing requirements
- Worker's Comp = varies by state requirements
- Compliance edits for medical necessity –
  - Medicare does not have “pre-certs” or “prior approvals,” but medical necessity payment calls for the same initial procedure.
  - Identify payors who require advance notification or request for approvals for services
- Payor specific coverage and billing requirements should control all patient care authorization processes and provision of services
- One client has 4-member team that rotates through Clinics and other physician offices on a quarterly basis to hold 15 min. payor specific sessions w phys / 30 mins with office care team and administrative staff – vary message depending upon relevance.

# Collaboration of Physician and Hospital Staff

## Ask for Patient Care Management Assistance!

- *Whether office or hospital* –
  - **Compliance (medical necessity) edits** – “front-end” edits
    - Compile “write-offs” by line item service, by department, by physician, and by registrar
    - Publish results and communicate to all parties
    - Use results for educational sessions for physicians / registrars / clinicians
  - **Pre-bill edits** – “back-end” edits prior to claim transmission
    - Require review by “eagle-eyed” manager prior to reversing to the Clinic or outpatient Department whose revenue cannot be collected
    - Post to spreadsheet for reporting to Departmental managers / clinical staff
  - **FISS edits** – “return-to-provider” claims with error reason codes
    - Require weekly report (itemized list) by biller or collector of claims in the FISS that have not been cleared for payment; identification of root cause – back to physician

# Collaboration of Clinical / Financial Staff

- How will your specific Clinics / facility / outpatient location positively affect these payment methodologies?
- Education = **knowledge base** of theoretical regulations translated into **practical “how-to’s”** for staff members
- **Involve Patient Care staff members in collaboration with ALL others to assist with action plans:**
  - Patient Access Management – Admissions and Registration
  - Patient Care Management – Case Managers, Utilization Review, Discharge Planning, Clinical Documentation Improvement
  - Health Information Management – Medical Records / Coding
  - Patient Financial Services – Financial Counselors, Billers and Collectors
- **Including physicians in all discussions, decisions and procedures.**

# Collaboration of Clinical / Financial Staff

- **Knowledge – Physician and Hospital – combine to form:**
- **Management Action Plan (MAP) that identifies **strategy, actions and projected outcomes****
  - Regularly assessed and progress communicated to staff
- **Incorporating facility or location specific “best practice” operational procedures**
- **Evaluation of daily / weekly / monthly / annual achievements**
- **Constant and consistent analysis and adjustment to Plan**
- **Re-education and incorporation of “lessons learned” into facility specific processes for continued improvement!**

# Collaboration of Physician and Hospital Staff

## What can be done?

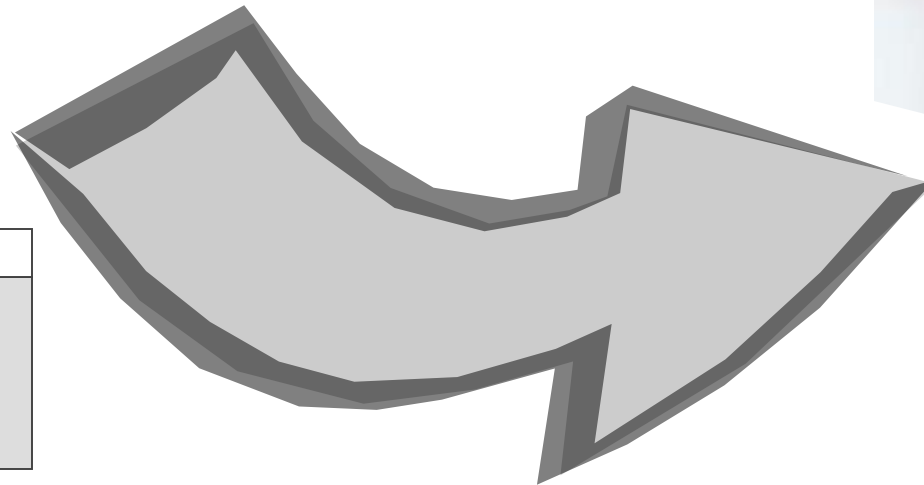
1  
**Create  
Management  
Workgroup**

2  
**Capture Data**

3  
**Analyze Data**

4  
**Prioritize and  
Attack !**

5  
**Monitor Results**



# Collaboration of Physician and Hospital Staff

## Team to include representatives from:

- Leaders across hospital or system-wide operations both Physician and Hospital!
- Patient Access
- Patient Financial Services (CDM, Billing and Follow-up)
- Health Information Management (Coding)
- IP / OP / Ancillary Registration (if decentralized)
- Patient Care Management (Case Management – Utilization Review – Discharge Planning – CDI)
- Nurse Auditors or Reviewers
- Systems (Decision) Support
- Contracting or Risk Analysis
- Compliance



# Questions a Leader Needs to Ask!

- How is measuring and reporting patient care outcomes and quality of care being addressed at my facility?
- Is being an active team player in all the P4P practices a priority at my hospital?
- Am I an active **team player in initiating process improvement** – or am I still expecting other staff members to lead the charge?
- Do I know my hospital's 30 day re-admission rate, and is it communicated hospital-wide on a monthly basis? (**Goal ??**)
- Who is the person or the team accountable for **P4P tracking, measuring and reporting?** Management Action Plan (MAP)?
- What is my hospital's current **HCAHPS score?** MAP?
- Do you believe that you and your staff have the capability to make improvements in conjunction with Physician and Hospital staff leaders? **This is a cross roads for change – Has “change management” been discussed?**



# Collaboration of Physician and Hospital Staff

## Celebrate Success!!!

### Successful collaboration results in:

- **Increased Patient (Customer) Satisfaction**
- **Increased Employee Satisfaction**
- **Increased Physician Satisfaction**
- **Increased Cash Collections**
- **Lower Days in Accounts Receivable – stronger financial performance to support new patient care endeavors!**
- **Greater “profit” – even if your hospital is “not-for-profit,” it must collect more cash than it costs to operate!**

# Crossing the Clinic Divide!

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**Xtend Healthcare**

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## Questions? . . .



# About Us



**Revolutionize** your revenue cycle

**Extend** your staff and IT assets

**Improve** your bottom line



**Thank you!**