CAH CFO-Administrator FORUM

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TRILOGY REVENUE CYCLE

Discovering Buried Underpayments Within Your Contracts

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Organizing Your Payor Agreements

I. Managed Care Grids

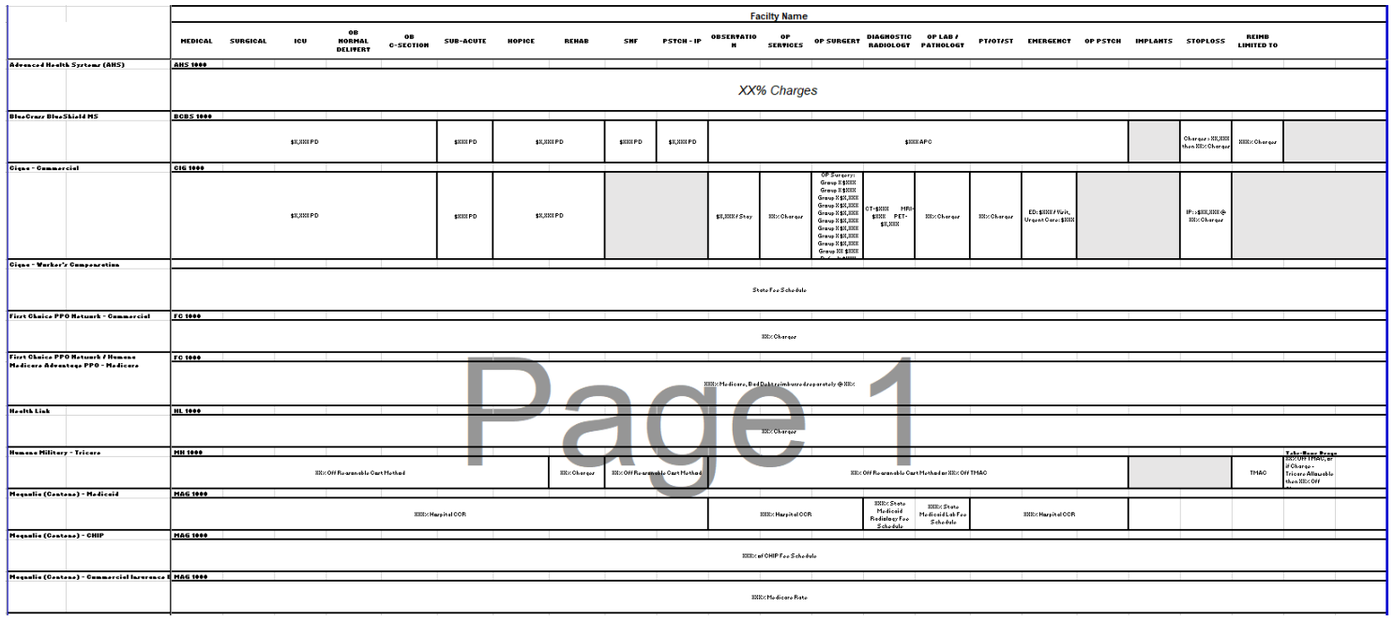
- Contracts By Entity
  - i. In a grid by payor, by contract, and product to determine which entities are contracted
  - ii. When reviewing contract terms, it directs which document to review
  - iii. Assists in identifying contracting inconsistencies
  - iv. Sample

		Name	Legal Name #1	Legal Name #2	Legal Name #3	Legal Name #4	Legal Name #5	STATUS	NOTES
		dba	Hospital #1	Ancillary #1	Hospital Based Physicians #1	Clinic #1	Clininc #2 (RHC)		
		TIN	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx	xx-xxxxxxx		
Payor	**Contract ID**	**Description**							
Payor 1		Facility (Comm)						Termed	1/1/94 - 8/14/09
Payor 1		Facility (Comm, WC)	X	X	X			Active	8/15/09 - __/__/__
Payor 1		Prof (Comm, WC)			X	X	X	Active	4/1/10 - __/__/__
Payor 2		Facility (Comm, WC)		X	X	X	X	Active	1/1/12 - __/__/__
Payor 2		Facility (Medicare)	X	X	X			Active	4/1/10 - __/__/__
Payor 2		Prof (Comm, WC)				X	X	Active	11/15/12 - __/__/__

Organizing Your Payor Agreements

I. Managed Care Grids

- Contract Rate Summary
  - i. In a grid that summarizes rates across payors, contracts, products, and entities
  - ii. Assists in identifying rate inconsistencies
  - iii. Assists in identifying rate notice requirements for CAHs & RHCs when allowed as a percentage of a Medicare rate letter
  - iv. Sample



Organizing Your Payor Agreements

I. Managed Care Grids

- Contract Provision Summary
  - i. Summarizes important contract provisions to support Revenue Cycle Operations
    1. 23 Revenue Cycle, 9 Contract Compliance
    2. Timely Filing / Appeals / Recoupments / Clean Claims Payment
    3. Retro Eligibility / UM Requirements / Medically Necessary
    4. Amendments / Notice Addresses / Renewal & Effective Dates / CDM Notice Requirements
  - ii. Assists revenue cycle in avoiding denials and winning appeals
  - iii. Assists in identifying language inconsistencies
  - iv. Sample

Payor	Timely Filing	Appeal Time Frame	Overpayment Offsets, Refunds & Recoupments	Billing Members	Clean Claim Payment	Medical Records	Eligibility Verification	COB/TPL	UM Requirements	Silent PPO	Emergency	Medical Necessity	Plan Policy and Procedure	Credentialing	Amendments	Acquisitions	Rate Renegotiation	Rate Increase	Assignment	Term w/o Cause	Term	Effective Date
Payor #1	[4.1.1] Primary payor - [illegible] days from DOS. Secondary payor - [illegible] days from Primary's EOB. Worker's Comp: [AWCA Addendum, VI] [illegible] days.	[4.1.1] [illegible] days	[4.1.2] 2 years after payment. [illegible] day notice w/ right of offset.	[4.5.1] Member must agree in writing to be liable for Non-covered service. Waived if member failed to identify themselves as a member of plan. [4.5.2] Member Held Harmless.				[see section 4.2]	[4.1.4] Provider shall abide by.	[2.18] Non-health benefit products require [illegible] day notice w/ facility able to reject.	[1.14] Prudent Layperson	[1.25] Clinical but doesn't define UM Criteria. Allows for denials based on lowest cost setting.	[5.1] Dynamic and may change from time to time. Includes . Includes newsletters, e-mail and letter. [illegible] notice including newsletter or e-mail w/ [illegible] days to object.	see pages [illegible]	[9.1] Mutual signature required. May deem for governmental compliance.					[6.2] 120 days prior to renewal date of April 1st. Worker's Comp: [AWCA Addendum, XI] [illegible] days.	[6.1] Evergreen	4/1/20[illegible]
Payor #2	[2.2.2.3] [illegible] days w/ best efforts in [illegible] days.		[2.2.7] Recovery allowed.	[2.2.5.1] Can't bill Members for services provided not in compliance with UM programs and policies. Member must agree in writing to be liable for Non-covered/Non-medically necessary service.	[4.3] Best efforts in [illegible] days.	[2.4.3] No charge.	[3.5] Not responsible for incorrect/release line information submitted by Group.	[2.2.5] See agreement.				[1.9] Clinical but doesn't define UM Criteria.	[2.2.2.2] agrees to comply. [3.6] BCBSNC will notify Provider of changes.		[9] See agreement.	[2.7.1] Provider to give [illegible] days prior notice.			[7.1.1] Prior written consent with at least [illegible] days notice. BCBS can assign w/o consent to another BCBS entity.	[4.3] [illegible] days. See 4.2. for exceptions.	Evergreen	11/15/20[illegible]
Payor #2	[2.2.2.3] [illegible] days		[2.2.7] [illegible] day notice w/ right of offset.	[2.2.5] Member Held Harmless. Member must agree in writing to be liable for specific Non-covered/Non-medically necessary service.	[3.3] Reasonable efforts in [illegible] days.	[2.4.3] No charge.	[3.5] Not responsible for incorrect/release line information submitted by Group.	[2.2.5] see agreement for limits on reimbursement and billing of members.				[E1.1.3] Clinical but doesn't define UM Criteria.	[2.2.2.2 & 2.5.1] agrees to comply. [3.6] BCBSNC will notify Provider of changes w/ reasonable time to comply.		[6.5.2] Mutual written agreement. BCBS may deem w/ [illegible] days notice for governmental compliance or NCQA. [illegible] days to object.	[2.7.1] Provider to give [illegible] days prior notice.			[7.1.1] Prior written consent. BCBS can assign w/o consent to another BCBS entity.	[4.3] [illegible] days	Evergreen	11/1/20[illegible]
Payor #2	[4.2.2] [illegible] days.			[4.5.1 & 4.5.6] Member Held Harmless. Member must agree in writing to be liable for specific Non-covered/Non-medically necessary service.	[3.3] Reasonable efforts in [illegible] days.	[6.1.1. & 6.1.2] No charge.	[4.6] Best Efforts to make adjustments w/in [illegible] days.	[4.7]			[1.9] Prudent Layperson	[1.17] Clinical but doesn't define UM Criteria.	[2.5.1 & 5.2.5] Shall comply. Changes require [illegible] prior notice.	[5.2.8] Notify of decision in [illegible] days	[6.5.2] Mutual written agreement. Changes in law - w/ [illegible] days notice. Changes in Reimbursement - [illegible] days notice w/ [illegible] days to object, BCBSNC may terminate. Benefit Plans - [illegible] days notice w/ [illegible] days to object, BCBSNC may terminate. All Other Terms - may deem w/ [illegible] days notice.				[6.4] Prior written consent with at least [illegible] days notice. BCBS can assign w/o consent to another BCBS entity.	[5.2.2] [illegible] days and no earlier than Initial Term.	Evergreen	8/1/201[illegible]
Payor #3			[f] Promptly refund.	[d] Member Held Harmless. Member must agree in writing to be liable for Non-covered service.									[g] Cooperate as outlined in provider manual.		[h] Upon written notice by Plan.				[d] May be assigned by Plan w/ Notice.	[e] [illegible] days.		11/1/20[illegible]

Organizing Your Payor Agreements

II. Standardized Naming conventions for electronic documents

Payor Name	Entity Type	Entity	Document Type	Additional Descriptor such as Product, Clinic location, Amendment description, Other	Start Date	Termination Date
United	Facility	SMRMC	Agreement	Clinic pneumonic/name	YYYYMMDD	YYYYMMDD
BCBS	Professional	LCH	Amend	CHIP		
AHS	Global	SLHH	Notice	Medicare		
Medicaid	Ancillary		Communication	Medicaid		
Medicare			Rate Letter (for Medicare, Medicaid)	Language		
				Rates		
			Examples			
Aetna	Facility	SMRMC	Agreement		20100101	
Aetna	Facility	SMRMC	Amend	Rates	20110101	
Aetna	Facility	SMRMC	Notice	*description*	20180101	
Aetna	Professional		Agreement		20100101	
Aetna	Professional		Amend	Language	20120101	
Medicare	Professional		Rate Letter	MFPC	20181001	
Medicare	Professional		Rate Letter	LCFP	20181001	
Medicare	Professional		Rate Letter	PMC	20181001	
Medicaid	Professional		Rate Letter	MFPC	20190101	
Medicaid	Professional		Rate Letter	LCFP	20190101	
Medicaid	Professional		Rate Letter	PMC	20190101	

Organizing Your Payor Agreements

III. Accessible to Revenue Cycle Staff

- Share Drive
- Snip contract language into payor communications

Regulations that Supersede Payer Contract Terms

I. ERISA

- Jurisdiction
- i. Covers All Employers (labor laws/regulations) EXCEPT NOT
    1. Governmental plans
    2. Church plans
    3. Worker's Compensation
- ii. Patient Protection and Affordable Care Act (PPACA)
    1. PPACA adds individual plans to the scope of plans covered under 29 CFR.B.XXV.L.§2590.715-2719 Internal claims and appeals and external review processes
    2. PPACA points to ERISA and says " …a health insurance issuer offering group or individual health insurance shall implement an effective appeals process….".

Regulations that Supersede Payer Contract Terms

I. ERISA

- Federal Law
  - i. Supersedes any state law or contracts
  - ii. Protections
    1. Clearly defined rights of appeal, bundling, illegal/improper recoupment of payments, etc.
    2. Providers are afforded the same rights as patients by the correct wording of the assignment of benefits
    3. Patient policy governs the claim
- Claim belongs to the patient
  - i. Providers cannot contractually give away rights the patient has
  - ii. Patient's coverage document rules
- Adverse Benefit Determination (ABD)
  - i. Reduction in payment
  - ii. Denial of any part of the claim
  - iii. Failure to pay for a policy benefit
  - iv. Must be sent to the patient or it's a violation

Regulations that Supersede Payer Contract Terms

II. Medicare Advantage

- Medicare Advantage

a. No less than under traditional Medicare CFR 422.100

b. Non-contracted Providers are owed no less than the provider's original Medicare.

i. PPS Hospitals - There is an adjustment if the hospital is to "shadow bill" Medicare for some non-Medicare related teaching payments such as GME, IME-operating, etc.

ii. CAH/RHCs – You are owed your rate letter.

c. Final Rule Medicare Advantage 2024 - CMS 421-F: Clarifies and tightens up interpretations relating to prior authorization denials

i. Must follow Traditional Medicare coverage requirements

ii. Missing Traditional Medicare coverage requirements must use coverage criteria that is:

1. Based on widely used evidence
2. Not proprietary to the plan
3. Coverage criteria must be publicly available

iii. Prior authorizations must be covered throughout the course of treatment.

iv. 90-day transition period when a member in active treatment switches Medicare plans or is new to Medicare.

v. MA plans must establish a committee, led by their Medical director, to ensure the plan is complying with Traditional Medicare coverage policies.

Regulations that Supersede Payer Contract Terms

III. State Statutes

- Unfair Claims Settlement – Most states have regulations based off model language
- Timely Filing
- HMO Regulations

Options For Detecting Underpayments

- Payment Verification / Contract Modeling Package
  - a. Expensive to buy, staff, support, and maintain
  - b. ROI
    - i. Detecting underpayments
    - ii. Revenue Cycle process improvement
- Manual Review
  - a. Small Sample Size
  - b. Focus on Simple Methodologies
    - i. % Charge
    - ii. Per Diems, DRG
    - iii. Stop Losses
    - iv. Percentage of Medicare rate letter

Where to Look for Underpayments

- If your agreements contain stop loss provisions or require invoices to be allowed at a percentage of cost / invoice price.
- For contracts based on a percentage of gross charges, audit several different services to verify that they are being allowed correctly.
- Contracts based on Medicare.
    a. CAH / RHC: It's not uncommon for plans to have CAH / RHCs loaded at PPS rates instead of the provider's rate. This can be done by pulling EOBs for each Medicare Advantage plan and verifying for a couple of claims that the allowed is based on the Medicare rate letter. Also, don't forget about sequestration.
    b. PPS Facilities: Inpatient reimbursement is straightforward to check. Use the CMS IPPS Pricer at https://www.cms.gov/IPPS-WebPricer to verify allowables. When inputting a claim make sure to check the "HMO Paid Claim" button as "Yes". Also, don't forget about sequestration. CMS does not currently have an OPPS Pricer. So, verifying an outpatient claim is not a simple task and requires knowledge and resources beyond a quick check.

Where to Look for Underpayments

- Contracts based on Medicare.
  - c. If you discover that you are not getting your allowed Medicare, there are several root causes.
    - i. The payor may be allowing correctly but you have a bad contract.
      - 1. CAHs/RHCs: Make sure where the payor references Medicare it is clear that rates are “the Providers” Medicare rate. If the agreement is unclear or it uses language such as Medicare Fee Schedule, Medicare Base Rate, Medicare PPS, or other similar phrasing, you likely have a contract that is based on Medicare PPS rates instead of the provider’s Medicare rate.
      - 2. PPS Hospitals: The Medicare inpatient methodology has a complex calculation that starts with a base rate, which stacks on additional amounts specific to the hospital. This is the rate multiplied times the DRG weight to get the allowed amount. Some plans attempt to exclude some of the provider-specific add-ons, which result in the hospital being allowed less than their Medicare rate. Make sure you read the definitions for how Medicare is defined in the contract and if the payor is trying to exclude some of the add-on components.

Where to Look for Underpayments

- Contracts based on Medicare.
  - c. If you discover that you are not getting your allowed Medicare, there are several root causes.
    - iii.There is a contract compliance / underpayment problem.
    - 1.CAHs/RHCs:
    - a.If the payor is allowing a per diem for inpatients and a percentage of charges for outpatients but not paying your current rates, there may be a breakdown in the notification process to the payors for current rate letters.
    - There is a formal notice process, with return receipts, to the addresses specified in the contract. Relying on the business office or others to send in rate letters, while not following the contract's required notice process allows payors to not fix their system. You must follow the contractually required process.
    - b.If the payor is not allowing an inpatient per diem rate or a percentage of gross charges for outpatients and you see line items being bundled into another line item, it may be that you are loaded as a PPS hospital.

Where to Look for Underpayments

- Contracts based on Medicare.
  - c. If you discover that you are not getting your allowed Medicare, there are several root causes.
    - ii. There is a contract compliance / underpayment problem.
      - 2. PPS Hospitals:
        - a. Inpatient – Check your payment for a sample claim from an EOB against the IPPS pricer. You may be able to back into which add-on components are being excluded. This needs to be compared to your contract language.
        - b. Outpatient – As mentioned above this is complicated and outside the scope of a quick answer.

Key Takeaways

1. Get your contracts organized to support revenue cycle
2. Know regulations to support revenue cycle
3. At a minimum, routinely audit a small sample of claims allowables

Contact Us

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