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REVENUE CYCLE RESOURCES

Navigating Compliance: Best Practices in UR and Case Management

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Current Landscape

Payor Scrutiny- In The News

Payor AI Utilization

- UHC, Humana, and Cigna are facing class-action lawsuits alleging the insurers relied upon algorithms to deny care
  - UHC AI program, *nH Predict*, superseded physician judgement, resulting in a 90% error rate, meaning 9 of 10 appealed denials were ultimately reversed
  - UHC set goals for employees to keep patient rehabilitation stays within 1% of the length of stay predicted by *nH Predict*.
  - Cigna algorithm, *PXDX*, denied more than **300,000** claims in a two-month period, which amounts to about **1.2 seconds** for each physician-reviewed claim

Sources: Cigna Sued Over Algorithm Allegedly Used to Deny Claims, Class Action Lawsuit Against United Health's AI Claim Denials Advances

Political Intervention-Federal

CMS Interoperability and Prior Authorization Final Rule

- Impacted Payors: Medicare Advantage, Medicaid, and Marketplace Plans
- Timeframe: January 2027, some provisions in 2026
- Key Provisions
  - Implementation of *Application Performing Interfaces* (APIs) to streamline exchange of information
    - Requires payors to implement technology that enables EHRs to:
      - Determine whether prior authorization is required for most services (excluding drugs)
      - Query prior authorization rules and documentation requirements for a particular service
      - Populate prior authorization forms directly from the provider's EHR
  - Prior Authorization Process Improvements
    - Timeframe Requirements
    - Detailed Explanation Required
    - Payor Public reporting of certain prior authorization metrics

Political Intervention-State

Nebraska LB 77, *Ensuring Transparency in Prior Authorization Act:*

- Adverse determinations to be made by a physician with appropriate expertise
- Prohibits use of AI as the sole basis for denying healthcare services
- Prevents compensation of review entities based on denial volumes
- Annual reporting of prior authorization statistics
- Prior authorizations valid for one year
- Prior authorizations for chronic conditions valid for length of treatment
- Exemption of prior authorization for certain healthcare services:
  - Emergency services
  - Cancer care consistent with certain guidelines
  - Preventive services

Level of Care Denials

Steps

1.) Ensure All Level of Care Denials Route to UR

2.) Understand Payor Reimbursement Implications

- Commercial Payors
  - Typically, IP and OP are paid the same, there is no reimbursement differential

3.) Contract Implications

- Evaluate if UR contract language applies

4.) Review Records

- Agree with Payor?
  - Request payor to provide written direction on rebill as observation
- Disagree with Payor?
  - Appeal!

Effective Appeals

- **Clinical Expertise Required!**
- **Ensure utilization of payor inpatient criteria**
  - Commercial- Milliman/InterQual
  - MA-Two Midnight Rule
- **Point to specific places in the record that support your case**
- **Utilize AI as a starting point**

Effective Appeals

- **Medicare Advantage**
  - Utilize CMS Regulations!
    - Two Midnight Rule
    - Medical necessity determinations reviewed by a physician with expertise in the appropriate field for that service
    - Authorized stays cannot later be reviewed for level of care
  - Not Contracted?
    - Additional appeal rights available!!
    - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Two Midnight Rule

Two-Midnight Presumption

- All IP claims that cross two midnights are “presumed” appropriate for payment under Medicare Part A and are not the focus of medical review
- MA Plans do NOT have to follow

Two-Midnight Benchmark

- MA plans may select claims for review, following CMS-established procedures
- May use prior authorization or concurrent review of inpatient admissions to assess medical necessity
  - MA medical necessity reviews may be conducted before the service is provided, during, or after as long as complying with Two-Midnight Benchmark

Two Midnight Rule

Source: § 412.3 Admissions

- An inpatient admission is generally covered by Medicare if the physician expects care to span at least two midnights
  - *The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration*
- Exclusions to Two Midnight Expectation
  - Inpatient only procedures
  - One midnight stay be covered if supported by the admitting physician's clinical judgment and medical record documentation

MA Swingbed Admissions

MA Plan Cannot Deny Admission to a Post-Acute Setting and/or Redirect the Care to a Different Setting if:

- A patient is being discharged from an acute care hospital to a post-acute care facility that would be covered under Traditional Medicare
- Patient's attending physician orders post-acute care in the specific type of facility
- Patient meets all applicable Medicare coverage criteria for admission into that facility type

Exception for Qualifying Hospital Stay

- MA organizations may cover post-hospital SNF care without the required prior qualifying hospital stay (3 day stay)

AI Appeal

Example of a two-midnight rule appeal generated from ChatPT

Summary of Appeal

The patient was admitted for **[briefly describe the medical condition or reason for admission, e.g., heart failure exacerbation, pneumonia, severe dehydration, etc.]** and remained hospitalized for **[number of days hospitalized]** days, with discharge occurring on **[Date of Discharge]**. During the course of hospitalization, the patient required **[describe the medical interventions or procedures performed, e.g., intravenous medications, monitoring, diagnostic tests]** that necessitated continuous inpatient care.

Justification for the Two-Midnight Rule

Under the **Two-Midnight Rule**, CMS states that a patient should be considered for inpatient admission if their stay is expected to span at least two midnights, and the patient requires inpatient-level care due to the complexity of their medical condition or treatment needs. In this case:

1. **Clinical Severity of the Condition**: The patient presented with **[briefly describe symptoms, diagnosis, or clinical indications]**, which required **[describe treatments, monitoring, or diagnostic procedures that were inpatient-specific]**. These conditions and the treatments necessitated **[a level of care only available in an inpatient setting]**, thereby fulfilling the requirement for inpatient care.
2. **Anticipated Duration of Stay**: The attending physician and clinical team anticipated that the patient's condition would require an overnight stay for observation and treatment. Given the severity of the medical condition, the plan was for the patient to stay at least two midnights, ensuring adequate time for **[diagnostic evaluations, stabilization, etc.]**.
3. **Documentation of Medical Necessity**: The medical records clearly demonstrate the need for inpatient admission. **[Cite specific documentation such as physician's orders, progress notes, diagnostic results, or any other supporting records]**. These documents corroborate that inpatient care was both medically necessary and appropriate given the clinical circumstances.
4. **Compliance with the Two-Midnight Rule**: Based on the clinical evidence, the patient's stay clearly met the **two-midnight rule** criteria, as they required more than 24 hours of inpatient care, with a reasonable expectation of at least two midnights of continuous inpatient treatment and monitoring. **[If applicable, mention any specific events that occurred during the hospitalization that required extended monitoring or intervention.]**

Tough Situations!

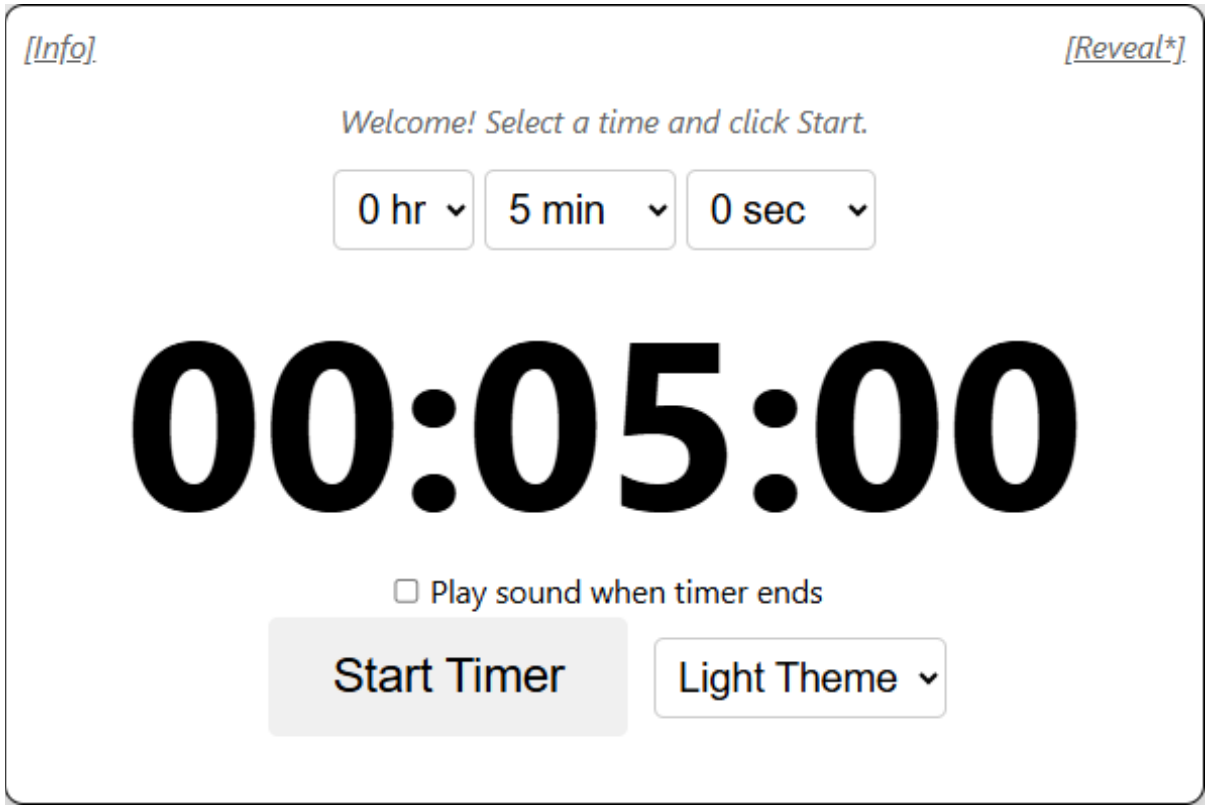
Situation #1:

- Patient had VA for inpatient stay, but VA denied swingbed stay, can patient utilize their Medicare?
  - Yes, as long as IP stay was medical necessary and meets all other criteria
  - Add the stay dates in the 70 occurrence span as normal

Situation#2:

- Patient has BCBS primary, but swingbed days have run out, can we submit to Medicare?
  - Its Complicated!
  - Medicare will require adjudication from BCBS
    - BCBS will most likely deny as provider responsibility
  - 3 day stay not on file with Medicare
    - Unknown affect

Discussion Time



Change of Status

The Order - Observation

CMS Guidelines state that an order for Observation may not be backdated:

State Operations Manual – CMS – Appendix W

"The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. ***The order may not be backdated.*** *"*

The Order - Inpatient

Per Federal Register, Title 42, Chapter IV, Subchapter B, Part 412, Subpart A §412.3c

"The physician order must be furnished at or before the time of the inpatient admission"

Additional resource: Hospital Inpatient Admission Order and Certification (CMS)

Prior to Discharge

Change of Status Prior to Discharge- Inpatient to Observation

Medicare - Follow the Guidelines!

- Medicare Claims Processing Manual – Chapter 1, Section 50.3.2
- Medicare Change of Status Notice – Imp. Date 2/2025
- Observation Hours start from the time of the decision - do NOT backdate the order
  - *"Hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order."*

Change of Status Prior to Discharge- Inpatient to Observation

Medicare Advantage

- *Should* follow Medicare guidelines
- An observation order should be placed prior to discharge – follow Medicare billing guidelines
  - Timing of the order is in question – Refer back to CMS guidelines regarding backdating orders
  - Request clarification from the payor regarding when to start observation hours

Other Payors

- No specific guidelines
- Set a facility policy

After Discharge

Change of Status After Discharge

Medicare

- Not applicable

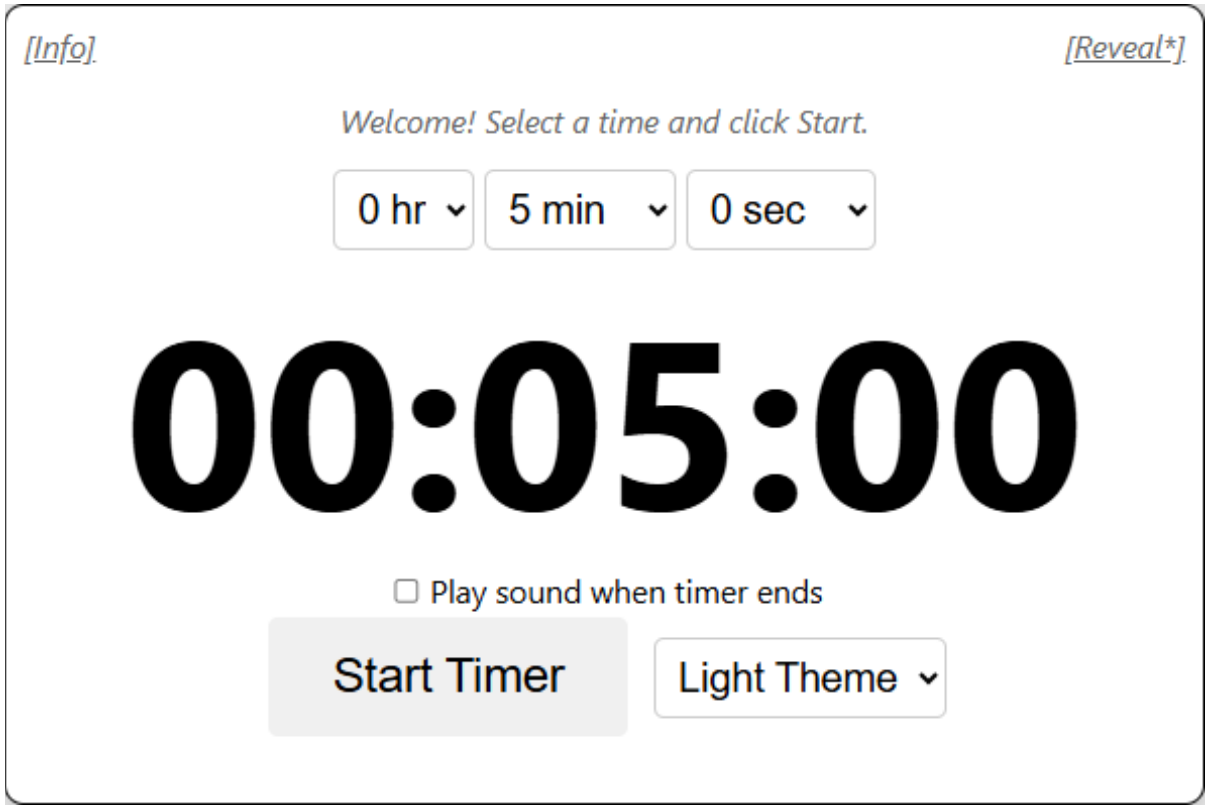
Medicare Advantage

- Force payors to give direction (get it in writing if possible!)

Other Payors

- Payor directed
- Force payors to give direction (get it in writing if possible!)

Discussion Time



Best Practices

Clinical Perspective

Utilization Review - Clinical Background Recommended

Team Effort – Include Billing and HIM Staff in discussions

- Eligibility and Benefits
- Coding

Weekend Practices

- Identify Current Processes- If Any
- Anticipate Discharges vs. Worsening Patient Status
- Priority Communication Points
- Consistent Form that Works Across Team Members
- Electronic vs. Paper
- Communicating Patient Status at Shift Handoff

Tools

Create a template to remove the guesswork and ensure a well-documented process

UR Template

UR Prepwork

Discussion Time