HCA, one of the nation’s largest hospital companies, is also one of the nation’s premier providers of acute inpatient rehabilitation services. HCA is the second largest provider of acute rehabilitation services in the U.S. and the largest provider of hospital based rehabilitation units.

HCA has over 1200 Medicare certified inpatient rehabilitation beds located in over 58 hospitals from Alaska to Florida and its programs admit almost 25,000 rehabilitation patients annually.
What you need to know to overcome managed care struggles

Disclaimer

- The intent of this presentation is to share lessons learned with Managed Medicare Organizations (MCOs) and what we have learned in order to “create partnerships to improve care for the patients we serve.”
- This presentation is not a legal document.
- The presentation and materials were prepared as tools to assist rehab programs, and was current at the time of creation.
- The presentation is based on lessons learned and the materials included are examples of resources that have been gathered, developed and found to be useful in our efforts.
- We do not confirm that the information nor the materials meet any specific guidelines especially in your state or facility.
- Reproduction of this material for profit is prohibited; you are encouraged to share this education with staff.
Goals & Objectives for This Presentation

- Data collection process and tools
- Operational tips & techniques
- Opportunities for increased success in approval rates for admission to rehab
- Communication tools to be used to facilitate the approval process
- What we have learned and continue to learn
- Case studies presented and discussed
- Sample letters & other tools
- Questions & Discussion

The Issue at Hand

Percentage of Increase in Total Medicare Advantage Denials divided by Total Medicare Advantage Submissions

A 23% increase in denial percentage over a 2 year period

DATA COLLECTED BY HCA REHABILITATION SERVICES MAY 2013-MAY 2015
**History & Overview**

- Roots in the 70’s with HMOs
- Balanced Budget Act (BBA) - 1997 Medicare+Choice
- Medicare Modernization Act (MMA) – 2003 Medicare Advantage
- Medicare Advantage plans are paid to provide all Medicare benefits that one could receive under traditional Medicare.
- Medicare Advantage Plans must adhere to the original Medicare fee-for-service’s definition of medical necessity and coverage guidelines.

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**History & Overview**

- Population is aging – the number of aged Medicare enrollees has increased 32% in the last 10 years – from 40.7M to 53.8M
- Number of MA enrollees as of March 2015 is 16.8M, an increase of 1M since 2014 and triple the 2004 number of 5.3M
- Increased from 13% to 31% of the Medicare population during that time
- On average, beneficiaries have 18 MA companies to choose from, down from 48 in 2009; UHC and Humana account for 39% of enrollment
- 1,945 Medicare Advantage plans will be available nationwide for individual enrollment in 2015, down from 2,830 in 2009
History & Overview

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015

National Average, 2015 = 31%

NOTE: Includes MSAAs, cost-sharing and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2015.
Collection of Denial Data

- Historical background
- What questions did we want to answer?
- What data did we decide to track?
- What is the best way to collect this information?
- What did our data reveal?
- What are we going to do different going forward?

Historical background
- Lots of anecdotal stories and requests for help from multiple programs
- Hard to quantify actual size of issue due to lack of quality data tracking
- Very little dedicated focus and training available on the issue
- Poor manpower allocation with liaisons performing intake and Medicare Advantage approvals/denials
- High level of concern began
- Observed many times where liaison didn’t even try a historically difficult payer
Collection of Denial Data

What questions did we want to answer?

➢ Is this a large or small issue?
➢ Is this happening regionally or nationwide?
➢ Are the high denial rates specific to all payers or just a few?
➢ Are there particular diagnoses being denied more than others?
➢ Why is this happening? Is this being caused by “us” or “them”?
➢ What can be done to correct the problem?

Collection of Denial Data

What data did we decide to track?

➢ Date
➢ Patient name
➢ Patient Diagnosis
➢ Referral source name
➢ Payer name
➢ Payer decision and response times
➢ Payer denial reason
➢ Appeal attempted
➢ Denial overturned
➢ Patient admitted Yes or No?
Sample—Collection of Denial Data

What is the best way to collect this information?

- We needed uniformity across 58 HCA IRFs
- Created a web-based “Team Room” library environment for data entry into an Excel-based log
- To promote uniformity in information, pull down menus with pre-populated choices were developed
- This data collection gave HCA the ability to compile and analyze data by market, region, and nation
Analysis of Denial Data and The Next Steps

- What answers to our initial questions did our data provide?
- What are we going to do different going forward?

What answers did we get to our initial questions?

- Significant amount of patients being denied
- National and Regional Payers involved in denials
- Not all payers were behaving the same
- Payers rarely look at the CMS required pre-admission screen
- Identified uniform top reasons for denial by payers
- Acute PT/OT documentation needed improvement
- Need to speak and document the correct “payer language”- InterQual/Milliman
- Payers take every weekend off
- Pre-admission screen improvement
- Medicare Advantage plans apply their own criteria
- Many types of 60% CMS approved diagnoses are being denied to Medicare beneficiaries who chose a managed Medicare plan
Analysis of Denial Data and The Next Steps

Many types of 60% CMS approved diagnoses are being denied to Medicare beneficiaries who chose a managed Medicare plan.
Denial Rates of Payers

10% Denial Rate is the Goal

Analysis of Denial Data and The Next Steps

What are we going to do differently going forward?

- Continue to collect, share, and promote action to improve oversight and accountability with CMS and Congressional members
- Communicate further with Medicare Advantage providers
- Learn from our own data and continue to make changes in our own training, expectations, and processes in areas we can improve
  - Acute therapy documentation
  - Pre-admission screen content improvement
  - Centralizing authorizations

“Insanity is doing the same thing over and over again and expecting different results.” —Albert Einstein
Operational Tips
The MCO Appeal

- Peer-peer – Rehab Medical Director with Insurance Medical Director
- Request denial letter
- Write appeal letter
- Involve patient/family member in the appeal process - invite patient/family to call insurance company

Tell the Patient's Story!

Story Components:

- Previous
  Functional • Medical • Social
- Transition
  Events leading to admission
- Current
  Functional • Medical • Risks and Complications
- Future
  Expected Outcome • Ability to Perform • Therapy Recommendations • D/C Plan • Caregiver(s) • Caregiver ability • ELOS
Patient Example

Acute Therapy Documentation and Recommendations

- Importance of Therapy Documentation

- Documentation to avoid
  - Dual recommendations to 2 different post-acute providers: Skilled vs Rehab
  - Ambiguous terms
    - Skilled Services
    - Unable to tolerate; tolerated well
    - Baseline
  - Poor rehab potential (when patient's acute process is not resolved)
  - Total distance ambulated (include only longest distance without rest break)
Acute Therapy Documentation and Recommendations

- Documentation to include:
  - Safety issues / deficits
  - Effects of abnormal muscle tone, lack of coordination, strength, ROM on functional activity
  - Needs that require the skill of a therapist and intensity of IRF
  - Potential for functional improvement
  - Discharge needs requiring coordination of a multidisciplinary team
  - Educational needs: patient and caregiver
  - When appropriate placement recommendations are unknown, consider comments such as, “Patient will require continued therapy services in Post Acute setting.”

Acute Documentation Examples

**Standard**
Pt ambulated 200 ft with mod assist of 2. Gait is unsteady and patient requires O2. Pt desats but recovers quickly. Pt will continue to required skilled PT services upon discharge from acute.

**Better**
Pt ambulated 50 ft x 4 with rest breaks, requiring mod assist of 2 persons. Cueing required for proper foot placement as pt has a decreased BOS and lacks coordination for safety. Pt is O2 dependent and desats to 86%. Recovery to 94% in 5 min. Pt has the potential for mobility at a S level but family will need training to assure eventual safe discharge to home. Recommend inpatient rehab for a coordinated interdisciplinary approach including rehab nursing and respiratory therapy.
Better
Pt bathes both arms, chest, abdomen and thighs. Dependent for legs and feet. Pt cannot manage washing back and is unable to use long handled sponge at this time. When eating, pt experiences tremors with dominant RUE and requires hand over hand assist to bring food to mouth. Pt has not had the opportunity to dress in street clothes but expect issues with LB dressing. Pt has the potential for significant improvement in self care skills but will need the intensity of IRF upon discharge from acute.

Standard
Pt is mod assist for ADLs. Tremors present during treatment. Tolerated well. Will continue to treat until D/C from acute.

Better
Pt I with simple 1-step commands only. Req's verbal & physical cues for simple 2-step commands. Pt has difficulty making basic needs known & is limited to gestures and single words. Pt impulsive at times, increasingly when frustrated. Pt unable to solve simple problems of daily living. Pt oriented x 4 but demonstrates severe short term and working memory deficits. Pt's aphasia, cognitive deficits and impulsivity makes d/c to home unsafe at this time. Pt is able to fully participate in skilled therapy services and demonstrates appropriate motivation. Pt would benefit from acute inpatient rehab program once medically stable.
Acute Documentation Examples

Standard
Pt has oropharyngeal dysphagia. Recommend dysphagia II diet with nectar thick liquids. Maximum aspiration precautions are recommended. Meals should be supervised. Strategies are small bolus for food and liqs, chin tuck with nectar thick liquids. SLP will follow and upgrade diet as appropriate.

Better
Pt has severe oropharyngeal dysphagia demonstrated by silent aspiration of thin liquids & impaired oral predatory stage. Pt unable to safely manage a regular PO diet without significant risk of aspiration pneumonia & choking hazard of solid foods. For patient to maintain PO intake pt requires modified diet of dysphagia II with NTL. Pt requires close S during all PO intake by skilled therapist or trained rehab nurse. Pt requires verbal cues to complete chin tuck and small bolus to reduce risk of aspiration pneumonia or choking of solid food. Pt requires intensive ST for ongoing assessment of dysphagia to ensure least restrictive diet.

Change

“Man cannot discover new oceans unless he has the courage to lose sight of the shore.” —Andre Gide

“A year from now you will wish you had started today.”
—Karen Lamb

“By changing nothing, nothing changes.” —Tony Robbins

“If you do what you’ve always done, you’ll get what you’ve always gotten.” —Tony Robbins
Operational Tips
Central Authorization

• What did we do?
• The goal of the centralized admission and authorization center is to have a subject matter expert who can effectively and efficiently manage the authorization of admissions to the acute rehab programs.

<table>
<thead>
<tr>
<th>Central Authorization Admission Conversion Rates</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>All Ins Cases</td>
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<tr>
<td>Managed Medicare</td>
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<tr>
<td>Commercial</td>
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Operational Tips
Central Authorization

• Benefits: improved relationships with payers—only two people to work with; centralized communications; smarter about what we are submitting.
• More time for your liaisons and/or other program staff who were “burdened” with this responsibility.
• Allows you to know your payers and their needs.
• Pilot for Q1 demonstrated $450K in net revenue as a result of increased admissions directly related to this project ($1.8M annualized).
Managed Care Contracts

- Contract language—what’s in there?
- Review the payment structure
- What are the terms of the agreement?

- Suggestions for change
  - How are appeals handled?
  - Timeliness of responses
  - Disclosure of admission criteria
  - Involvement of your rehab medical director
  - Denials in writing
  - Weekend & holiday approvals
  - Tracking of denials/identify trends, issues

The Value of a Face-to-Face Meeting

- Ask for a meeting
- Key leaders from both sides
- Prepare, prepare, prepare
  - Prepare an agenda in advance that both parties have worked on; expectations and accountability
- Know your data
  - Case studies
  - Percentage of admits vs non-admits
  - What are you willing to change or concede?
Lessons Learned Directly from the Managed Medicare Organization

- Questions to ask:
  - Is this patient medically complex?
  - Does this patient need to be seen frequently by a doctor?

- Also:
  - 24 hour licensed nursing care
  - Requires multiple therapies
  - Interdisciplinary plan of care
  - Ability to tolerate 3 hours of therapy per day or 15 hours in a week

Opportunities for Partnership

- What are the opportunities?
  - Pose the question; you never know until you ask

- What is being measured?
  - Sharing of ideas and data

- Re-admission rates
  - Everyone’s talking about it
Know the Guidelines

- Guidelines
  - Milliman
  - InterQual
  - CMS guidelines
- Company policy
- “Good clinical judgment”
- Questions to ask
  - What part of the guidelines kept the patient from being approved??
  - Can I get that in writing??

Discharge Planning

- The importance of collaboration and communication with acute care case managers and social workers

- Understand the discharge planning process
  - Timeliness of responses
  - Early identification
  - Communication (if denied, why?)
  - Are you meeting on a regular basis?
  - Are you sharing case studies?
  - Have you asked about your referral process?
  - Avoid the pitfalls of dual referrals (SNF and rehab)
SNF vs. Rehab

- Know the differences—key talking points
- Educate the providers, referral sources, patients, and caregivers on the differences
- Use published information to your advantage
  - Dobson/DeVanzo study: [https://www.amrpa.org/newsroom/Dobson%20DaVanzo%20Final%20Report.pdf](https://www.amrpa.org/newsroom/Dobson%20DaVanzo%20Final%20Report.pdf)
- Share your outcomes
- The importance of ongoing communication
  - Don’t assume people know
- Explore opportunities for partnerships
Key Takeaways

- Collect data; analyze the data; use it to influence MCO/share your findings
- Find out what your MCO wants and organize accordingly
- Utilize all levels of appeal
- Summarize patients need for rehab in a “story”
- Train acute therapists on documentation
- Know the guidelines that are applied in the decision making process
- Know what your contracts with payers state; ask for what you want; cultivate relationships
- Educate those who influence discharge decisions
- Evaluate opportunities for partnering with MCOs and others to influence patient care and outcomes

Questions & Discussion