Managed Care Friendly

a guide to better reimbursement and a simpler process

Presented by: Cade C. Saurage

To Contract
Or NOT To Contract

Why go **IN** ?

1. Relationships
2. Referrals
3. Less Policy Limitations
4. Less Resistance
5. Leverage

Why stay **OUT** ?

(Get started Quicker?)

1. Less Regulation
2. Higher Reimbursement
3. 'Fair' Reimbursement
4. Balance Billing

Look at the BIG Picture…

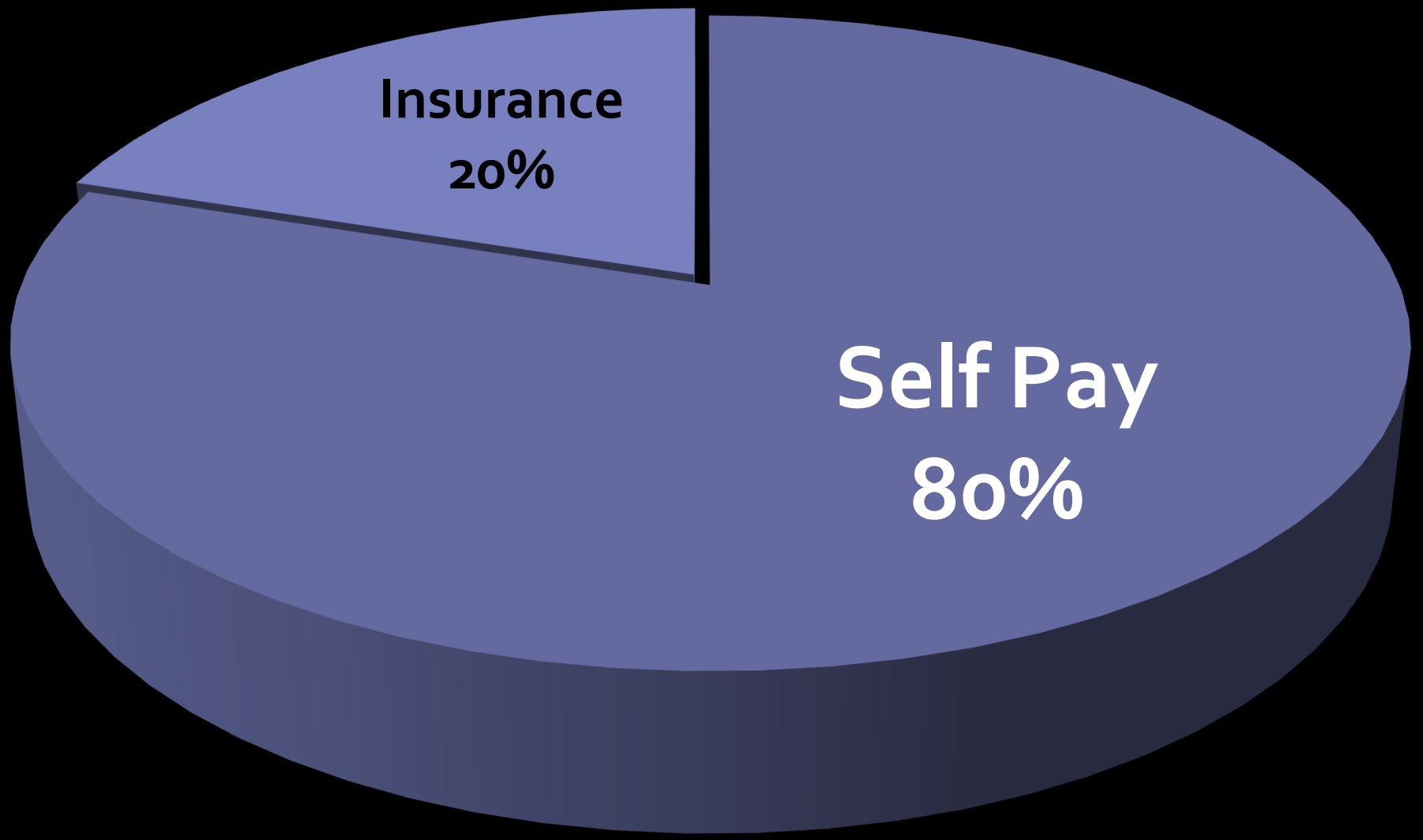
What is important for you?

What help$ you meet your goal$?

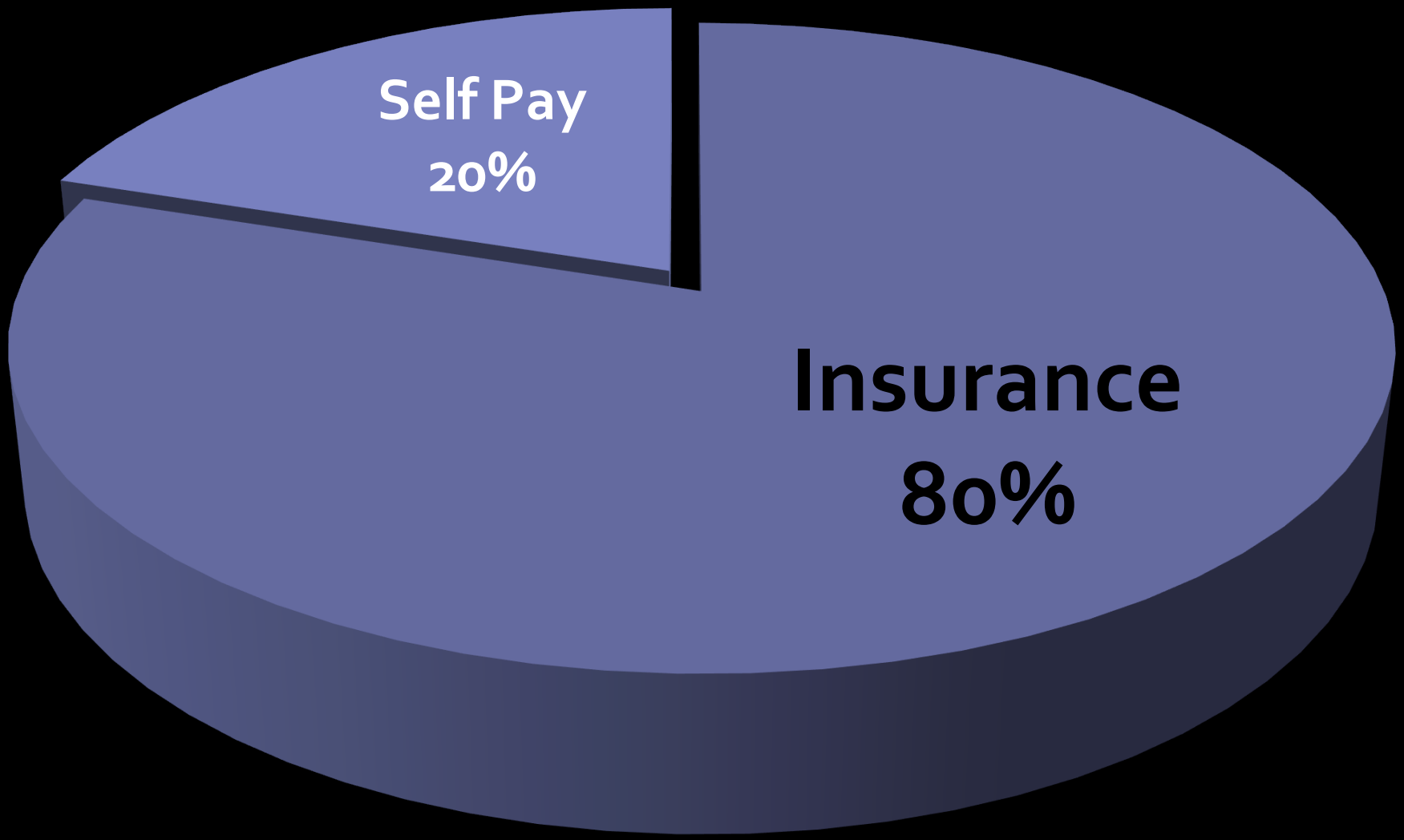
Trending. . .

- CD Inpatient: 180 days to 90 days to 45 days to 30 days to day by day.
- More facilities > more patients > greater cost > more denials.
- 3rd Party Doctor Groups (different from IRO) = hired hands. Stats?
- Healthcare Exchange **BOOM**…….Healthcare Exchange withdrawal.
- Chart audits / ROI for benefits / delayed payment / lawsuits
- Policy Changes (High Deductible, PPO to EPO, PPO to HMO, Employer Group incentives
- UR: Standard (once simple) healthcare protocol became BUSINESS

REIMBURSEMENT



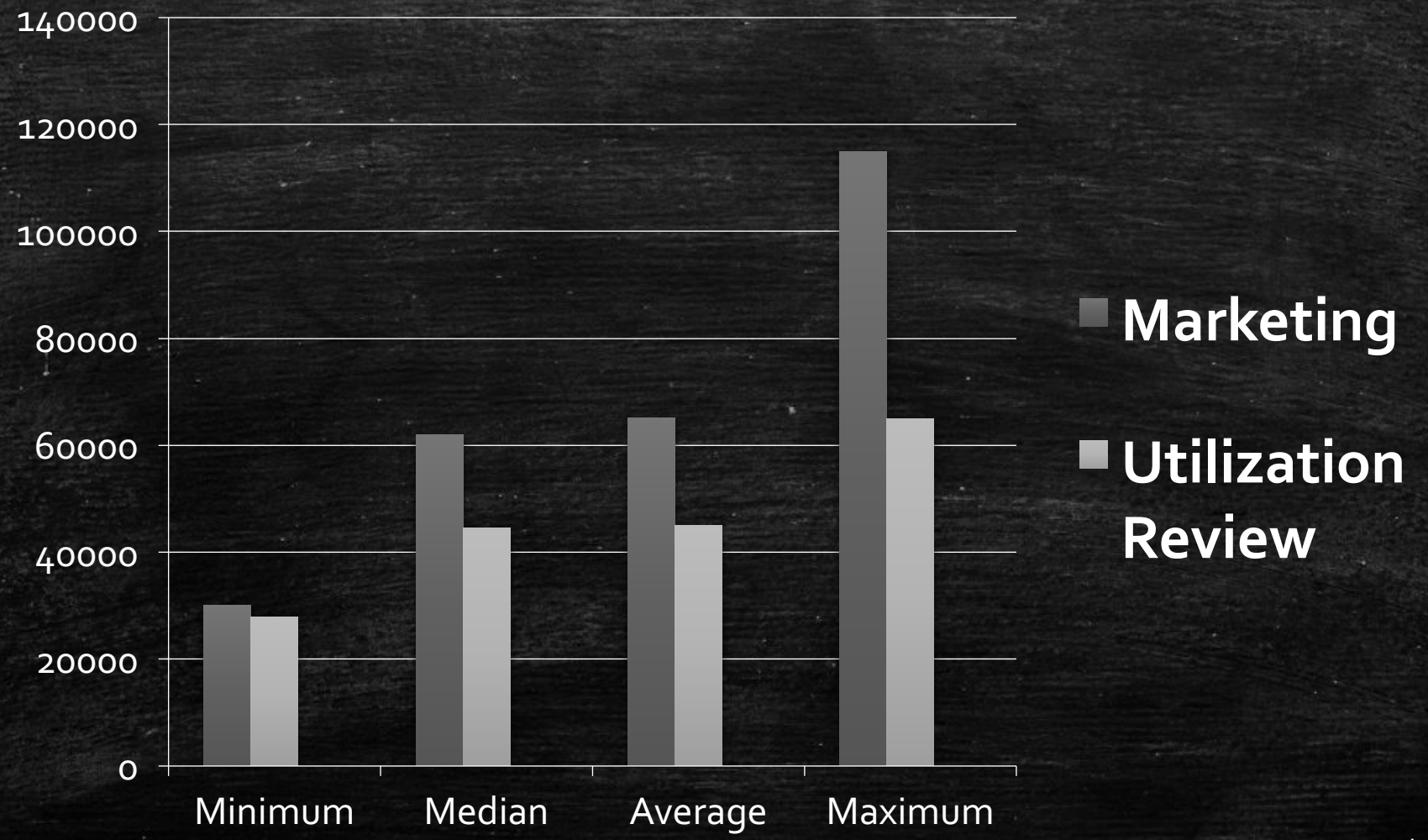
REIMBURSEMENT



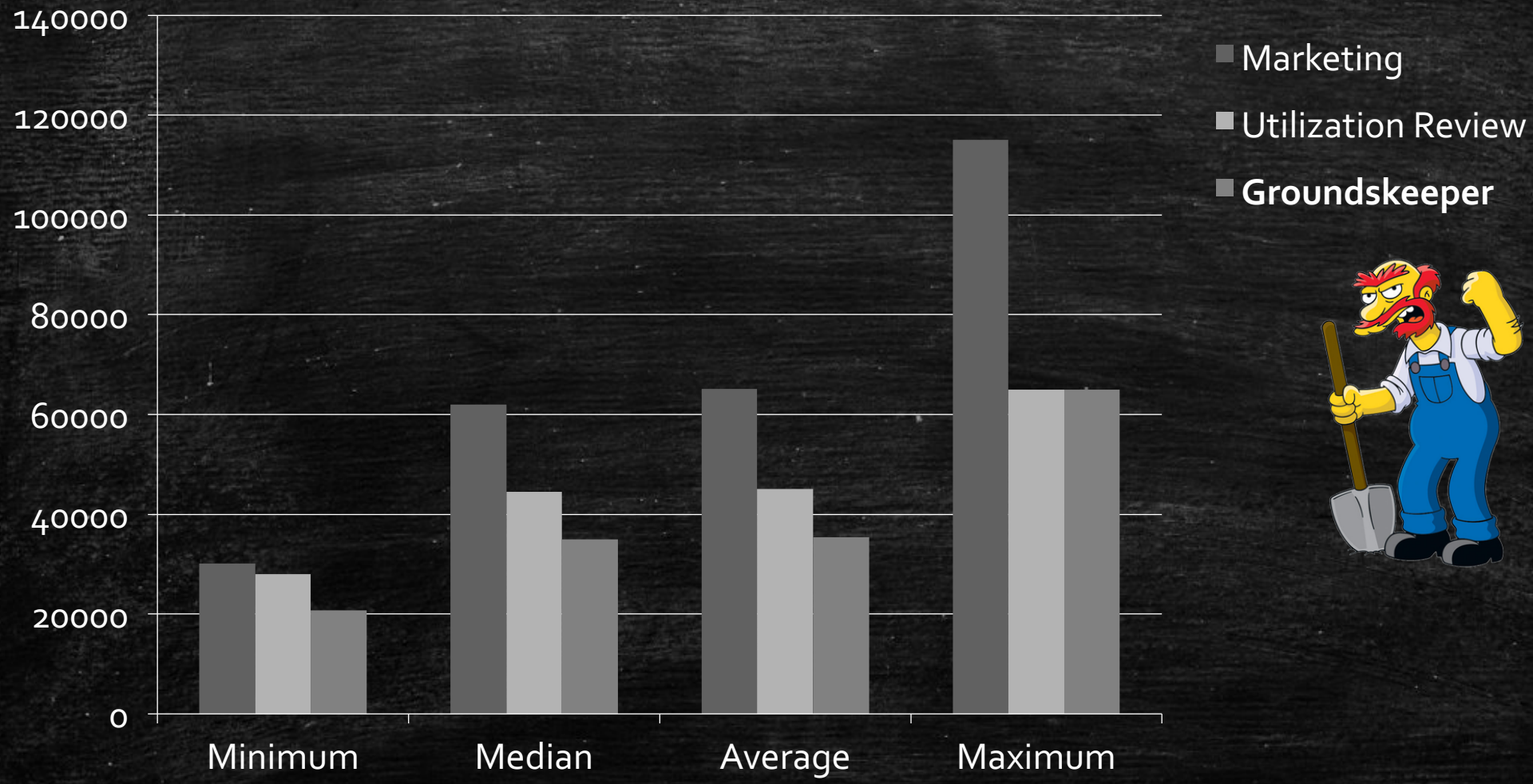
Million Dollar Question. . . Literally

- Who is representing your facility with 80% of your patients……with 80% of your

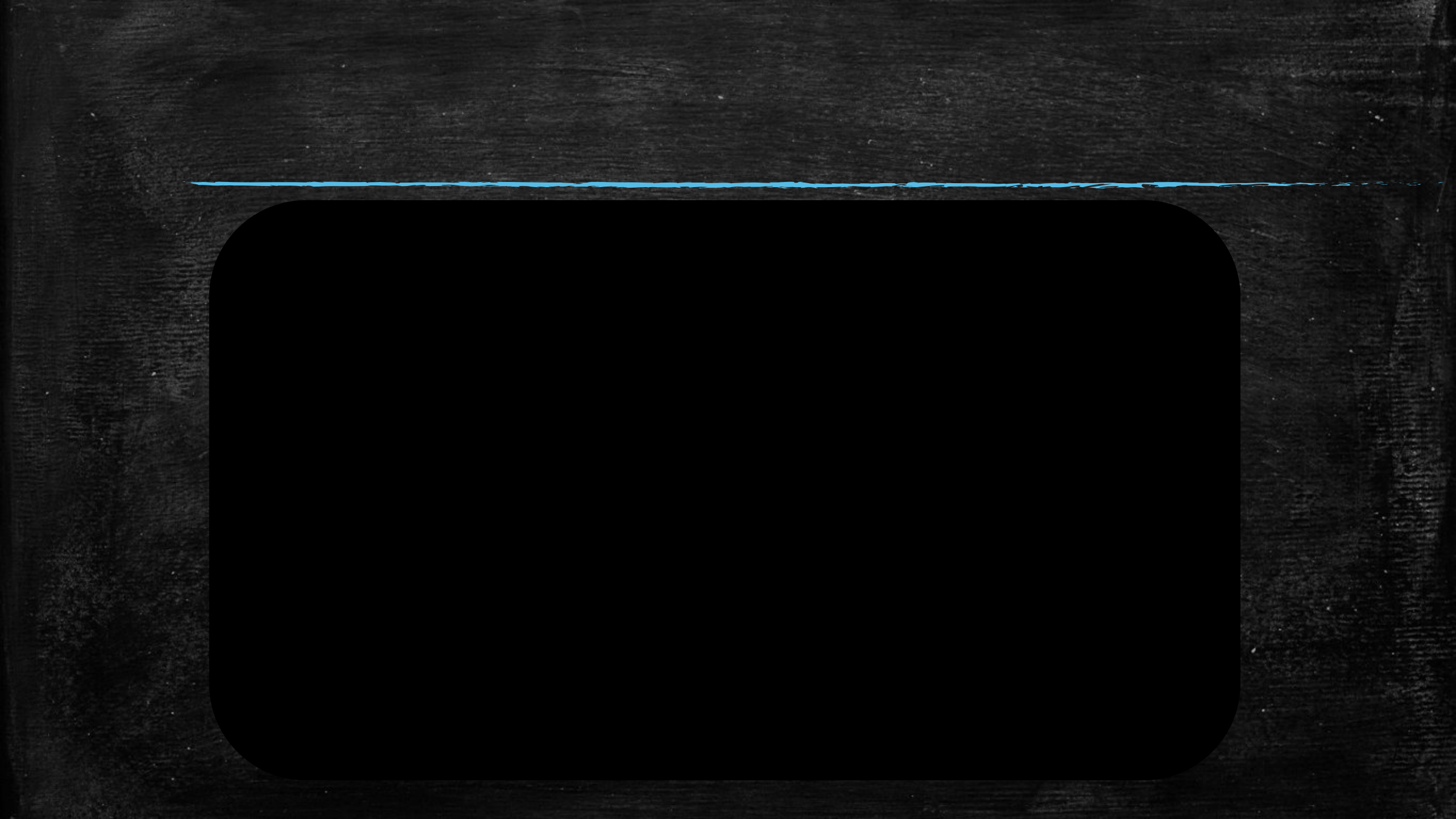
How do the FACES of your facility compare?



- NAATP bi-annual Salary Survey 2016



- NAATP bi-annual Salary Survey 2016



Are you assembling the right UR team?

Are you assembling an ‘A’ Team?

The A Team

Head of UR:

Keeps Ethics above everything else.

- Knows the rules of the game better than anyone.
- Knows medical necessity criteria, Parity and NCQA regulation.
- Has ability to complain without being confrontational.
- Has ability to sell without being a salesman.
- Works effectively with ALL departments.
- Creates reports, studies and uses data.
- Has support from leadership and time to get it all done.

Medical Necessity Criteria FACT

- Note: Each state mandates and regulates which level of care guidelines and medical necessity criteria will be used in making determinations for authorization. The most popular criteria used is ASAM criteria with the exception of Texas which uses TAC (or TACADA) criteria. Insurance companies have created their own criteria which can be found online by searching "Behavioral Health Medical Necessity Criteria" and reviewing each link provided by respective Managed Care groups (ie Magellan, Cigna, UBH, Aetna, etc.). These criteria are simply a combination of ASAM and a 'preference' of sorts AND hold no legal bearing on the authorization outcome. Insurance / Managed Care criteria was simply created in-house as a guideline for their case managers to use to provide authorization without needing consult of the supervising medical doctor(s). There are many factors which can influence the criteria designation such as employer group home office, employer group of state and/or federal ownership, policy holder home and/or state in which the care is provided. It is imperative that the criteria being used is verbalized and identified before each review takes place. This can solve any confusion. Texas facilities should know and understand both TAC and ASAM criteria and surrounding states should know the ins and outs of ASAM.

The A Team

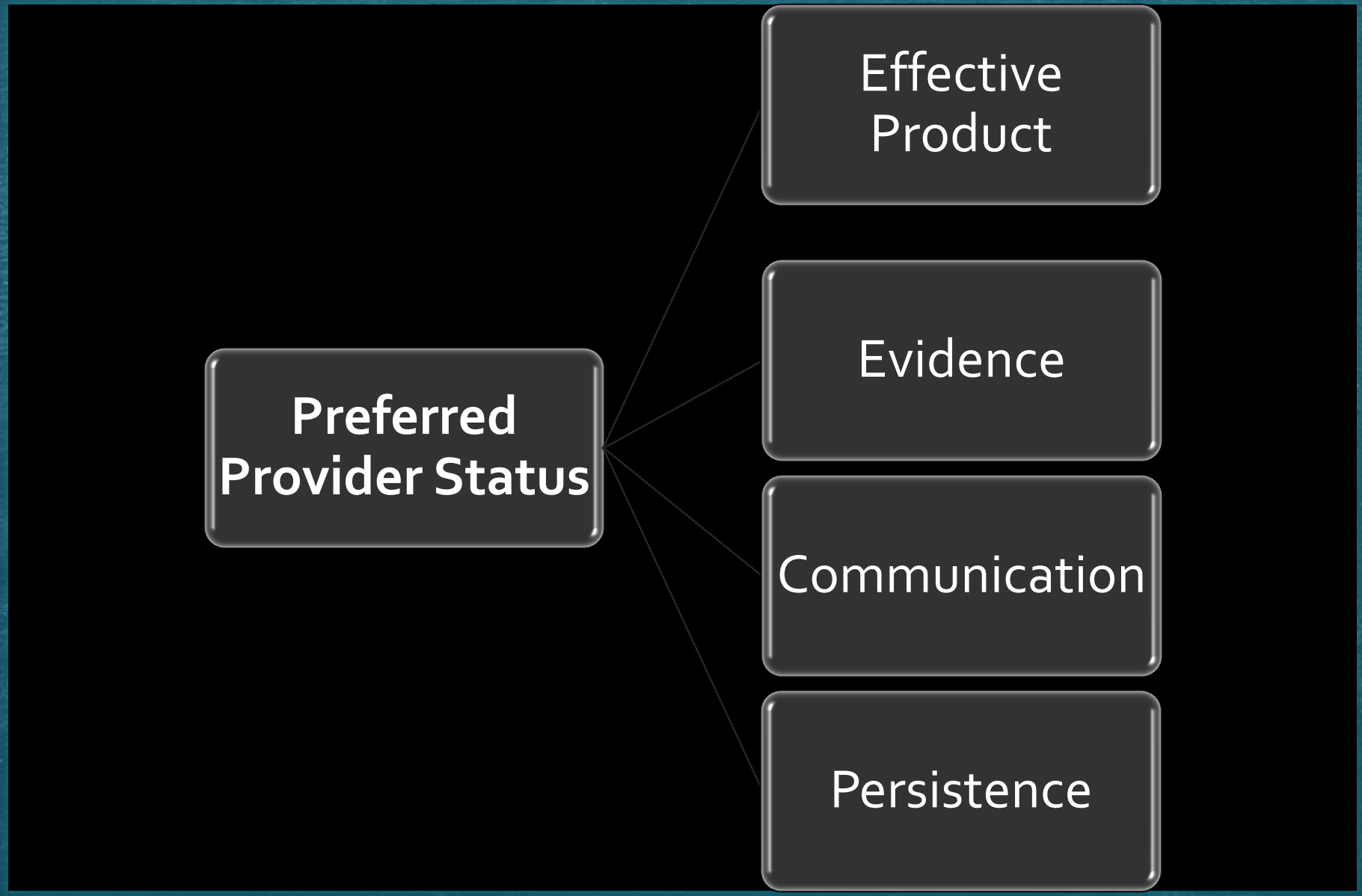
The Best UR Staff:

- Combines the art of storytelling with the TRUTH.
- Knows medical necessity better than the state.
- Works well with treatment team.
- Has a willingness to challenge determinations.
- Has a competitive streak and likes to win.
- Makes few mistakes and keeps good notes.
- Has strong relationship skills and even stronger drive.
- Believes in rehabilitation and the provider they represent.

Managed Care Organization Relationships

- Book of Business – If you don't have one, start one
- (Even UR staff needs a book of business)
- (Every Insurance company employee needs a profile)
- Begin on the phone with a GOAL of face to face
- (Harder to say NO to someone you know. Harder to get to know someone on the phone)
- Outcome Studies and Score Cards – MCOs love data!
- Provider Relations / Medical / Clinical / UM / Appeals


Who is putting out your fires?


Preferred Provider Status
Effective Product
Evidence
Communication
Persistence

What is Utilization Review / Management?

- **Utilization Review (UR)** is a critical evaluation (as by a licensed treatment team member) of health-care services provided to patients that is made especially for the purpose of controlling costs and monitoring quality of care.

- **Utilization Management (UM)** is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care. It is the process of evaluating the medical necessity, appropriateness, and efficiency of health care services.

- The term "utilization management" is often used interchangeably with “utilization review”. Although they both involve the review of care based on medical necessity, utilization management usually refers to requests for approval of future medical needs, while utilization review refers to reviews of past medical treatment.

10 Points to PONDER

(Before you write or report)

1. Document 10% progress, 90% struggle
2. Be Descriptive and support with evidence.
3. Document Quality vs. Quantity (Bullets vs. Narrative)
4. Use ‘Powerful’ words to describe. Make reader uncomfortable.
5. Make reader sympathetic, empathetic for patient.
6. Never cause reader to oppose patient.
7. Put yourself in Insurance’ Shoes.
8. Creative treatment – What MUST be done before discharge?
9. Turn **UP** the notes as treatment extends.
10. Better your craft by learning Criteria

The REVIEW

Drive Perception

- Tone of Voice
- Big Punch - Open with most significant.
- Paint picture / Tell Story / Find an angle……And use POWER WORDS!
- Bring it home (Why will they fail at a lower level).

MCO Relationship (out of network)

- Build Profile of each reviewer (likes, dislikes, something personal to ask about on future call).
- Create database of profiles, team and team lead contact names assigned to your program.

Criteria

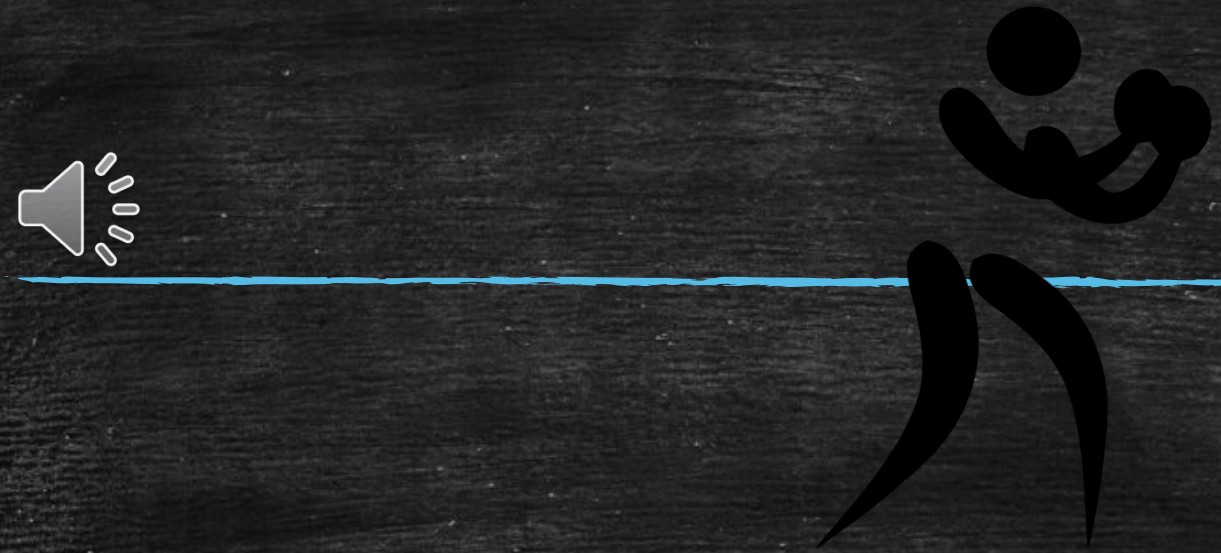
- Verbally establish the criteria being used on first call.
- Keep copy of criteria accessible during reviews and **Quote criteria.**

Case Prep

- Take notes during review to use on next call.
- Accommodate **EVERY** request from the Insurance reviewer.

Closing

- Decide on standard (written) appeal or expedited (verbal) appeal…*AKA* D2D (Doc-to-doc) and inquire with your reviewer how many appeals will be allowed before exhausted.
- Some insurance companies require a Doctor, but most will allow any qualified representative.



DOC-TO-DOC

Phase 1 – D2D / Verbal Appeals / Higher Level Review

Know your Doctor

Know credentials, specialty, likes, dislikes, convictions, philosophies. Keep profile.

Build your case

Plan out case. Anticipate rebuttals. Never wing it.

Check for 'logistic impairments'

Drive Perception

Tone of Voice. Be stern. Be articulate. Be confident. Be respectful.

Be assertive, but professional.

Begin "I understand we are mandated by the state ___ to review under ___criteria. (This statement tells them that you know compliance and you are prepared)

Control Conversation

Initiate call. Request Doctor's name and number and place phone call for review.

Review scheduled time and call 2 minutes early.

NEVER let him/her gain control of call. Interrupt any philosophical rants.

Open with a 'Big' Punch

Most significant patient struggle verbalized first and then followed up with others.

His/her decision is usually made within first 30 seconds of conversation.

Phase 2 - D2D / Verbal Appeals / Higher Level Review

Document his/her reasons for denial

Add reasons to Reviewer profile

Use these reasons against them in next call in case of contradictions.

Get political. Get legal.

Quote criteria 'verbatim' – have hard or electronic copy criteria in front of you

Use words such as 'liability' (We are liable for this patient's life)

Use 'partnership' (How does this contribute to partnership w/ one another)

Negotiate to salvage

If a denial is imminent, then request days simply for discharge planning. (Well, at least give 'us' a few days so we can get the patient's 'aftercare' and 'next-phase' planned)

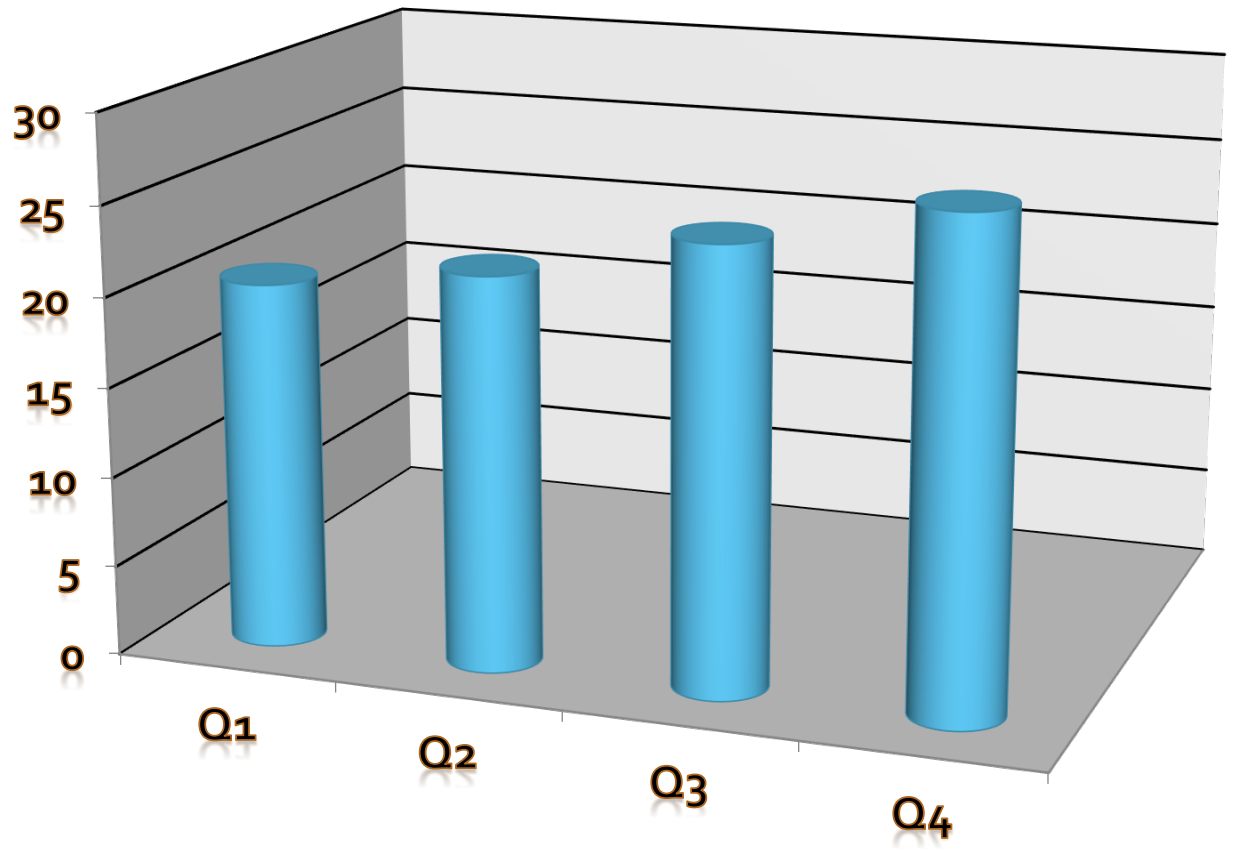
Never break a promise

If you promise to step a patient down on a future date, always keep that promise. (Extenuating circumstances may supersede)

Promise may just be that you will do everything you can to get patient to step down and unless patient takes a turn for the worse, then it will happen.

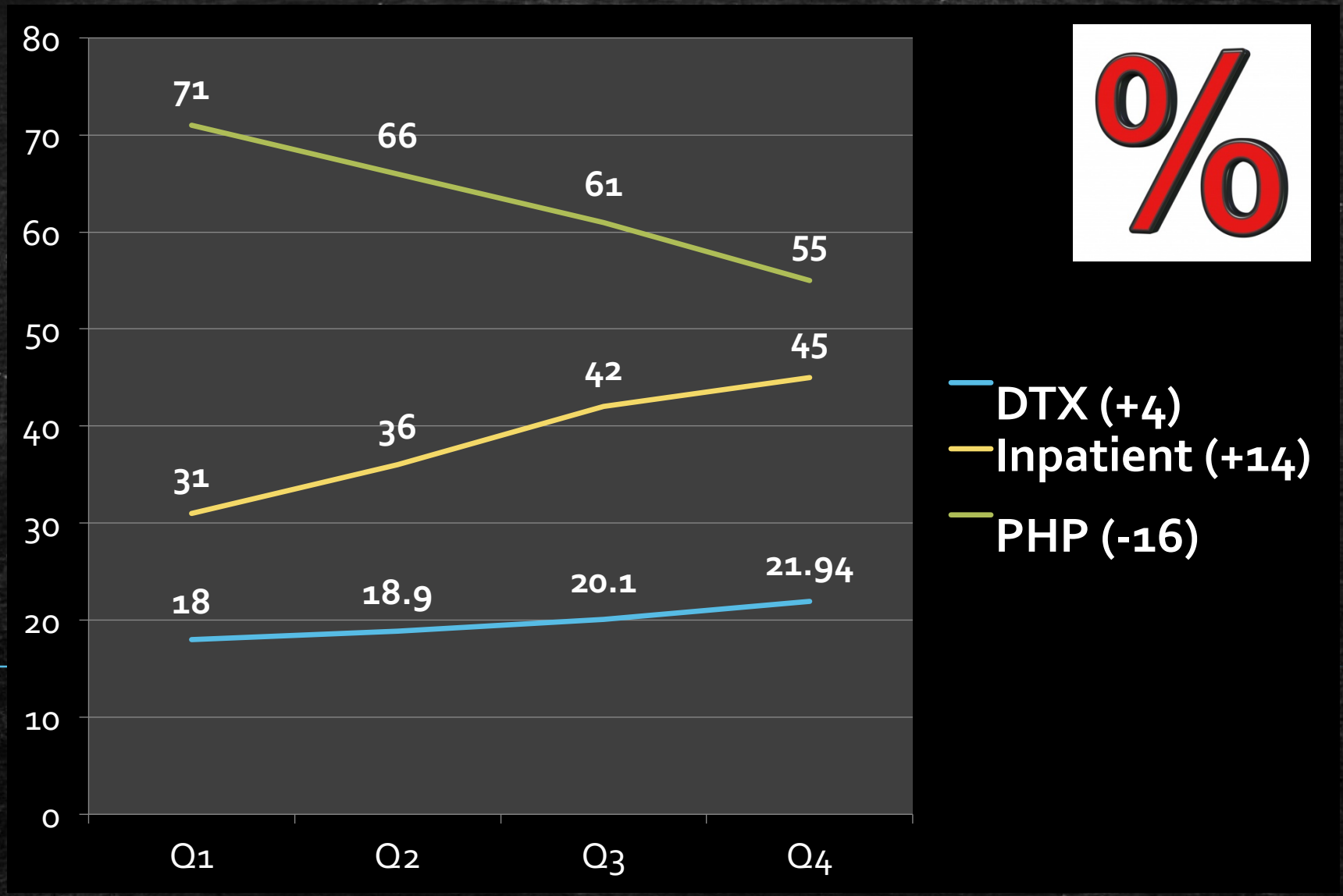
Agree when you must

If you do not feel patient meets criteria, verbalize that. Always let Doctor know that you agree with them……if you do. Add this to Doctor Profile. Remind them of these during future reviews.



AVERAGE DAYS AUTHED

24.6% Increase in Total Inpatient Days authorized


80
70
60
50
40
30
20
10
0
71
66
61
55
45
42
36
31
21.94
20.1
18.9
18
Q1
Q2
Q3
Q4
%
DTX (+4)
Inpatient (+14)
PHP (-16)

Re-cap

1. Hire like it matters
2. Identify your goals and go after them
3. Know the game better than they do
4. Keep a book of business
5. Find the Partnership
6. Follow the trends & address the negative
7. Put strategy and method into everything you do

---

8. Invest in your UR Department

"If you can hire people whose passion intersects with the job, they won't require any supervision at all. They will manage themselves better than anyone could ever manage them. Their fire comes from within, not from without. Their motivation is internal, not external."

-Stephen Covey

"If you pay peanuts, you get monkeys."

Chinese Proverb