The Future of Patient Access:
Preparing for ICD-10 Regulatory Change
Agenda

• Elevated role of Patient Access in Revenue Cycle
• Industry trends affecting Patient Access
• Outpatient Medical Necessity & ICD-10:
  • CMS Medicare/Regional MACs
  • Commercial Payer Rules
  • Clinical Aspect of Prior Authorization
• Southeastern Ohio Regional Medical Center (SEORMC)
• SEORMC’s ICD-10 Journey
  • Challenges
  • Solutions
  • Where we are today
• Q&A
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Mary Guarino
Vice President of Product Management
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Brenda has over 10 years of professional healthcare experience. Her ability to identify where process improvements can add efficiency, encompasses the span of the revenue cycle – from patient access through denials management.

As Patient Financial Services’ Revenue Assurance Team Leader for SEORMC, Brenda leads development & management of the Medical Necessity verification and chargemaster management processes. Her special expertise ranges from Medicare & Medicaid billing and follow-up, to chargemaster maintenance & denials management.

She is an active member of the Central Ohio Patient Accounting Managers (COPAM).
Mary has over 25 years of professional healthcare experience that includes fiscal operations, revenue cycle management, compliance, physician practice management & extensive third-party reimbursement/contracting.

As a Vice President of Project Management for Craneware, the leader in automated revenue integrity solutions, Guarino has been instrumental in the development of Craneware’s leading all payer Medical Necessity verification & Compliance solutions.

She is an active member of both the Healthcare Financial Management Association (HFMA) & Mass. Association of Patient Account Managers (MPAM).
• MACs  Medicare Administrative Contractors
• LCDs  Local Coverage Determinations
• NCDs  National Coverage Determinations
• ACA  Affordable Care Act
• ACO  Accountable Care Organization
• CMS  Centers for Medicare and Medicaid Services
• CPT  Current Procedural Terminology
• ABN  Advanced Beneficiary Notice
• ICD-9  International Classification of Diseases, 9th Revision
• ICD-10  International Classification of Diseases, 10th Revision
Industry Changes Impacting Patient Access

- ACA is causing a shift in commercial payer mix & benefits
- First-time new payers & plans being introduced at a state level
- Increased eligibility requests – shift from free care
- Patient liability increased deductibles & co-pays
- Increased financial constraints
- ICD-10
- Medical Necessity shifts to prior authorization
- ACO reimbursement shifting to quality & cost models
Industry Changes Impacting Patient Access

Patient Access’ key role in revenue cycle

- Denial management best practice: front-end avoidance
- Lack of pre-authorization: the #1 patient access-related denial
- More federal dollars focused on compliance
- Advanced Beneficiary Notice (ABN)
- Continuing shift from inpatient to outpatient
- Increased partnerships & affiliations
- Relationship building
Understanding outpatient Medical Necessity
What impact does this have on Patient Access?
Regional MACs
LCDs & NCDs
Medicare ICD-10 readiness
Future LCDs – ICD-10 defined
Future NCDs – ICD-10 defined
Significant increase in ICD-10 codes
Patient Access tools
Medicare MAC – Regional Review

<table>
<thead>
<tr>
<th>MAC Jurisdiction</th>
<th>Previous MAC Jurisdiction</th>
<th>Processes Part A &amp; Part B Claims for the following states: Effective November 2013</th>
<th>MAC 12 Regions support Medicare &amp; Medicare Advantage Rules *</th>
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<td>California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands</td>
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<td>5 5</td>
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<td>Wisconsin Physicians Service Insurance Corporation</td>
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<td>H 4 &amp; 7</td>
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<td>15 15</td>
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Per United Healthcare

*Medical Necessity* is the process for determining benefit coverage and/or provider payment for services that are medically appropriate & cost-effective for the individual member. Evidence based.

*Prior Authorization* is a member-centric review that evaluates clinical appropriateness of requested services in terms of the type, frequency, extent & duration of stay. Determines benefit coverage prior to service being rendered.
• Payer shifts from Medicare/Medicaid to replacement plans
• Shift to Prior Authorization
• Clinical criteria
• Medical Necessity policies often lack CPT & ICD-9 codes
• Different rules at the plan level
• ICD-10 readiness
• Physician responsibility vs. Patient Access
• CPT to diagnosis alone does not support payment
### Commercial Payer Requirements: Shift to Prior Authorization

<table>
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<tr>
<th>Service Area/Payer</th>
<th>Aetna</th>
<th>Cigna</th>
<th>United</th>
<th>Humana</th>
<th>Medicare Advantage Plans</th>
<th>Medicaid Replacements</th>
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<td>PA - depends on State</td>
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<td>PA - depends on State</td>
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<td>MN/PA - both required</td>
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<td>MN</td>
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<td>MN</td>
<td>MN/PA - both required</td>
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<td>MN/Frequency limits</td>
<td>PA</td>
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<td>MN/Frequency limits</td>
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<td>MN and/or PA</td>
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*PA = Prior Authorization  
**MN = Medical Necessity  
MN/PA = both required
• We have verified your diagnosis does support the need for a C-Scan. There is no Prior Authorization needed for this service.

• **Future**: We have also verified you are in enrolled in new insurance. Your deductible is $1200.
• ICD-10 Training
• Review protocols & procedures
• Cross-walk/understanding of ICD-9 to ICD-10
• Access to future LCD policies
• Electronic Health Record
• Non-hospital physicians
• Tracking of Medical Necessity & Prior Authorization denials pre & post ICD-10
• Worker’s compensation & auto accidents
• Review top 100 diagnosis codes
Southeastern Ohio Regional Medical Center
Cambridge, OH
Not-for-profit
• Sole Community Hospital
• 92 Bed Acute Care Hospital
• 3,812 Admissions
• $78.6 million Net Patient Services Revenue
Mission:
To provide high quality, comprehensive, affordable, patient-centered health care in a caring & safe environment while addressing community needs.

Vision:
We will be the healthcare provider of choice in the region we serve, for patients, physicians & associates.
Hospital Journey

• Determined need for Medical Necessity process in Patient Access
• Developed Medical Necessity process flow incorporating software
• Trained staff & gave access to solution:
  ✓ Patient Access
  ✓ Scheduling
  ✓ Nurse auditors,
  ✓ Patient Accounts
  ✓ Hospital physicians staff
Hospital Journey

- Nurse auditors own Medical Necessity
  - Front-end: scheduling/registration
  - Through back-end: Billing
- Created coding reference guide
- Public Relations Coordinator works as our liaison between hospital & physician’s office
- Upgraded to a more robust Medical Necessity Solution that included reporting & Pre-Authorization checks
Hospital Journey

- Recent process improvements
  - Prior Authorization & physicians
  - Development of clinical questions
  - Reporting Medical Necessity Results at the physician/CPT level

- Creating additional Pick-List
  - Service description to CPT codes
  - Diagnosis codes for expanded service areas
Lessons Learned

• The importance of tracking denial trends
• Retraining is a key to success
• The importance of physician education
• Explaining the importance of compliance to the staff
• Ensure efficient registration process
• Monitor performance of staff & physicians
• Do not forget to include clinical departments
ICD-10 for Non-Coders

• HIM Director Product lead for ICD-10 Transition
• Training hours depend on the employee’s position
• Patient Access Staff: 3-4 hours of training
• Patient Access Management: 5-6 hours of training

Objectives

- Learn the operational & documentation impacts of ICD-10 on Patient Access
- Hands on training examples of Medical Necessity & ICD-10 codes – understanding the importance of increased specificity
- Examine areas of risk & opportunity & the importance of the Patient Access Department
ICD-10 for Non-Coders

- Include scheduling staff in training
- Be prepared don’t forget weekend & evening coverage
- Are there members of the team that are already ICD-9 certified?
- Most common diagnosis codes for ICD-9
- Account for the increase in diagnosis codes
- Cross walking to ICD-10 to discuss with physicians
- Dual Coding
- Review tools to support ICD-10
ICD-10 – Delay for Another Day?

• We know change is coming – delayed or not delayed
• Next steps for readiness
• Implications from the legislation for healthcare providers & health plans
• Strategies & tactics to consider
• Scenario planning : impacts, opportunities & challenges
• Preparation Time-lines
• Post-go-live planning
Where do we start?

Process Design & Training, Training, Training!
Key Takeaways

- Healthcare demands a new way of doing business
- We share the same problems; we can share the same solutions
- Automation & data capture at Patient Access are key
- Ensure Patient Access is included in ICD-10 training
- Objectives & processes must be aligned internally & across business partners
- Reducing costs is critical to clinical, financial & operational performance for all
- Don’t lose sight that the Revenue Cycle is a team process
Questions?

Thank you!

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