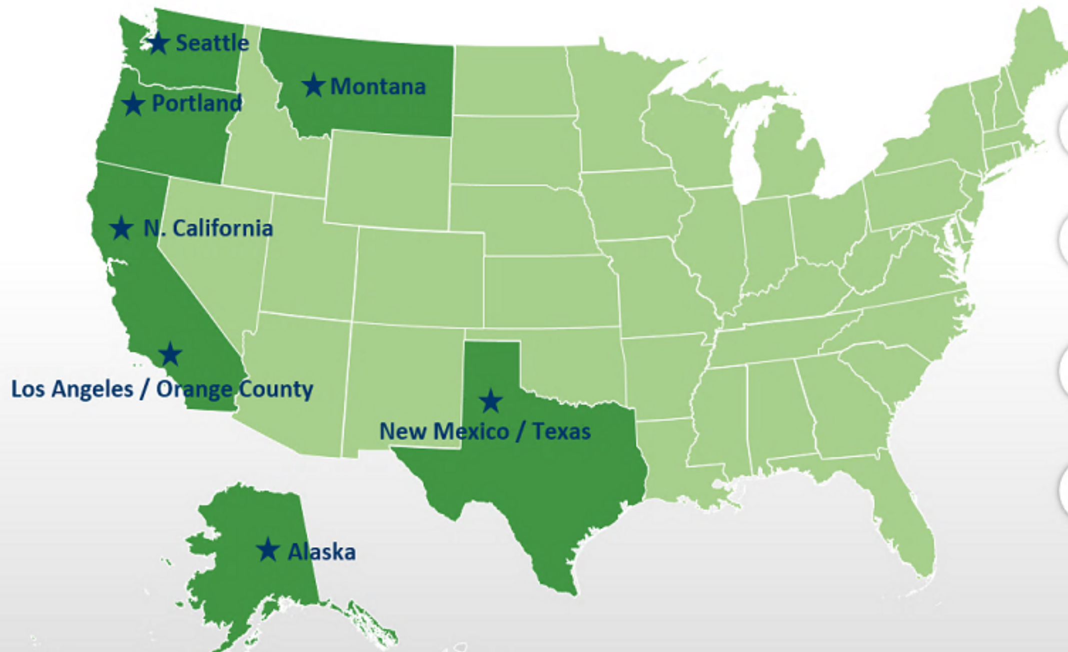
Providence St.Joseph Health

Hospital Medical Necessity Reporting

February 12, 2020

PIONEERING HEALTHCARE FOR OVER 175 YEARS BUILDING FOUNDATION FOR FUTURE SUCCESS



Contiguous Markets, population growth 40% faster than U.S.

Diversified Assets and Revenue

~$25B Revenue | 51 Hospitals | 1,000+ Clinics

18% Premium & Capitated Revenue

Leading Market Share in All Our Markets

Total Addressable Market expands with new tech-enabled offerings

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Overview

- Denial team structure
- Overall incoming denial view
- Using our numbers
- Volume of encounters sent to UM teams
- What happened to those encounters?
- Controllable write off comparisons
- Payer trends
- How we used the data?
- Getting support
- What do we see coming our way?

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Denial Team Structure

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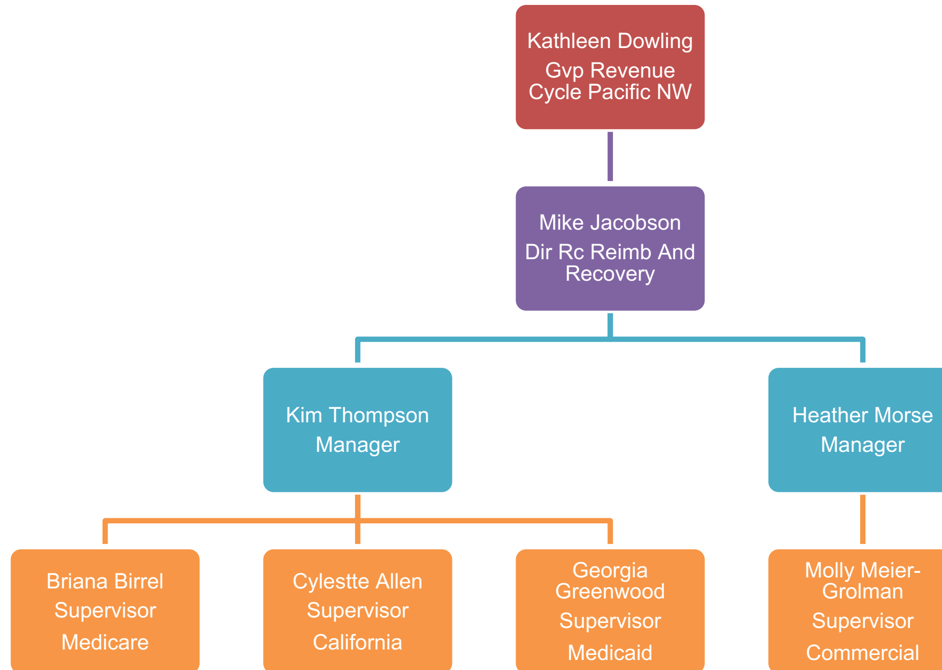

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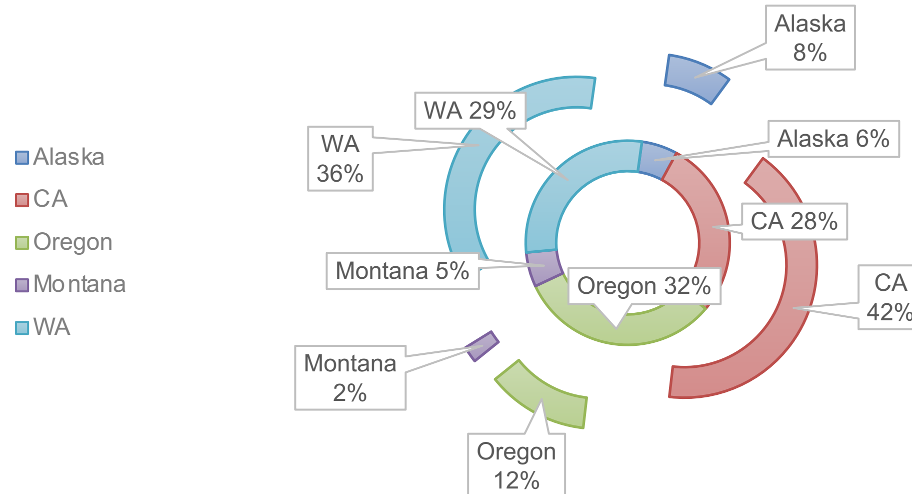
Overall Incoming Denial Volume and Dollars

2019	Volume	Denied Dollars
Alaska	39,713	$357,476,564
CA	196,537	$1,895,671,962
Oregon	221,295	$563,359,931
Montana	37,971	$89,398,020
WA	199,819	$1,636,732,690
	695,335	$4,542,639,167

2018	Volume	Denied Dollars
Alaska	50,020	$394,725,251
CA	228,920	$1,631,218,600
Oregon	282,233	$567,800,196
Montana	46,068	$96,819,579
WA	179,672	$1,115,470,161
	786,913	$3,806,033,787



Cash Collected from Denials

2019 Commercial Team collected $350,481,467
Regulatory Team collected $475,711,562

2018 Commercial Team collected $352,419,419
Regulatory Team collected $442,965,294

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Using our numbers

- We have used our data to create change in timely filing denials, authorization and notification issues as well as coverage denials.
- As we get smarter and more creative with our practice management system, we are able to link fields and highlight trends.
- For us, this complex and detailed Medical Necessity denial outcome reporting started 2 years ago.
  - The target was how do we report the incoming volumes, trends, payer issues and outcomes. How can we find where we are doing great, where we need help and how to avoid denials?

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Brief overview of bedded patient medical necessity workflow

- When we receive a medical necessity denial, our respective business office denial team confirms the denial, details of the denial, appeal timeframes and location, etc.
- Account is transferred to the onsite UM nurses to review the case and develop the appeal.
- Account comes back to the denial team to confirm appeal received by the payer and monthly follow up begins.

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2019 volume sent to respective UM teams

Region/Ministry by Denial Status Month	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Grand Total
Region 1	13	21	31	38	24	45	46	44	46	30	44	31	413
Ministry 1A					2	2	3	4			3		14
Ministry 1B	13	21	31	38	22	43	43	40	46	30	41	31	399
Region 2	203	240	204	330	342	305	316	228	245	181	195	250	3,039
Ministry 2A	41	42	51	73	78	51	64	50	42	33	47	67	639
Ministry 2B	35	42	26	46	68	52	60	34	35	28	18	24	468
Ministry 2C	7	12	7	24	14	16	7	5	7	9	15	12	135
Ministry 2D	46	45	34	46	54	50	79	57	63	42	35	30	581
Ministry 2E	43	58	55	84	84	86	63	56	68	47	46	83	773
Ministry 2F	31	41	31	57	44	50	43	26	30	22	34	34	443
Region 3	103	61	135	127	151	114	108	148	100	105	113	89	1,354
Ministry 3A	5	1	1	1	7	1	5	3	2	1	2	1	30
Ministry 3B	10	5	22	14	16	11	16	14	11	4	7	5	135
Ministry 3C	5	2	9	6	9	6	5	7	5	6	6	4	70
Ministry 3D	3	1	2	6	4	3	7	3	2	3	3	2	39
Ministry 3E	29	20	50	32	41	39	36	46	29	34	43	33	432
Ministry 3F	1		2	3	4	6	4	2	2	1	3	3	31
Ministry 3G	41	30	39	51	53	36	30	57	41	45	39	34	496
Ministry 3H	9	2	10	14	17	12	5	16	8	11	10	7	121
Region 4	2	2	3	3	1	3	4	12	10	6	10	4	60
Ministry 4A	1		1					1					3
Ministry 4B	1	2	2	3	1	3	4	11	10	6	10	4	57
Region 5	365	317	376	406	337	440	467	427	353	422	380	337	4,627
Ministry 5A	40	39	40	27	25	29	45	49	29	47	41	33	444
Ministry 5B	115	120	115	123	79	150	131	104	104	126	96	75	1,338
Ministry 5C	31	9	23	43	36	23	31	38	31	29	19	20	333
Ministry 5D	1		4	1	4	3	2	7		2	3	5	32
Ministry 5E	78	52	82	96	100	102	103	108	90	104	85	98	1,098
Ministry 5F		1	2	1	1		2	2	1	2	1	2	15
Ministry 5G	17	12	14	20	10	17	19	13	13	10	13	17	175
Ministry 5H	81	82	93	92	81	113	130	94	75	96	112	83	1,132
Grand Total	684	639	746	901	854	904	937	847	744	738	732	707	9,433

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What happened to accounts reviewed?

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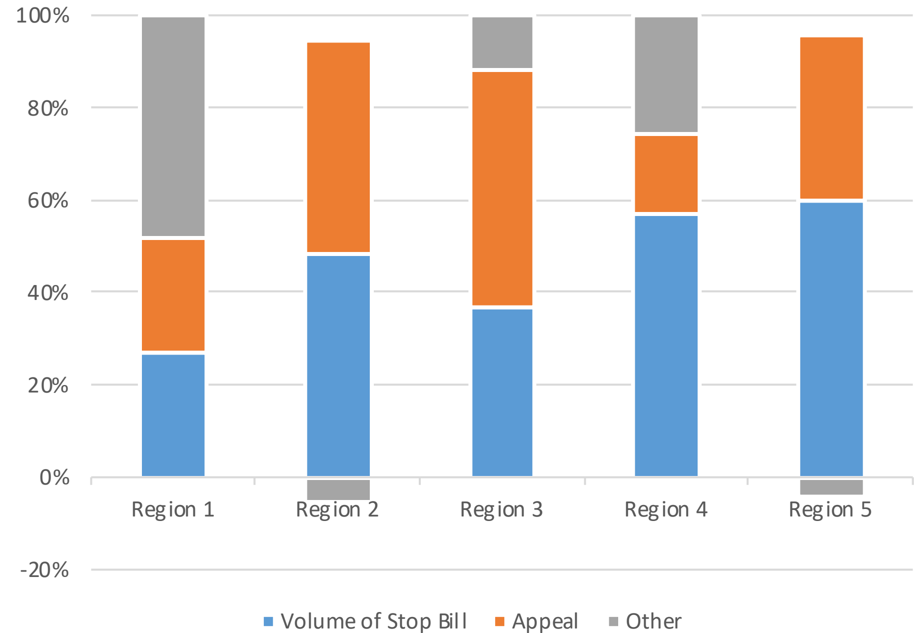
2019 total sent, stop bill, appealed

Total Volume to UM	
Region 1	413
Region 2	3,039
Region 3	60
Region 4	1,354
Region 5	4,627

Volume of Stop Bill	
Region 1	112
Region 2	1649
Region 3	22
Region 4	775
Region 5	3,012

Volume of Appeals	
Region 1	103
Region 2	1,580
Region 3	31
Region 4	230
Region 5	1,824



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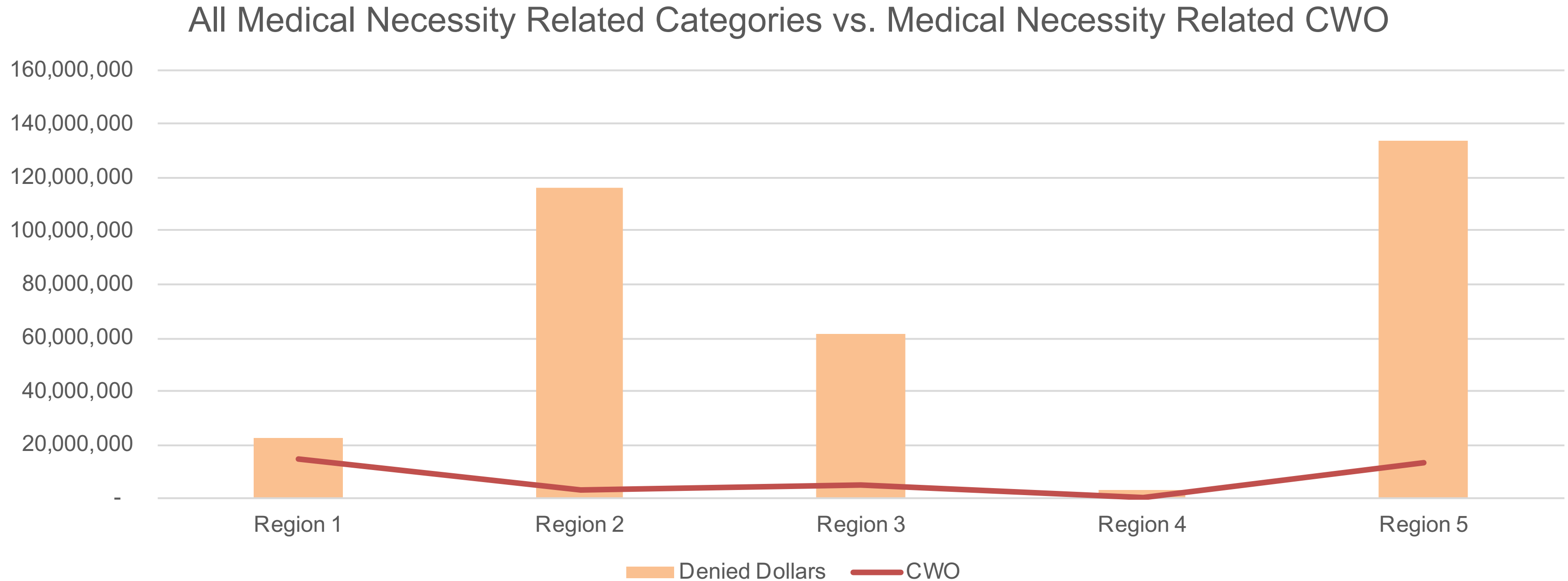
What happened to accounts reviewed?



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What happened to accounts reviewed?

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Payments after appeal

Ministry	Regional Average	Appeal After UR Status	Current Appeals Pending	Appeals Completed	Recovered Appeals	Loss (Appeal minus Recovered)	Recovered %	Resulting Payments
Ministry 1A	51%	2		2		2	0%	$0
Ministry 1B		101	25	76	42	34	55%	($2,126,312)
Ministry 2A	63%	328	47	281	175	106	62%	($4,816,091)
Ministry 2B		322	42	280	154	126	55%	($3,543,605)
Ministry 2C		56	13	43	34	9	79%	($169,570)
Ministry 2D		281	56	225	145	80	64%	($1,671,512)
Ministry 2E		371	62	309	221	88	72%	($6,655,948)
Ministry 2F		222	40	182	123	59	68%	($1,575,660)
Ministry 4B	48%	31	6	25	11	14	44%	($225,101)
Ministry 3A	67%	8	1	7	6	0	86%	($170,858)
Ministry 3B		27	4	23	11	0	48%	($158,086)
Ministry 3C		9	1	8	3	5	38%	($69,139)
Ministry 3D		6		6	2	4	33%	($40,722)
Ministry 3E		66	18	48	34	14	71%	($506,204)
Ministry 3F		5	5			0		$0
Ministry 3G		94	17	77	56	21	73%	($1,500,207)
Ministry 3H		15	1	14	8	6	57%	($85,144)
Ministry 5A	46%	157	51	106	54	52	51%	($652,305)
Ministry 5B		453	101	352	170	182	48%	($2,911,133)
Ministry 5C	47%	459	72	387	186	201	48%	($3,868,491)
Ministry 5D	58%	143	23	120	64	56	53%	($690,317)
Ministry 5E		16	3	13	6	7	46%	($139,493)
Ministry 5F		520	66	454	268	186	59%	($5,074,949)
Ministry 5G		4	1	3	1	2	33%	($15,954)
Ministry 5H	66%	72	17	55	38	17	69%	($322,394)
Grand Total		**3,768**	**672**	**3,096**	**1,812**	**1,271**	**59%**	**($36,989,195)**

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Payer Trends

Top 10 Root Cause Codes	Volume (3,768)
UR/UM/CM - Patient Class Mismatch	1,555
UR/UM/CM - Denied days (partial stay/pmt)	807
UR/UM/CM - Readmission (Medical Necessity)	192
UR/UM/CM - Degree of Inpatient care	188
AUTH -Authorization initiated, no follow up clinicals submitted	148
(blank)	146
UR/UM/CM-Notification not made to non-contracted payer prior to rendering post-stabilization care	87
Notification - Late notification	85
Auth - Auth requested and denied	82
UR/UM/CM - Post Pay Audit	62

- Clear leader at 41% of the volume is Patient Class Mismatch
- Within each Financial Class, Patient Class Mismatch leads except for Medicaid which is 1-day stay

Region / Top 3 Root Cause Codes	Volume	%
Region 1	**103**	
UR/UM/CM - Patient Class Mismatch	32	31%
UR/UM/CM - Denied days (partial stay/pmt)	27	26%
UR/UM/CM - Readmission (Medical Necessity)	19	18%
Region 2	**1,580**	
UR/UM/CM - Denied days (partial stay/pmt)	691	43%
UR/UM/CM - Patient Class Mismatch	434	27%
UR/UM/CM - Degree of Inpatient care	184	12%
Region 3	**230**	
UR/UM/CM - Patient Class Mismatch	149	65%
UR/UM/CM - Denied days (partial stay/pmt)	28	12%
UR/UM/CM - Readmission (Medical Necessity)	12	5%
Region 4	**27**	
UR/UM/CM - Denied days (partial stay/pmt)	11	41%
UR/UM/CM - Patient Class Mismatch	10	37%
(no root cause entered)	4	15%
Region 5	**1,855**	
UR/UM/CM - Patient Class Mismatch	940	51%
(blank)	140	8%
UR/UM/CM - Readmission (Medical Necessity)	137	7%

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Payer Trends

- Payers leading the way: 1,135 Blues (30%); 721 United (19%)
- Patient Class Mismatch – United: 28%; Denied Days – Blues: 43%; Pretty even split for 1-Day Stay denial

Region / Top 3 Root Cause Codes	Volume	%
Region 1	**103**	
PREMERA [1344]	26	25%
MEDICAID [200]	23	22%
AETNA [511]	21	20%
Region 2	**1,580**	
BLUE SHIELD [1740]	427	27%
BLUE CROSS [1739]	158	10%
IPA MEDICARE ALT [1716]	126	8%
Region 3	**230**	
BCBS [1267]	43	19%
'Redacted' MEDICAID HMO [1222]	34	15%
'Redacted' MEDICARE [1166]	25	11%
Region 4	**27**	
HUMANA MEDICARE [1086]	11	41%
'Redacted' HEALTH COOP [1660]	10	37%
PACIFICSOURCE [1148]	4	15%
Region 5	**1,855**	
'Redacted' MEDICAID HMO [1229]	176	10%
UHC WEST MEDICARE [1428]	164	9%
UNITED HEALTHCARE MEDICARE [1063]	156	8%

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How we use this data

- Appeals
  - Find our appeal success rate by payer, how long it takes us to do appeal, how successful we are in 1st level and 2nd level?
- Payers and our appeal
  - Which payers we are successful with, how long it takes the payer to process the appeal?
- Internal improvements
  - Which services and physicians have a higher denial rate, which DRG's are problematic, use the root cause to target the core issue?

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Getting support

- Overall we developed a list of 61 targets to our contracting partners and have been successful in updating our contracting terms and conditions with many payers.
- Contracting Language Workgroup taking this list to include in contract renewal discussions.
- Internal and external attorney support.
- Connect with our physicians to provide details.

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What do we see coming our way?

- Push towards increased value-based results and patients researching for alternatives to lower or cheaper care as patients take greater ownership in their healthcare expense.
- Increased Employer Engagement in Healthcare – I suspect that employers will continue to negotiate their on contracts directly with the provider and/or provide access to onsite clinic or near onsite.
- Continued payer scrutiny on Patient Class or Location –at times deviating from national established level of care standards. In addition, increased used of payer proprietary assessment of outpatient level of care.
- Increased Line Level or Forensic Audits.
- Clinical innovations, patient preferences, and government program payment policies are prompting hospitals to shift certain services to alternative points of care and even to virtual environments that benefit from a cost and access perspective.
    - Online tools that "assists health care providers with appropriate ordering of DI, laboratory testing, improving patient care and reducing wasteful spending."
- Increased litigation or escalation to achieve reimbursement.

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Are there any questions?