**HEALTHSPRING MINUTES**
**July 17, 2017 RIC/RAC Meeting**

**HEALTHSPRING REPRESENTATIVES PRESENT:**
**Ms. Whitney Poole**
**Mr. Andrew Freeman**
**Dr. Elizabeth Stahl**

**FACILITATORS PRESENT:**
**Mr. Wesley Ashmore**
**Ms. Debbie Rubio**

MR. ASHMORE: Today we have Whitney Poole, Andrew Freeman and Dr. Elizabeth Stahl from HealthSpring. Before we get into the questions, they'll do a brief introduction and let you know what they do.

MS. POOLE: My name is Whitney Poole. I'm a network administrator for Cigna HealthSpring. I cover the hospitals for North Alabama and South Alabama, and then I have a counterpart who covers Central Alabama. So any claims issues, any issues that are going on with an account, we're the direct contact. So it's kind of a backdoor through customer service that you get a direct contact. We can help you with any issues that are going on. We also do the contracting with the facilities and just follow up to make sure your account is operating the way it should be.

DR. STAHL: My name is Elizabeth Stahl. I'm an endocrinologist by training. I've been with Cigna HealthSpring now for several years, and I do a lot of the case management discussions amongst our case managers with your case managers. There's a lot more to my role than that, but suffice it to say that's where I will leave it at this time

MR. FREEMAN: Hi, I'm Andrew Freeman. I'm the director of contracting for the Alabama markets. I work with Whitney and Lauren and a few other folks to cover the state of Alabama and our hospital network. We want to thank you for the opportunity and thank Jennifer Bartlett specifically for the invitation. We've been looking forward to this opportunity.

1. Please advise if you have written policy regarding the coding of signs and symptoms ICD-10 codes to justify Medical Necessity of an ordered test or procedure that has an associated LCD or NCD. Coders are instructed to code the final determined-most definite Dx. and this often results in a rejected facility claim as final findings DX is not a covered Dx per the NCD or LCD. Example: Doctor orders a breast biopsy for a lump in the breast. Dx for lump in the breast N63 is a covered code per LCD-NCD and this is coded as a reason code…Final determination is often benign and this code is not a covered code per LCD-NCD. Our procedure CPT 19081 is then denied for not meeting medical necessity. Coders are reluctant to code the reason dx other than as a reason code when final findings are documented.

   We have this same issue with Diagnostic colonoscopy, pt. has rectal bleeding which is covered DX per LCD but final finding DX internal hemorrhoids is not. These are surgical examples however we have various tests (cat scans, duplex scans, etc.) that also have a covered reason dx but not final dx.

   Are there any plans in the future to consider reason for visit codes listed on the claim for claim processing and to support medical necessity?

   **Discussion at meeting**

MS. POOLE: I want to start out with as we started to look into this question, especially with the example that was provided, it didn't seem like it was actually a coding issue. It seems to be a claims issue, and what happened was probably the claim was rejected for an improper reason. So what we wanted to get across with a lot of these questions is if you do have these specific examples and claims that are being rejected for a reason you don't think they should, your contact is us, the network administrators, so myself or Lauren Jefferies. We're going to leave our information because what we would like to see with this is for you to follow up and provide this specific example so we could get it corrected for you. These are paid based on the auth. If you have the auth for that procedure to be done, it will be paid.

If for some reason it was rejected, it should not have been if you had that auth beforehand. Whether it came back benign or malignant should not change that outcome. If it was, we feel like that probably was a claims error that we want to resolve for you, so we hope that you'll reach out so that we can get it resolved.

I'm not sure who submitted this, just to let you know that if you are seeing this, reach out to your network administrator so we can figure out what's going on, get those claims corrected for you, and submit it to claims so they can identify something is going on with that account.

2. How do facilities handle discharge dispositions when a patient is discharged and presents to another acute care facility within 72 hours or less?

**Discussion at meeting**

DR. STAHL: I can handle that one. When we have a HealthSpring customer who's discharged from one facility and then gets readmitted to a different facility, those are treated as two separate admissions, those are evaluated in two separate manners. They are never combined automatically. For that matter, they're never combined because it's two different facilities. Whether you discharge, and you come to another hospital within six minutes, six hours, or six days, you will not be combined because you are at a different facility. Those are handled differently, and not ever going to be the case.

If you find a situation like that, as Whitney said previously, let us know. But we are very particular to know which hospital, which customer, which medical director, and those are not combined. So if there's a question about that, I'm absolutely happy to handle it.

3. Our hospital is considering the use of the Automated Breast Ultrasound (ABUS), which is to be used adjunct to mammography. The vendor suggests using CPT codes 76641 and 76642 to bill for this service. The aforementioned CPT codes represent 2D ultrasound, when the ABUS is 3D. There are no specific examples to provide at this time as we have not purchased the equipment. Prior to purchasing equipment, we would like to determine the appropriate codes to bill for this service.

**Discussion at meeting**

MS. POOLE: When we reached out on this answer, we were provided with this would be determined by whatever CMS covers. If this is a procedure that they are going to cover, then we'll follow that based on any restrictions that they also place on it. CMS will cover it based on the restrictions that they have implied.

We are going to follow that methodology as well. As for the specific codes, that would offset the vendor if this is what they are suggesting to you and what CMS is saying we will follow. You should also follow that procedure, but without more specific information, examples, things like that, we really can't go into more detail except for following whatever CMS is going to pay with the restrictions.

4. If a Psych patient seen in the Emergency Room has an order to admit to Psych but is being held in the acute care Hospital for more than 1 day while waiting on a Psych bed: How should providers bill for the charges from the patient's initial presentation until the Psych bed is available?

**Discussion at meeting**

DR. STAHL: So we look at that in a couple of different ways. The hospital stay, if it's a medical admission, is paid as a medical admission and is reviewed by medical directors that do what we would consider internal medicine, family practice, endocrinology, pulmonary, those types of medical specialties. That first stay would be reviewed as a medical stay. When that particular patient transitions to a behavioral health unit or to a geri psych unit or whatever the psych unit is that that patient goes to, that falls under behavioral health. That gets reviewed by a behavioral health medical director, and that stay is considered separate. In this particular situation, these would be considered two separate stays, one medical stay and one behavioral health stay.

5. In April, CMS requested recommendations for innovation and improvement of the MA program. This Request For Information (RFI) came as a part of the annual Part C and Part D Announcement and Final Call Letter. In response to this RFI, the American College of Physician Advisors (ACPA) issued a position paper that was submitted to CMS, dated April 24, 2017. This position paper outlined many challenges observed by the ACPA and included recommendations for improvement.

   In light of the above statement, and with specific regard to one of the items listed in the position paper by the ACPA, we would like for you to review and respond to one specific challenge that the ACPA reported to CMS. Please respond with what your health plan can do, has done or is doing to address the specific challenge of misinterpretation/misapplication of the CMS readmission review process?

   **Implementation of 30 day readmission denial policies:**

   a. MAOs claim that these policies are based on the Quality Improvement Organization (QIO) Manual provision whereby the QIO may deny payment for a readmission within 30 days if an identified quality of care issue resulting in premature discharge from the first admission may have reasonably caused the second admission.

   b. In issuing these denials, the MAOs generally fail to demonstrate any quality concern on the part of the healthcare facility – denying payment solely because the readmission occurred within the 30-day window and was for the same or similar DRG. CMS has recognized that some readmissions are unavoidable (and inevitable); the **CMS Hospital Readmissions Reduction Program only penalizes facilities for excess readmissions**.

   c. These MAO denials are not called "denials" by the MAO, but rather claims in which payment for the first admission includes payment for the readmission. However, the diagnoses and

procedures from the two admissions are not combined onto a single claim. The second claim is merely not paid. By not calling it a "denial," reporting of these "denials" to CMS may be averted by the MAO.

(***ACPA Position Paper,* filed April 24,2017**, Baker, Emkes, Field, Fore, Hegland, Hirsch, Hu, Johar, Locke, Myerson, Mothkur, Rejzer, Hopkins, Zirkman)

**Discussion at meeting**

DR. STAHL: What we do at Cigna HealthSpring is every admission is reviewed independently. If you leave hospital A, and you are discharged appropriately and safely, then in the parking lot, you fall and you break a hip, and that's different from your previous admission to the same facility. If you come in 30 minutes later, those admissions are going to be looked at separately. We do not automatically combine admissions. If you leave hospital A -- and let's make, for example, the diagnosis congestive heart failure -- and you're discharged after a six-day length of stay, we have documentation in the chart that your oxygen saturation is still below 90 percent and you're still short of breath and you still have lower extremity edema and you feel a little reluctant to go home, but you're being told that you're ready for discharge, you come back into that same facility within the next few days -- we do look at cases individually. We do not have a hard and fast blanket, you know, three days, five days, seven days, 30 days. We do look at readmissions as a readmission, and we do use CMS's same 30-day guidelines.

There's a possibility that that admission is going to be combined with the previous admission. We have case managers that look at every single admission to a facility. Most of our case managers are on-site at your facilities. Some facilities unfortunately we have to cover telephonically because of the geography, volume of patients admitted there, just the fact that they are extremely far away from the other facilities that a particular case manager covers.

Each admission is looked upon individually, and we do not do an automatic combine for anything. We want to make sure we're looking at quality just like you all are looking at quality. We're very cognizant of readmissions, just as you are, and we want to make sure that we make the appropriate clinical decision for that particular patient.

AUDIENCE: We have an issue in our facility that the patient is discharged and then readmitted within the 30 days, it could be two different diagnoses, unrelated. We can't even get the claim to process because it comes back saying that they have to be combined. So in a case like that, should we address those to you?

MS. POOLE: Yes, to the administrator, absolutely.

AUDIENCE: Are you going to leave us a card so we know who to address these issues with? Because we have several of them.

MS. POOLE: Yes. I have a stack of cards right here that I will leave for you.

AUDIENCE: That's great. Thank you.

MS. POOLE: To follow up with getting in touch with us, I think that's why we really wanted to come today because there are several hospitals we haven't been able to connect with the correct

people. We would like to get out to introduce ourselves so you have an actual physical person you can contact, call, that will pick up the phone or respond to an e-mail quickly when you have a situation that's coming up. Please, if you haven't connected with us, do pick up one of those cards, and we'll set up a meeting to come introduce the whole team to you so you know who does serve your hospital, and you do have those appropriate contacts to resolve these cases that you might have.

6. Please provide clarification on whether HealthSpring requires NDC codes on all the drug codes submitted on a UB claim. If yes, providers need to get official notification on a workable effective date since this requires programming changes by providers that will take time.

**Discussion at meeting**

MR. FREEMAN: This one is very similar to the first question we had. The answer is, no, we don't require NDC numbers on every single drug code; and some codes do require a matching NDC code. So if you have a specific question or a specific code you have questions about, please route those to Whitney or Lauren, and we'll get those to the appropriate people in our claims department who can give you the correct answer for that specific code.

**Additional discussion at meeting**

AUDIENCE: Just for the benefit of those in the room, could you give a recap of some of the process improvements that have been made with regard to the appeal shop and appeals processes and things like that, just to kind of give everybody an idea of what we've been working on? Feel free to use us as an example.

MS. POOLE: Sure. I'd be happy to. When Jennifer and I were finally connected, I started last April with HealthSpring, and she had the same issues where she was going through customer service, getting the runaround and no answers. Once we were connected, we were able to work together to figure out what worked best between her hospital and HealthSpring. What works for them might not work for you, but once you get connected with an administrator we can figure out what does work best. We have a reoccurring call that happens every week. Sometimes we need it, sometimes we don't; but it's there so we can talk. Some do monthly, some do bimonthly. It really depends. We want to create that relationship that works best for you when a situation comes up that allows them to bring it up for us to find the root cause of it. I think we built a relationship where Jennifer knows she can call, toss it off, but know it's being handled. We'll provide those updates as we can until we get to the resolution. Even if it takes a while, we're going to work towards it, but we have the relationship where we can know what's going on.

She knows that if she sees a trend in something, she can pick up the phone to let us know before it continues, we can stop it immediately. We can go through any processes, procedures, that there's no clarification on. She knows she can route other departments to us, but it really is about making that connection and figuring out what works for each hospital with HealthSpring and just making sure that that relationship is a good one. It's more of a partnership than one-way communication.

MR. ASHMORE: I encourage you to come up and meet them and get their contact information. I want to thank Whitney, Andrew and Dr. Stahl for being with us today.