HEALTHSPRING MINUTES
November 6, 2017 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Debbie Rubio

MS. RUBIO: We have here with us from HealthSpring Andrew Freeman, Dr. Stahl, Lauren Jeffries, and Whitney Poole. Welcome.

1. In readmission review, are all diagnosis billed on the claim considered or just the primary diagnosis?

Discussion at meeting

DR. STAHL: Thank you, Debbie. Just so you all know, there are three medical directors at Cigna HealthSpring. Two of us sit in Birmingham, and one sits in Mobile. So our physician in Mobile covers most of the admissions down south, and the physicians that sit in Birmingham, of which I'm one of those, cover the admissions from Selma up north to Huntsville. Every single admission is reviewed by a medical director. We have no automatic anything. There is nothing that goes specifically to, you know, this many hours, it's automatically this. We look at every admission holistically from beginning to end. A lot of times, we're requesting records from the hospital's facility. Our acute care case managers actually come to your facilities, if you're kind enough to let us come into your facilities and see our customers in your hospitals and try to figure out the best discharge plan for them.

But from an admissions standpoint, every single one is reviewed, and we don't automatically do anything. So we do keep in mind all of the circumstances. We look at physician progress notes. We look at nurse and physical therapy progress notes. We look at labs. We look at x-rays. We look at advanced imaging. So if you're ever concerned that we're automatically doing something, please bring that to our attention, because I will tell you, having been on the phone most of the trip down here as well as for about an hour earlier today, we take a lot of care with the admissions from our acute care case managers, and every one of them is reviewed. The only one that might not be reviewed in realtime is somebody who comes in Friday evening and is discharged prior to Monday morning. But those are reviewed as a retro-admission, and they're still reviewed.

2. Why does your entity only offer one level of appeal, when Medicare and other MA payors offer an informal reconsideration level and then a formal level of appeal?

Discussion at meeting

MS. POOLE: Again, my name is Whitney Poole, and I'm one of the administrators. Let's do a little bit more of an introduction. Lauren Jeffries is also my counterpart. So any that are with HealthSpring should be assigned to one of us. With that, we like to think that

we have a lot of collaboration, and you can work directly with us on any matters that are a problem or systemic issues. So once you've gotten to the appeal level, you've already had peer-to-peer discussion with medical directors. We've had case management in the hospital. Once we get to wanting a second level of appeal, we feel like that's just another level of administration on something that's probably more of a systemic issue, then we need to sit down as a partnership and collaborate and discuss and come up with another way to resolve the issue. So that's probably why some of the entities do not have that second layer is we just feel like it's one more layer that you have to go through that's not really solving probably what the issue is.

So if any of the facilities in here have that concern, and you are having problems where you need another layer of appeal, let's talk about it and partner together and collaborate and figure out why this is and why we aren't agreeing at this point. We can bring case management to your hospital. Our medical directors are always willing to come out and meet as well. So we would rather resolve that through that type of resolution, instead of just adding another layer of paperwork that you have to go through that probably won't resolve what the problem is, you know, just by adding that. Just reach out to us, and let's talk about it, and let's see what's going on.

3. If a patient receives care at a hospital on the same date of service as the beginning date of a hospice episode and the care is related to the hospice diagnosis, but the services were provided prior to hospice accepting the patient, can both the hospital and hospice receive payment from Medicare? For example, a patient presents in the morning to receive observation services and the decision is made to move the patient to hospice. The patient is discharged at 3:00 pm to home hospice care. The hospice nurse comes that evening and the hospice begins care at 6:00 pm.

   Additionally, if both the hospital and the hospice can be paid by Medicare – what about patients who are enrolled in a Medicare Advantage plan? Would Medicare or the Medicare Advantage plan be responsible for the hospital care received prior to the start of hospice?

Discussion at meeting

MS. JEFFRIES: Thank you. I'll take that one. So, basically, a good way to look at this question to begin with is to ask yourself in this specific scenario, who was the patient with prior to admitting to the hospital. So, for example, if the patient was already enrolled in hospice, then that would roll over to traditional Medicare. So as a Medicare Advantage Plan, once a patient is enrolled in hospice, they go back to traditional Medicare. So in this scenario, if the patient had not been enrolled in hospice yet, and they were still on our Medicare Advantage Plan, then, yes, we would cover the hospital stay until they did move over to hospice in that which it would be covered by Medicare.

So with this question, if you're asking if the patient was already enrolled with hospice prior to admitting, if Medicare would cover both, that would be a question per CMS guidelines. I know that question was kind of long, so does that answer the question?

AUDIENCE: We've asked some other Medicare Advantage Plans. Just to make sure I understand, so you're saying in this scenario outlined here, where the patient was, let's say, they were in the hospital today, they left at 3 p.m. and tonight, they were enrolled. Before

midnight, they were enrolled in hospice. So if you look at the common working file, it says the hospice start date was 11/6/17.

As long as we have documentation that the patient wasn't enrolled in hospice when they came to the facility, would HealthSpring still cover that?

MS. JEFFRIES: Yes. That is correct.

4. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at 1:45pm. Can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier -76?

Discussion at meeting

MS. POOLE: I'll take this question. I'm going to break it down, if that's okay. It's a few questions. The first part is, can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1:00 p.m. and the patient is stabilized, but then requires CPR again at 1:45, can we bill for two units of 92950? Answer: Yes. We follow CMS guidelines for medically unlikely edits. The MUE for 92950 per date of service is two.

Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Answer: No. Billing guidelines exist for the time span between performing CPR.

Or should we only bill for one unit, no matter how many times CPR is performed while the patient is in ED? Answer: Two units per date of service will be paid.

Should additional units of 92950 be reported with modifier 76? Answer: Modifier 76 is not appropriate for repeating procedure 92950. If more than two units are medically necessary, the provider should appeal for payment of the additional units by submitting supporting documentation.

I do think the last three questions, just to put this out there, sometimes there are tricky situations. You know, the hospice question is just tricky all around. But if you'll reach out to us, a lot of times, we can work through that. I know we have a hospital recently with a hospice situation that it was just kind of going back and forth. And our reply to that is just pass it on to us and let us figure it out. And in the end, we could get it figured out as to who would pay. So if there's ever a question that comes out, please, don't just rely on customer service outline or just submitting whatever has been said. Reach out to Lauren and I, and we can work with you and work through it until the resolution is in place.

AUDIENCE: I just want to add something to that on the hospice issue. We brought this up with a previous payor. I just recommended that if the MA plan can put out some education to the hospice providers in the state, that's where I think most of the issue comes in, is with the actual hospice provider. So where we get a date that comes through that says patients started on 11/6 with hospice, and let's say the MA plan rejected the claim and said, well, you should have billed Medicare for that. Well, in the scenario we brought up, the patient didn't really have

hospice. Well, then, the hospice says, we're not paying for it, because they didn't sign up until after hospital discharge so if we can push that education out to the hospice agencies. I think they are the main culprit of a lot of the confusion and issues that come up with those particular patients.

MS. POOLE: Thank you for that.

Additional discussion at meeting

AUDIENCE: Just one follow-up on question number one. I understand you talked about the energy that you put into reviewing a particular patient's record, but the question is more about the readmission process. If patients are readmitted within 30 days, and that there's a potential denial there, what's the determining factor? Is it that if a patient presents back with the same diagnosis as the previous admission, or what's the criteria that says we're going to deny this admission because the patient is readmitted within 30 days?

DR. STAHL: So, again, we will review every admission. I'll come up with an example actually that I did on rounds this morning. So there is a customer of ours who had an aortic aneurysm repair last week, and it was done in the new way, not the way I'm familiar with where you open people up and they stayed in the hospital for a week. These are some of the newer procedures, the endovascular procedures. And so this triple A was repaired last week. And the gentleman had a very uneventful hospital course and went home as appropriate. And two days later, fell at his home and came back in with a broken hip. So you could say, well, that's a 48-hour readmission, but in our mind, that really had nothing to do with the first admission. Those are being paid as two separate inpatient DRGs.

So what we look at, if we're thinking about combining an admission, is some lack of either follow-up on a lab. So, for instance, the potassium was 2.8 at discharge, but it wasn't reviewed, and the patient comes back in three days later weak and falling and the potassium at the time was 2.5, we're going to consider combining those admissions. So we're going to look for something in the first admission that leads to the second readmission. If these are completely separate admissions; for instance, like the gentleman I just spoke about with the fall and the hip fracture, those would likely be considered as two separate DRGs. So, again, I can't quote you A, B, C, D criteria because every admission is different and every admission is considered on the entire basis; but if we see, for instance, another one that I'm familiar with, somebody who is admitted for one reason and goes home with a hematocrit of 24, their base line hematocrit is 36, a lab gets drawn the day of discharge, it doesn't get followed up on, it doesn't get reviewed, it doesn't get documented in the chart, and that patient comes back in in less than a week weak, falling, now has a hematocrit of 20 and positive stool for cold blood, the likelihood is that could be combined. But both admissions are going to be reviewed, absolutely.

And, honestly, we probably spend more time reviewing those admissions than we do any other, because we want to get it right, and we want to make sure that the patient gets exactly what they need.

AUDIENCE: My experience and the concern and I have with patients saying they have heart failure, and they're in an exacerbated state, they go home on Day 29. Before Day 30, they're back in an acute phase again, and that is combined. But, truly, that patient went home stable.

The follow-up was there, but because they readmitted within 30 days for the same thing, a lot of times, those admissions are combined to the previous admission, because it took place within 30 days.

DR. STAHL: Sure. Are you seeing that specifically with Cigna HealthSpring customers?

AUDIENCE: I can say that I have seen it, but we'll see.

DR. STAHL: Okay. So just personally speaking, that's not something I would typically combine, only because if that patient went home on the appropriate medical therapy and was discharged safely and not hypoxic and stable and for whatever reason they didn't pick up their scripts, they got two weeks' worth, but they didn't take them after that, they didn't like using the diuretic, I try very hard not to fault the hospital for patient behavior. We all understand that sometimes folks, we're not perfect, and not all of us do exactly what we're supposed to do when we leave the hospital, which is why admissions are really looked at holistically from beginning to end. Certainly, if there is ever any concern on your hospital's behalf and on the physician's behalf around combining admissions, we are here to do peer to peer's. And if your physician requests a peer to peer with Dr. Puckett, Dr. Easton, or myself, we're going to very gladly do it. And, honestly, we would likely learn a lot more about the admission and the readmission when we do that peer to peer, and that is always available.

So please let us know about that. Because in that particular scenario, on Day 29, I would not combine that. I can't speak for my fellow medical director colleagues, because they're not sitting up here. But that is not something I would combine. That's not the hospital's fault, right, so I would not combine those.

MR. FREEMAN: We just want to thank you again for having us here. And we greatly enjoy the opportunity to get out of the office and meet familiar faces and meet some new faces as well. Hopefully, the message we've tried to deliver today revolving around a consistent thing that we want to build relationships with our facilities. Whitney and Lauren are on the forefront of that. So if you have issues or if you have problems, please reach out to us. Please reach out to them. We would much rather work through the issues together than you experience frustration, trying to go through another means. So thanks for the opportunity, and if anyone has any follow-up or anything, we'll make ourselves available for a few moments as well. So thank you.

MS. RUBIO: Thank you for being here today.