INSIGHTS FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

MINIMIZING REVENUE LOSS DUE TO INPATIENT STATUS DOWNGRADES

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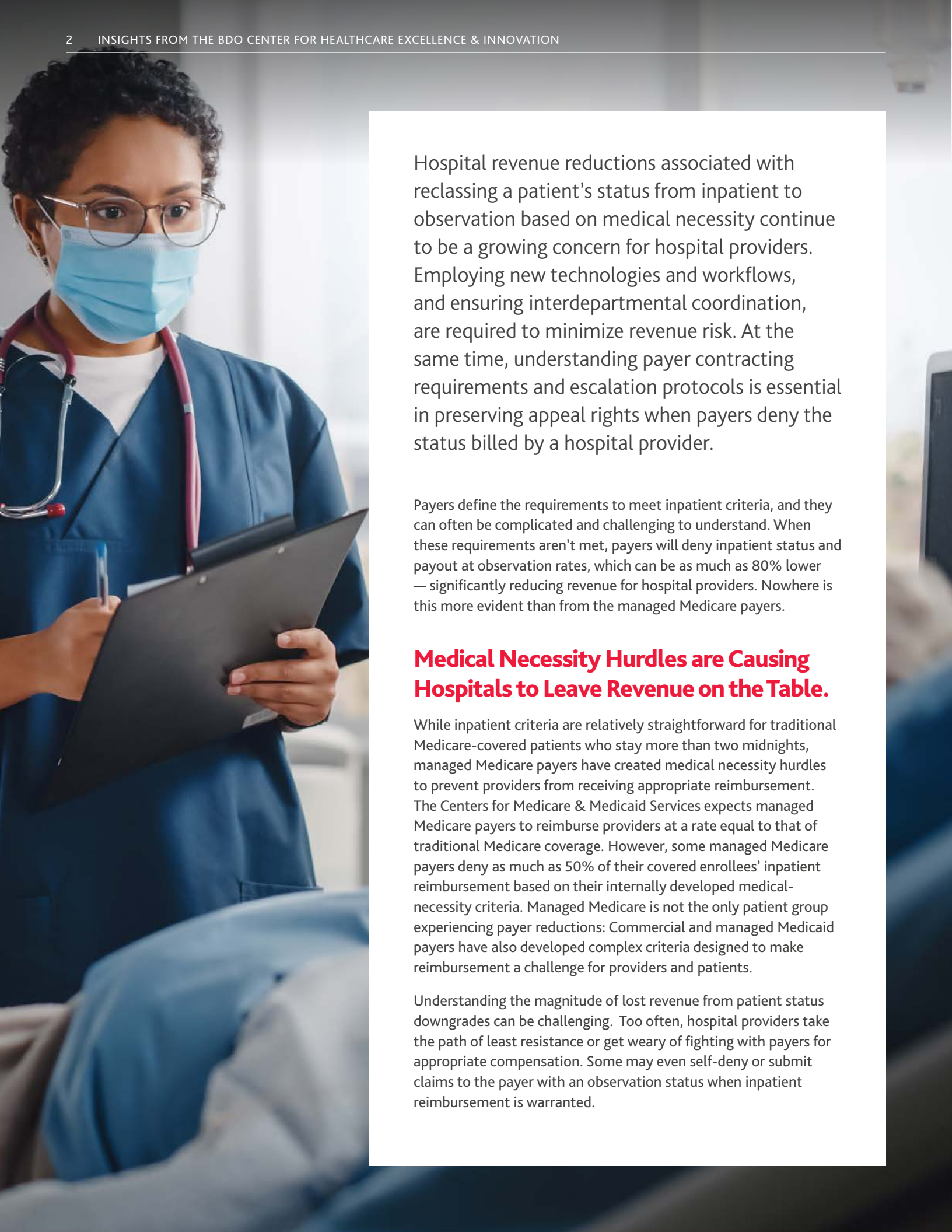


Hospital revenue reductions associated with reclassing a patient's status from inpatient to observation based on medical necessity continue to be a growing concern for hospital providers. Employing new technologies and workflows, and ensuring interdepartmental coordination, are required to minimize revenue risk. At the same time, understanding payer contracting requirements and escalation protocols is essential in preserving appeal rights when payers deny the status billed by a hospital provider.

Payers define the requirements to meet inpatient criteria, and they can often be complicated and challenging to understand. When these requirements aren't met, payers will deny inpatient status and payout at observation rates, which can be as much as 80% lower — significantly reducing revenue for hospital providers. Nowhere is this more evident than from the managed Medicare payers.

Medical Necessity Hurdles are Causing Hospitals to Leave Revenue on the Table.

While inpatient criteria are relatively straightforward for traditional Medicare-covered patients who stay more than two midnights, managed Medicare payers have created medical necessity hurdles to prevent providers from receiving appropriate reimbursement. The Centers for Medicare & Medicaid Services expects managed Medicare payers to reimburse providers at a rate equal to that of traditional Medicare coverage. However, some managed Medicare payers deny as much as 50% of their covered enrollees' inpatient reimbursement based on their internally developed medical-necessity criteria. Managed Medicare is not the only patient group experiencing payer reductions: Commercial and managed Medicaid payers have also developed complex criteria designed to make reimbursement a challenge for providers and patients.

Understanding the magnitude of lost revenue from patient status downgrades can be challenging. Too often, hospital providers take the path of least resistance or get weary of fighting with payers for appropriate compensation. Some may even self-deny or submit claims to the payer with an observation status when inpatient reimbursement is warranted.

Lessons Learned

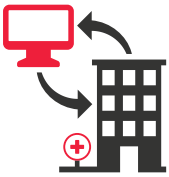
We have learned valuable lessons from evaluating thousands of medical records. The following tips can guide providers on how best to prevent denials. At a minimum, providers can ensure that their workforce, processes, and technology are aligned to fully document care, submit claims appropriately and dispute improper denials.

People

Multiple departments and teams should work together to minimize the risk of lost revenue from status downgrades. It is vital to have engagement and coordination across hospital teams, including patient access, case management, physician advisors, health information management/coding, patient accounting, denial management, payer contracting, information technology and legal.

Process

Process maps can ensure that responsibility is well-defined, and handoffs occur in a timely manner. Any breakdowns in the process could result in the loss of appeal rights. Payer contract terms, including clinical criteria and the appeal process, should be well-documented and aligned with the process map. A payer matrix defining appeal and dispute criteria should be available to all teams to ensure proper payments are received and appeal rights preserved.



Technology

Technology should be developed to support the process and assist team members to mitigate revenue reductions. The use of system flags and work queues can ensure team members are alerted when they need to act, and system prompts can identify when steps are delayed. Leveraging technology to automate and monitor the process helps ensure each individual payer requirement is completed and documented.

Failure to establish these protocols and alignment can mean providers will continue to leave money on the table as payers inappropriately reduce payouts. Hospital providers should take stock of lost revenue from these reimbursement downgrades and develop a playbook that includes a path to litigation to mitigate risk. Analyzing the revenue differential from managed Medicare payers compared to traditional Medicare for patients staying in the hospital for at least two midnights is a great starting point.

Using strategies to integrate technology with well-defined processes can help teams ensure revenue is appropriately captured and appeal rights are preserved. Organizational perseverance is required to secure appropriate reimbursement from every payer and every patient population. Hospitals across the country continue to provide excellent inpatient care and save lives, and they should be reimbursed appropriately.

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