April 2015 Infoline

Happy Spring!   Hope it is as beautiful as it is in Idaho. \*Yep, we have been WAY spoiled!

We have a lot going on so let's get started.

**IT IS BOOT CAMP TIME!  Yes, the dynamic 3rd National Physician Advisor and UR Boot camp is ready to rock and roll.  July 22-24th in San Antonio, Texas, co-created by ARS and RAC SUMMIT.**

Early bird discounts expire **May 8th**.  HURRY! We are also offering a multiple attendee group rate as the training is all about the strength of the partnership with PA and UR -plus lots of better practice ideas in the 4 key areas:

    First point of contact

    Concurrent and daily review

    Denial prevention

    Ongoing Education

PLUS 2 excellent pre -conferences: one for 'next steps" with a PA program (co-sponsored by the American College of Physician Advisors) and one for UR -"exploring an integrated CDI program."

PLUS  sessions on operational approaches to daily work, working lunches with case studies, panels for Q&A, networking dutch dinners, table talk breakfasts and learning from WPS/MAC on weaknesses found in Probe and Educate and...LIVE web streaming if you can't join us in person.  We also offer Critical access hospital rates as well as applying for scholarship assistance.

It is all about helping you be successful!  **Faculty are energized and can 'keep it simple' while teaching OPERATIONAL concepts for both PA and UR.**

Would love to have you join us!

GO TO:   [www.RACSummit.com](http://www.RACSummit.com) to see the full agenda

GO TO:  <http://racsummit.com/registration.php> to register

GO TO:  <http://www.racsummit.com/scholarships.html> to apply for assistance with scholarships

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**Short Stay Proposed DRG = AHA proposed with MedPAC and CMS considering.  (Doing a free webinar with Appeal Academy on Fri , May 1st at 11:00 MTN.  Or if you can't join us, go to Appeal Academy.com as the call is archived. (Thanks, Ernie D.) YEAHOO)**

There is a great deal of dialogue around the Feb 13th letter from AHA and the follow up letter to MEdPac from AHA regarding their recommendations to Congress.

Additionally, CMS indicated they would be looking at the recommendations over the next few months.

CLOSELY LOOK AT THIS PROPOSAL FROM AHA:  At risk are the 1 MN stays that resulted from a) transfer, b) expiring sooner than expected, c) 1 MN out/1MN inpt, d) recovering sooner than expected, e) moved to hospice after 1 MN, f) all other 'responded to treatment' and only had 1 MN.

AHA:  They are proposing creating an entirely new DRG grouping system for Short Stay DRGs.  IF the pt did not have 2 MN as an inpt, the payment would be reduced to the lower SS DRG!

I would strongly recommend that you all read this very very carefully.  It is a HUGE Loss for the hospitals who have 2 MN expectations/Presumption and ended up with transfers out, etc   or  the 2 MN BENCHMARK -which is 1 MN outpt/.1 MN inpt...all would be paid at a lower than full DRG payment.

AHA also outlines:

    Not clear on whether to allow 2 MN benchmark as FULL DRG but in their letter, they identifed them for SS DRG!  UGUGUGU

    They recommend eliminating the  2 MN rule - and replace it with???????????????????????

    With the creation of a new DRG system, the 'buy in ' from the end coder companies/like 3M and the cost to add the new system???

    2013 forward financial hit unknown as prior 2 MN data was the only information available to use.  UGUGUGUGU

    1st MN as OBS being counted toward the 3 MN SNF transfer - MedPac speaks to it but vague if that is one of the 'wins' for the hospitals.

MEDPAC also speaks to the 'highly financial benefit of a 1 MN stay with the current DRG system." (See MedPac April 2, 2015 - "Hospital short stay policy issues and March 30th letter to MedPac from AHA.)

**RECOMMENDATION:**

    It may be a much better use of resources for AHA to sponsor FREE 2 MN education on HOW TO GET THE STORY TOLD RIGHT FROM THE BEGINNING... why 2 MN/presumption?

what is the plan for why 2 MN and lay out the plan AT THE FIRST POINT OF CONTACT?    The biggest lost inpt - still after 1.5 years- CONVERTING OUTPT to INPT if a 2nd Medically appropriate midnight is needed.  NOT INTEQUAL, NOT MILLIMAN...  let it go, UR!  You are killing the Medicare inpts..since Oct 2013, never ever ever ever ever have more than 1 MN as an outpt. It is not 24 hrs, it is 1 MN ...  Then look to the record and ask - why still here after 1MN?  Does the pt need a 2nd MN and why?  CDI work is all about capturing this potential inpt.

**RECOMMENDATION TO UR-FIND YOUR LOST INPTS.**

    UR's primary function every day is to get the pt status right.   Every day - why is the pt still in an outpt bed after the 1st MN?  UR's PRIMARY GOAL - get the pt converted to inpt if 2nd MN is necessary OR discharge timely.  NEVER EVER have a 2nd MN in an outpt setting for Medicare.  This has been clearly outlined since Oct 2013. Has not changed!

RECENT AUDIT FINDING:

    To demonstrate how hospitals are hurting themselves - we just concluded a 22 chart OBS audit for a great 120 bed hospital.  Of the 22 charts, 13 had more than 1 MN.

What did the record look like as the 2nd MN approached?  10 of the 13 had a beautiful reason for admit/conversion clearly outlined by the record...BUT the doctor never outlined the reason nor did they convert.  UR - primary job to NEVER let this happen.   Many multiple days in OBS...   10 lost inpts...   We are killing ourselves...  LET "Clinical guidelines' GO!! MEDICARE DOES NOT USE THEM NOR ENDORSE THEM.  Unfortunately, this is not an uncommon finding...

    Remember - commercial payers and Medicare Mgd Care plans have their own rules.  Check your contracts, call the payers - get in writing what is their definition of an inpt.

Protect yourself with contract language ---ESPECIALLY Medicare Mgd Care plans as they DO NOT follow traditional Medicare Part A. Treat them like a commerical payer -and fight when they won't authorize an inpt...  You have lawyers, use them.  (Dr S/NJ had had enough - got legal involved.  Amazing change!)

**ICD-10 IS ALIVE AND READY TO GO IN OCT, 2015**

Yes, it is time to get ready.  (FYI: our remote coding and ICD -10 coding validation work is ready if you need us.  Check out our webpage.  We are NOT having a rate increase with the move to ICD -10.  Just in time coding, no limit, lots of education on weaknesses in the record, per chart fee for ease with budgeting = lots of fun.  Our ICD -10 training classes for non-HIM folks/payer interaction, provider office staff, pre certs, business office, medical necessity edits with dept heads, plus our ICD -10 training for providers and coders = all on our webpage.  Go get them!  It will help!)

Rollout ideas to improve the 'readiness' for a transparent conversion:

1)  Involve the provider office staff. Host FREE training for them.  Hospitals will need an ICD -10 code to run medical necessity edits against- ABN.  HARD even now, after all these years with ICD 9.

2)  Payer testing.  HUGE as testing should be by pt type, not just a batch.  With the many new codes, the PFS dept needs to see the potential new edits - start with ER and then inpt surgery as these are the 2 biggest areas for impact.

3)  Provider dual coding with direct feedback on risk- do by specialty.  HUGE as it is important to identify a month/week to do specific areas - EX)  May is ER Month. All the ER doctors know this is the month that coders will be doing dual coding- ICD -10 practice.  The ER doctors get immediate feedback on how well they did during the dual period.  Immediate changes/enhancements to the EMR, other ques = move on rapidly.  Then schedule another ER period and do it again.  LOTS of changes in ER.

EX)  Inpt surgery next...  same with identifying distinct period for this group... feedback loop

4) Track and trend current queries. WOW !  This is a major area of weaknesses as patterns need identified with education/potential changes in EMR/ques built.  If the provider is struggling now, it will get worse.  No reason to make ICD -10 harder than it is.  Teach how to tie ICD9 queries to ICD 10- see how easy it is!!

5)  Sign up for testing with ALL payers.  Send letters, get contact names and WATCH the 837 UB file go thru the edits and back to the 835 payment.

6)  AFTER go Live. There will definitely be claims with ICD 9 codes AFTER go live.  Are all vendors, payers, etc. ready to handle TWO sets of edits?

7) Evaluate the case mix index as dual coding is occurring.  Heavy focus on surgeries as big impact with case mixes.  Don't just dual code, run thru to see if there is a change in DRG..

**TID BITS**

* **Thanks, Ray C/RAC SUMMIT for sending us a 'nice balanced piece of Fierce Healthcare reading: The return of the RACs.**  Go to: <http://www.fiercehealthpayer.com/antifraud/story/return-rac/2015-04-14?utm_medium=nI&utm_source=internal>.  (PS: says $10B in about 5 years recouped)
* **Thanks to Dr Hirsch/Accretive and Dr J/Physician advisor for bringing us an EXCEPTIONAL 2 MN article from CGS/MAC:  The 2 MN Rule and Physician Progno**stication.  (I am going to use this for all my provider training.  Lays it out very simply.  STOP making it so darn hard..)  Go to:  <http://www.cgsj15partablog.com/inpatient/the-2-midnight-rule-and-physician-prognostication-3/>
* **NEW CLASS**:  If you are interested in a audio or a face to face/chapters too-  I am doing a new class:  "Top At Risk Issues Learned From Audit:  Charge Capture documentation and Pt Status Documentation."  About 60-90 mins.   (I recently taught this as part of ***Compliance 360's*** free webinar series.  Touch base with them to hear it.  WAY FUN!)
* Thanks to Dastgir/RAC RELIEF for letting us know about **a new QIC/level 2 appeal**:  Effective March 1, 2015 - C2C Solutions will begin serving as the PartA West Jurisdiction QIC.  Maximus Inc. will continue to processs reopening requests for Maximus issued decisions thru May 31, 2015
* **Pending Appeals - Senate hearing.**  April 28th -hearing on the massive amt of pending appeals - now over 500,000.   Aver # of days for an appeal has grown from 95 in 2009 to 547 projected in 2015, according to OMHA.  Lots of interesting issues - like charging to fee so only 'good ' cases are filed. WOW!  Stay tuned...  (Thanks to all the RAC RELIEF folks)
* Recent govt report for Jan thru Sept 2014, survery respondents assessed their own health as follows  (HealthExecMobile )  36.5% excellent, 30.1% very good, 23.6% good, 7.6% fair, 2.2% poor.
* The % of persons who reported excellent or very good health decreased with age:  84.7% under age 18, 64.7% aged 18-64, 45.2% aged 65 and over.

**HEY, come and say hi at the conferences where I will be speaking as well as the webinars.  They have asked me to let you know...happy to!**

May 1st            KS 19 hospital group        Identifying revenue opportunities thru charge capture and charge master    -webinar

May 14th          ORE HFMA                     Exploring an integrated CDI program - both traditional coding and UR

June 18th          CHC                               To be determined/Dallas

June 23rd          VHA                              Attacking the 2 MN rule - finding your lost inpts..and lessons learned - webinar

July 15th           Texas Hosp Assoc        ICD -10 changes everything in the revenue cycle - learn how - webinar

July 22-25th       BOOT CAMP

July 27-29th       Idaho Rural Road Trip     Pt Status education in 3 locations within Idaho.  YEAHOO

Thanks for allowing us to be a part of your professional commitment to excellence!

Pay it forward every day...the joy is personal...enriching our personal lives.  GO TEAM!