April 2018 Infoline

HI  Happy almost Spring Break!  Yep, we are having a typical spring weather pattern here in Idaho..snow, rain, warm.  But with such a mild winter, better not complain.  HA!

Lots happening, so let's get started.

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**SUPER EXCITING NEWS!   The 6th National Physician Advisor and Utilization Review Boot Camp Agenda is now posted and registration can begin!  YAHOO!**

**We are partnering with the RAC Summit team again this year to bring this 'get it done' focused boot camp.**

        Pre-Con:   **"What does disruption in healthcare look like?"** From patients, to physicians, to payers to new delivery system potential to national focus...  Including the Idaho Blue Cross Story. This agenda is getting updated almost daily... WOW!

        Main:       ' **Attacking Payer Denials - Chapter 2.  Lessons learned and strategies for su**cess."   Fabulous faculty will include operational focus by PAs and UR team leaders; payer input regarding new dialogue and hot at risk issues; Total Knees will take center stage with education and case study luncheon discussion; with regulatory updates, payer denial stories and how to be successful internally and with the payers.  Non-Contracted Rules with Medicare Advantage plans Plus National update on Part C plans - more hot topics.  WOW!  Did I mention tons of opportunities to network with the faculty?   Can't wait to see you all there!

WHEN:        Weds-Fri, July 25-27th

WHERE:      Hyatt Regency Los Angeles International

PLUS:          Live streaming/like being with us; group pricing; early bird discounts, CME credits.

go to:  <https://racsummit.com>    or    our website.

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**Updates:**

1)  United Healthcare:  Effective 3-1-18, United will begin auditing facility level 4&5 using their OWN E&M leveling tool/Optum Ed Claim Analyzer tool.

Action:  Immediately look to your contract with United.  a) does it require you purchase their product/Optum;  b) where does it allow them to arbitrarily use their own software product to audit you and c) what are you currently using for E&M leveling?  Most/all hospitals are following Medicare's guidelines from 2000 that we must have our own system that "reasonably related resources to levels assigned."  CMS cannot mandate you purchase anything; just have an auditable leveling system with no double dipping in it/CPTs are to be billed separately; not included in your E&M leveling system.   Does this situation with United pass the 'smell' test?  They are using for Medicare Advantage and Commerical plans.  Time to report to CMS, yet again, for abuse.   Their definition of 'medically necessity level 4 & 5 is to buy their product...then you can pass their audit???    (Why are you contracted with United, exactly?)

2)  RAC are asking new HHS Sec Azar to let them audit additional claims/March 12, 2018.  (Thanks, Peter Grant, RAC Summit/Boot Camp)  The Council for Medicare Integrity - which is the group who represent the Recovery Auditors, are asking Azar to let RACs audit more claims and to push Congress for a PERMANENT RAC prepayment review program.  The RACs say the audits 'have absolutely no direct impact on the Medicare providers' but past provider complaints about audits led to program reforms.  Allowing PREPAY reviews and reviews of additional claims could go a long way toward improved solvency (of Medicare.)  The council also says these are private sector best practices.  (really??)   The Council is asking HHS to allow RACs to review 5% of claims.  The group also says that in the long term, it would welcome a discussion about RISK-BASED document review limits.  (what??)   The letter also speaks/defends the 5% as if any provider has this high, they need a more comprehensive audit.  The Council also says it would like to EXPAND the types of claims for billing errors.

RACs state the prepay review program was successful so make it permanent.  (Better get busy with your hospital association & legislators, asap.  Read the entire story:  <https://insidehealthpolicy.com>  Michelle Stein.)

**\*\*\*Need help with remote coding?  Full time, specific patient type or Just in time coding support?  No required volume or patient type.  24-48 hr guaranteed coding turn around.  All patient types. Large and small facililties and practices.    If you would like to learn more, drop me a note and we can chat.  Thanks a ton! \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**HealthCare Buzz Plus Disruptions in Healthcare   (New Class is on the webpage:  "What Does Disruption in Healthcare Look LIke! " Cool)**

As we outlined in last month's Info line, we will begin adding national highlights impacting the changing healthcare culture.  These are loving referred to as "Disruptions in healthcare.'

We will include Healthcare Buzz/hot topics along with ongoing potential changes that will impact our patients and yes, each of us in healthcare.

1)  California Dept of Insurance is investigating Aetna - after medical director admits he did not review the medical record- just took the advice/recommendation from the nurse reviewer.

Ed Norwood - new faculty at the Boot Camp - will help provide strategies on:  ***'Sometimes you are the only thing that stands between the single crushing blow of HMO and a patient or provider.***"   There could be a ripple effect with other payers.  (Aetna indicates the ex-MD misspoke.)

2)  Anthem patients are afraid to use the ER.  Anthem has implemented denials BASED ON FINAL DX, not presenting DX, for claims not deemed as emergent. They added some additional exceptions - if the pt is on an IV - to the small list of covered dx.  Impacts: Kentucky, Ohio, GA, Indiana, Missouri/4 M BC subscribers.

EX)  Pt in Franfort, KY -after experiencing increasing pain on her right side of her stomach, thought appendix had ruptured.  After testing, diagnosed as ovarian cysts.  DENIED payment as not emergent FROM FINAL DX and pt owed $12,000.

**CONCERN:  ER physicians are highly concerned that patients are trying to 'self diagnosis' if it is a true emergency or not - with the decision being made by Anthem after the visit.  American College of ER Physicians:  "The changes do not address the underlying problem. Patients have to decide if their symptoms are medical emergencies or not BEFORE they seek treatment."**

Common Theme with United and Anthem BC:  No longer want to pay for expensive ER visits.  Hospitals - further beef up your 'triage' to a lower level of care option in the ER.   Refer to onsite Urgent Care Clinics... and bill with the non-ER E&M level for the provider and hospital.   But horrible for the patients who don't know -what is happening?? " I am in new, unexplained pain   or    I have had this condition for days/tried to get in to see doctor/no availability and had to come to the ER    or     I don't go to a doctor but this is severe".   Lots of uses for the ER and if patients are insured, many more options for primary care than the ER....episodic emergent care...

PS  Where one payer goeth...others followeth...

3)  **Total knees off the inpt only list.** After a multitude of calls and emails, let's try a process approach to the new world of Total Knees for Traditional Medicare.

(As always stated, where one payer goeth....)  Here are some action -oriented ideas that may help.

1) Change took effective 1-1-18.  Grace period is for audits to begin.

2) When addressing the change, think about this motto:  **Every patient/every time, 1st point of contact** - Utilization management/UR/Case Mgt intervenes.

3) At the point of scheduling a Traditional Medicare total knee, UR always reviews the surgical order.  Reviews all the other medical factors, living situation, ability to discern instructions/home rehab as identified thru the provider's notes, discusses ALL the factors involving the patient's ability to be 'safely discharged as an outpt after total knee."  HUGE piece of the new process.

4) Look at each case thru 3 different scenarios and work with the provider accordingly:

a) Using the 2 MN rule to justify inpt - 2 MN presumption.  UR ensures there is a clear PLAN why the medical indicators - many times beyond the TK - are present and will clearly meet the expectation of 2 MN for the inpt surgery.  Then, if the pt does respond better than anticipated/laid out in the initial 2 MN plan - note an unexpected early discharge and leave as inpt. It is all about the PLAN that addresses all the reasons why it can't be an outpt.

b)  Using the outpt option - after UR reviews the case at the point of scheduling- the patient has the total knee as an outpt.  Close monitoring thru the routine recovery period (using the 4-6 hr CMS recommended routine recovery which allows for a threshold each time/every pt to ask: why are they not safe for discharge yet?   UR must review all outpt cases as they move thru routine recovery and then to extended recovery/which is billable if ordered (no separate payment but billable is the key as it is done the same for all payers)  until the pt has met the pre-determined 'safe discharge criteria' for total knees.   There is no such things as a status called 'stay the night' -but we move thru all levels of planned recovery.  Stays as an outpt.

If there is an unplanned outcome or event with the outpt surgery - Observation is a appropriate...with an ACTION PLAN for treatment.  UR is always looking to the 2nd MN Benchmark in the event the 'unplanned' occurrence is not resolved prior to the 2nd MN.

c)  Using the 2 MN benchmark option.  UR and the provider agree pt starts as an outpt - expected not to need 2 MN for post surgical care.  But as the 2nd MN approaches - extended recovery is still not resulting with the pt meeting the 'safe discharge' thresholds.  HIGHLY important - UR reviews the case with the treatment provider.  Why isn't the pt discharged?  What are the clinic reasons the pt needs a 2nd MN?  THE PLAN for the 2nd MN needs included with the order to convert to inpt.

TRACK and TREND all patterns by the Orthopedic surgeons...  Teach from the excellent examples of how to find and keep the inpts -when appropriate.

Remember - 3 day inpt qualifying stay is required for SNF.  So option b and c will create a problem as 1st MN was an outpt.  Be diligent...  it will get easier...thru every pt/every time...

ps  Someone is going to ask - what about the exception to the 2 MN rule for Total knees? Not going to mention it as it is highly dangerous to try to get inpt thru that route. Use one of the options - a or c - and get it thru the 'normal 2 MN path.'

**Pharmacy, Pharmacy, Pharmacy**

CVS pharmacy buying Aetna.   Walgreens buying Express Scripts.  What is the common theme?  Pharmacy ...

Something to think about:  If you have Aetna insurance, you will have to buy your pharmcy at CVS or you are out of network. HUGE $.  If you use to get your drugs at Costco, out of network as you have to buy at CVS/Aetna.  It is all about capturing the pharmacy business.  There is going to be more and more of this...  just keep watching all the mergers, new business models, and buy outs.  Directing the market = upset, ill-informed public.  Private Pharmacies???     (We discuss these and more in the Disruption classes... never a dull moment!)  Changing the HealthCare Culture..

Buzz:

    **Stakeholder views on which healthcare sectors will be worse off a year from now?**   (MCOL Future Care 2018 e-poll)   3-16-18

    68.7% responded consumers will be worse off   (Think higher deductables, moving to HSAs/variation, less paid by employers, changes in national ACA protections)

    67.2% said hospitals worse off   (same reasons as above)

    50.8% said physicians

    28.4% said pharmaceutical

    19.4% said employers

    14.9% said health plans/payers

 **\*\*\*\*\*\*\*\*\*\*Hey, I am going to be participating in the upcoming events and/or webinars\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Come and say HI or join us\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**March 23rd        Finally Friday            Noon - part 1 of Disruption series**

**April 11th          Tex Hosp Assoc          Webinar series:  Lost revenue found - why I love the 2 MN rule - finding lost inpts**

**April 25-26th      IA HFMA                    Women's Conference presenter and general session**

**April 27th          AAMAS annual          General sessions:  Finding lost revenue; Attacking Payer Denials**

**April 30-May2    APCA conference      Presenter:  UR in th ER**

**May 9-10th        GA HFMA                    Disruptions in Healthcare and Lost Revenue**

**May 22nd          VHA                            Webinar series - Attacking Mgd Care Denials**

**May 24th          Western MI HFMA       Presenter - still to confirm topic**

**WOW~ we do have fun!**

**Have a great one!  Love sharing with you and learning from each of you.**

PS  Historica Info Line are always on our web page...plus powerpt classes.... plus articles..... plus Pearls.

All free... Enjoy!