August 2016 Infoline

Hi and Happy End of Summer!  Hard to believe that we are almost at the end of Aug.

There is plenty of activity for this sunny day in Idaho so let's get started.

**WOW - NEW PROGRAM thru AR Systems, Inc... Physician Advisor Onsite Training Options**

Check out our Physician Advisor Training options /under boot camp on the webpage.  2 -day onsite shadowing and operational training - we come to you or you can do a buddy program/shadowing with a physician advisor in a like sized hospital.  A seasoned physician advisor and yep, me!   Happy to chat more about this...drop me a note..

**SAVE THE DATE:  We are excited to announce the 2017 Boot Camp- (co-sponsored by RAC Summit and ARS).**

    5th National Physician Advisor and Utilization Management Boot Camp:

        "***ATTACKING Payer Denial's Boot Camp - Creating a Collaborative Dream Team***.   Turning anguish and aggravation into ACTION".

        Plus a dynamo pre-con:  "Documentation 101 - Clinical ques to improve the patient story. Words do matter!"

     Date:         July 19-21, 2017

    Location:      Hyatt Coconut Point Resort

                       Bonita Springs, FL  (Fort Meyer's airport)

    Stay tuned for more on this dynamic agenda and the tools to become action -oriented with ALL PAYER DENIALS & DISPUTES:   Medicare Advantage/Part C Medicare, Commercial Mgt care, and Medicare/MAC plus other goodies...regulatory update, Part C audits/troubles, Peer to Peer tools, dynamic tracking/trending/IT systems, and TONS on Contracting key elements...  Not to mention lessons learned from denials/rejections/disputes with operational 'how tos' to tackle each one.  Success stories and struggles included.  **Three hot spots**:  DRG downcoding, Pt status, and deadly definition of re-admission.   WOW!   Can't wait !!

PS:  We just taught a free webinar by Sai Global/Compliance 360 that has many of the elements necessary to become aware and action oriented items with the DREAM TEAM!  It is recorded so go to their webpage.  (This is the only company we work with as their products are results oriented and provide the tools necessary to track and trend payer challenges.)

**Updates**

* **Aetna** is pulling out of 11 states/exchange product.  Take at look at USA TODAY 8-17-16 as to the "why" .  Short version- too many risky patients, not enough premiums.   But also there is an undertone message that the merger was put on hold/challenged so could be a bit of a 'temper tantrum.'  Just saying.  But still bad news as United as already pulled out in some markets.   Same issue - only double digit profits..really??   The stories do reflect the insurance industry upheaval.   **(WOW!  PAYER CONTRACTING and patient impact from this...)**
* **Hospital appeals settlement update 8-18-16**    CMS executed settlements with 2,022 hospitals, representing appproximately 346,000 claims.   CMS paid approx $1.47 B to providers.  (Read more:  [www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medicare-review/inpatienthospitalreviews.html](http://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medicare-review/inpatienthospitalreviews.html))  Thanks, Sharon Easterling for sharing.
* **MOON** is delayed.  CMS moved back the start date for the requirement in the 2017 IPPS final rule to 'no later than 90 days' after the final version of the form is approved.  A new draft was released on Aug 1st.  The act requires hospitals to provide a verbal and written notice of outpt status to any pt in obs who has been in the hospital more than 24 hrs, stipulating that hospitals must inform patients within 36 hrs from the start of the service, or at the time of discharge, about their status.   CMS stated: "We expect the final paperwork reduction act/PRA approval of the MOON around the time the implementing regulations are effective.  Therefore the implementation period for the hospitals and CAHs will begin sometime after the effective date of the final rule.. announced here:  <https://www.cms.gov/Medicare/Medicare-general-information/bni/index.html>.  Expect not to begin until 90 days after PRA approval.  May be longer due to 30 day comment period.  (**WOW!  Be thinking about those pesty inpt flips back to obs/CC 44!  And be excited about the 2 MN benchmark where as the 2nd MN approaches - think converting to inpt for a clinical appropriate 2nd MN...and no MOON!)Medicare Advantage/Part C are subject to the MOON at this time.  Watch closely when we get it final.**
* **Big issue with MOON:**  Who is going to present it to the pt? How will the scripting look?  If using Case Mgt, what about weekends? If using admission staff to back up Care Mgt - who is training them?  Who is documenting where in the EMR that it was given?   Lots of operational issues...get ready now...
* **Inpt only surgical procedures.** Still plenty of confusion but take a look at MLN Matters MM9097, CR 9097 effective April 1, 2015.  Always double check with your MAC on 'interps" of when inpt only orders must be signed and when to 'collapse' outpt into inpt-order issues.
* **Medicare A/Part C is not Traditional Medicare--think and treat Part C like a Commercial payer**.   We will be aggressively addressing many issues with his huge challenge in the 2017 Boot camp -and we had many dynamic presentations/dialogue in 2016 Boot camp...

          Golden rule:  If there is a contract, the contract language supersedes ALL traditional Medicare regulations.   If no contract, revert to Traditional Medicare but expect a fight.   If the contract is  'Silent" on the issues - like allowing Peer to Peer, turn around times for requests, definition of an inpt, coding following correct coding guidelines/DRG,  related readmissions /30 days,  drugs deemed experimental-just to mention a few - what then?   The hospital must become very sophisticated  with contract terms - BEYOND the rates...   We will address all these elements in the DREAM TEAM ....

Ginger M/Cleveland Clinic has been graciously sharing numerous **Q&A from CMS** regarding many Part C rules.  In addition to the regulatory issues- here are some Q&As.

Reply from CMS PART C Policy. Aug, 2016

    Q)  Issue 305: inpt only.  For the commercial insurance that provide Medicare coverage - Medicare Advantage/MA- do they have to follow the inpt only list for billing and coverage?

    A)  Medicare Advantage/MA plans 'need not follow original Medicare claims processing procedures and may create their own billing and payment procedures as long as providers - whether contracted or not - are paid accurately, timely, and with an audit trail.  (Section 10.2 of chapter 4 of the Medicare Managed Care Manual.)  We have taken the position that the inpt only list used in the outpt payment system under original Medicare is a payment rule and as such, MA plans are NOT bound by it.  Thus, CMS allows MA plan directors to make decisions regarding the appropriate settings for enrollee's surgical procedures.   (**WOW!  Must have pre-certs done and clarify inpt vs outpt PER THE MA's DEFINITION, not Traditional Medicare.)**

    Q) Issue 320:  Concerning ABNs  We have been issuing ABNs for the MA plans.  Are we required to do so or would a financial responsibility letter reviewed with our financial counselor be appropriate?

    A)  ABNs are used in original Medicare but are NOT appropriate for enrollees in MA plans.  If there is a question as to whether or not a service will be covered by an MA plan - the provider enrollee should seek an organizational determination from the MA Plan.  A summary of when an organizational determination maybe needed is furnished in Section 170 of chapter 4 of the Medicare Mgd Care Manual.    (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c13.pdf>)   (**WOW!  Better check on this one and your internal  claim submission edits as Medical necessity denials/rejections will not apply to contracted MA plans)**

**Other hints:
    Pt status CAN BE CHANGED AFTER DISCHARGE for Disputed pt status with Managed Medicare Part C.  They are not following traditional/original Medicare.  It is a dispute; can easily take after discharge to resolve.**

    **Condition code 44 would not apply**.  Once the dispute is resolved-and the facility agrees to down code to obs/crap - confirm that ALL obs hrs from the beginning of care are billed on bill type 131.  There are no CC 44 rules with Mgd Care unless it indicates same in the contract.

    **What is the Mgd Care's definition of an inpt!** HUGE HUGE HUGE!   Beyond - medically appropriate care...

 (NOTE: We will begin adding MGD CARE CORNER feedback from the great sharing of information - thru the RAC RELIEF group and the Info line. We have an army of information and more coming...)

**Join us for webinars or in person...as the organizations have asked me to let you know...  HAPPY TO!**

    Oct 3rd            NJ HFMA                            Attacking the 2 MN rule - Lessons learned from Pt status audits and regulatory updates

    Oct 10th          ID HFMA                            Finding lost revenue - inpts and charge capture. Lessons learned while making it easy!

    Oct 20th          MI HFMA                            Finding lost revenue...

    Oct 21st          First Ill HFMA                     Attacking Mgd Care Anguish-  Part C Medicare  and Commercial at risk issues with ACTION.   (NEW CLASS)

    Nov 3rd            San Diego HFMA               Finding lost revenue

    Nov 7-8           Region 9 HFMA                    Still to finalize

    Nov 11th          MN AAHAM                        Still to finalize

    Nov 16th          AICPA Health care conference     Finding lost revenue

Hope you are all doing excellent!  Moving forward...

Thank you for sharing your professional life with us... it does take a village!