December 2015- Infoline

Hi and happy holidays!  Merry Christmas!  (Yes, I was on a major travel marathon and had to skip 2 months.  Gads)

We have plenty going on so let's get started.

**ICD -10 is alive and well.... SURPRISE!**

Yes, after all the gloom and doom, the health care providers and even the payers, seem to have come thru with minimal damage.

Biggest issue to continue to monitor: Case Mix index.  This is where the problems with specifics related to the inpt case/especially surgery may come into play.  Closely monitor 'before and after ICD-10' to gauge this potential hit.Congrats to all the hard work to get the industry ready...

**Coding denials/downcoding -** Mgd care, Commercial, Part C/Medicare and Traditional Medicare

Holy moly!  The world continues to be dramatically hit by the Mgd Care plans/both Part C Medicare and Commercial.

1. Large Blue plan has started challenging the DRGs associated with Sepsis.  This one is also hot for contracting.  Even though the facility may have 'internal clarification/standards in the industry' - what is the payer using to further clarify?  EX)  one of the elements is fever.  Facility using 101.  BX is using 102 or cannot use it as one of the complicating factors. Simplistic as other items come into play but this could be the 'trigger' they are using to downcode.)   Another huge audit finding:  the ER provider speaks to the severity; yet the hospitalist or attending states: all within normal limits.. YIKES! Yes, this appears to be a standard part of the E H R.. yet another reason to read and re-read throughout the stay.  CONTRACTING:  What elements beyond coding clinic is the payer using to clarify parameters for Sepsis? The new world is full of the need for this level of specifics within the payer contracting.
2. Humana replacement plan/Medicare Part C.  Thanks to RAC RELIEF- folks from Ill, PA, etc. for sharing some of the anguish with Humana's DRG disputes/downcoding.  A recent denial/down coding: "The documentation has been reviewed by a licensed physician to determine whether the medical record documentation supports the dx billed.  A coding auditor does not make a clinical determination.  Pneumonia is not a valid dx in this patient history of COPD who presented with cough and congestion...with more on presenting symptoms.  Then states: results in a deletion of dx code 486 (pneumonia) changed MS-DRG 190 to MS-DRG 192. "    Challenge?  How to appeal these?  CONTRACTING:  Managed Medicare have the same appeal levels/5 but most don't indicate same.  The contract may say 3 levels or only appeal back to the plan that denied!!  No Peer to Peer is allowed.  Contract must indicate all levels of appeal with timelines including peer to peer if needed.  How to appeal?  Who to appeal to?

**Managed Care Anguish - on pt status, readmissions, disputed inpt status, etc.**

If there is anything NEW we have seen in the last year - it is the HUGE increase in managed care (specifically Mgd Care Part C Medicare).  The industry is 'chasing' the ever-changing environment of Mgd Care denials/disputes...with or without an actual contract. (Some payers are small enough, the provider determines they do not want a contract.  Time to re-assess, not for payment 'terms' but for safety with pt status and appeal rights!!)

1. What is an inpt?  Each non-Traditional Medicare payer gets to define this. What does your payer contract state?  We certainly have lots of varation occurring - look at United, Aetna and Humana.  What does a 'not Medically necessary ' stay mean especially if the stay was originally VALID with all pre-cert infor sent.  (EX:  Payer approves 2 day inpt stay at first point of contact. Then AFTER discharge, requests records and denies as stay was not medically necessary.  What does that mean? )  Ensure your contact PROTECTS against this type of abusive practice by the payer. On the other hand, ensure the provider clearly outlines the PLAN for why an inpt with the order.  Assume nothing...
2. UHC Medicaid- East coast appears to be the big hit at this time.  What are the STATE levels of appeal?  What is the definition of an inpt with Medicaid?  Appeals means massive delays in payment --so preventive work = getting the definition incorporated into the Medicaid plans.
3. ILL hospital - A UHC Part C plan plus other Mgd care plans/mid sized hospital so no contracted with all payers.  "Recently had a denial for a readmitted pt within 30 days.  Readmission reduction plan, per payer, FULL payment for the readmission is to be repaid.  There is no rationale, no related or unrelated language, and nothing in any contract to allow for this.  HUGE issue of abuse.  CONTRACT - immediately contact CMS to file a complaint.  They will continue to do this -especially with no contract.  If contract, get all readmission 'rules' included. NEVER allow it to say - whatever Traditional Medicare says as that is vague and open to lots of interpretations.

DATA: When doing the free Compliance 360/SAI Global webinars for the past 2 years - question asked:  Who else besides the RAC have you seen the largest growth with?

Managed care - 65% growth... HUGE  HUGE

THANKS for the Holiday Gift from J Skurski/Ill for doing the leg work to get contact names for providers to work with/complain to.  She shared this on RAC RELIEF - and again, thanks to all who are working so hard to bring information to the 'masses' as well as accountability to the payers.

CONTACT INFO:

    Questions.cms.gov - use but goes to Baltimore and may get lost.  She got the specific Medicare Part C regional rep.  for Indiana region it is [Rochido@cms.hhs.gov](mailto:Rochido@cms.hhs.gov)

    Humana Med C Contact at Medicare:  Uvonda Meinholdt  Kansas City Regional Office    [Uvonda.Meinholdt@cms.hhs.gov](mailto:Uvonda.Meinholdt@cms.hhs.gov)

    United Med C & Care Improvement Plus at Medicare:  Nicole Edwards   [nicole.edwards@cms.hhs.gov](mailto:nicole.edwards@cms.hhs.gov)

**IDEA:  Have excellent examples of problems - coding clinic guidelines not being followed, readmission denials with no basis/no foundation/no rules, inpt disputed, inpt denials as not medically necessary with no rationale or criteria used/outlined....and send to CMS.  If the providers don't complain, the abuse will continue.**

**IDEA: Continue to ensure that your UR team/1st point of contact with the payers and providers are the brightest and best.  They will need to know all the different payer's rule for 'status' as well as how to teach 'one standard of documentation' to support inpt.   Can certainly be a bit much...**

**Moving from MAC to QIO for Short Stay Inpt (Probe and Educate) Audits**

Effective 10-1-15, it appears the QIO is now doing all 0 and 1 MN focused audits - using the 10 record/small to 25 record/big hospital sampling.

But as much as we 'think' we have the rules for the 2 national carriers, there are challenges. (Be careful what you ask for...)

1. NY hospital/approx 120 beds - Livanta/QIO sent letter:  "2 MN rule, medical record submission instructions".  PROBLEM:  All but 1 of the 10 of the requests for records were for 2 + MN! HOLY!  When we requested what was used to select this sample as 9 of the 10 were at least 2 MN (3 were 3 or more MN) -Livanta did not know nor did CMS when called.
2. Still unknown - what is the error rate that will have the provider referred to the RAC for further auditing of at risk short stays?  UNKNOWN. (Thanks Dr Hirsch/Accretive for your help)
3. Look back period is 6 months- 'think' from date of service/admit but not stated.
4. QIO will audit- notify MAC to take back funds-hand off to RAC if too high of denial rate..which is??
5. But by gosh, we will have more physicians involved supposedly... what was wrong with the MACs doing these?  Just saying - as now we have 2 for the country..could be better/more clear interpretations but so far - a bit confusing.
6. KePro audit requests appear to be going to the original address vs the updated address that may have been provided when the site sent in the "Contact Information sheet for 2 MN short stay reviews."  Contact the QIO and ensure the correct address and attention to - if possible. (Thanks to J Barlett & G Higgins/Rac Relief)

**\*\*\*\*\*\*\*\*\*\*Save the date for the 4th national Physician Advisor and Utilization Review Boot camp - July 20-22nd - live and web streaming options \*\*\*\*\*\*\*\*\*\***

**We are thrilled to be co-producing with the RAC SUMMIT team our 4th national boot camp.  It is full of operational guidance from a 'how to' perspective for both UR and PA.**

**Both live and webstreaming options are available with discounts for multiple attendees.**

**Pre-con will have focused education with the full boot camp jam packed with panels of subject experts, case studies, and 'PA and UR in the trenches' teaching us better practice concepts.**

**and yes - lots and lots on finding lost inpts...**

**Save the date:  July 20-22nd**

**Where:              San Antonio, Tx**

**Stay tuned to our website and the RAC SUMMIT website for the full agenda by the end of the 1st Q.  YEAHOO**

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Upcoming in person and audios.  The sponsoring groups ask me to let you know- happy to:

    Jan 6th        GA HFMA/Regional HFMA audio        'Top Audit findings and better practice concepts - Charge capture and Pt Status"

    Jan 14th      Free Compliance 360                         "Two Midnight Rule:  Updates and lessons learned"

    Jan 26th       Region 11 HFMA                              "Finding lost inpts and keeping them."

***Holiday note:***

***As 2015 ends, it is a wonderful time to say thank you to each of you for always sharing to help /guide/teach the 'village' of providers.  Each of us has an unique opportunity to positively impact those we 'touch.'* It is a joy to be a part of your professional family.  I am also very blessed to have 4 dynamic children + 1 puppy (and spouses)and 8 super grandchildren plus a spouse who gets to 'keep up with me.!' HA -he tells folks he is teaching me how to slow down! Ha.  Wishing you all an exceptional 2016...  Here we go!**