December 2019 Infoline

 HI  Hope you are all doing great!  And yes, I did give myself a couple months 'break' to re-engerize...and just to be sure I wasn't getting bored!  HA

Let's get started...

**Jan 2020 - Total Joint activity with Traditional Medicare**

CMS to begin auditing documentation to support inpatient total knee, effective with date of service 1-1-20.   Are you ready?  Have you been ensuring that a) the medical necessity of having a joint procedure/RACs could always audit this and b) that inpatient has been documented, tying in the 2 MN rule?  There are two great guidelines from CMS -from 2017.  Take a look at our webpage for the "Inpt vs Obs - total knee (and now hip) anguish' class.  FREE!

Do you have risk?  Do a quick report:  Traditional Medicare, number of outpt total knee procedures since 2017.  It would be expected to a be a sub-set of the total volume.

Recently doing plenty of these audits with some common at risk findings:

    1)  Extremely low volume of outpt total knees.  Ones to look for as potential outpts:  2nd knee as all risks may have already been identified with the initial knee; no co-morbid conditions; great home support; no need for post -rehab; healthy patient!

     2) Using the two CMS guidlines, where is the documentation to support the 'at risk' issues?  It is seldom in the hospital's pre-op records or even part of the OP report/post surgery.  In assessing the social risks, home safety, other at risks - it is seldom found in the Ortho notes. Where are the Orth office notes?  How about creating a screening form -using the two CMS resources--have it sent to the Pre-Op /hospital Joint Clinic to ensure it is all complete and copy to the UR team member assigned to Surgery.  By using a pre-created, standardized form/tool - the documentation requirements for the Ortho will be consistent.

     3)  A coordinated effort - OR leadership,   Ortho, Pre-op, UR, compliance, physician advisors - working together to ensure the record AT FIRST TOUCH clearly shows inpt/ 2 MN presumption.   If documentation does not support inpt at the point of scheduling, start as outpt and watch for unplanned events.  If a 2nd MN is medically appropriate, move to inpt with a PLan for the 2nd MN.

Total Hip replacement will be moving off the inpt only list for Traditional Medicare, 1-1-20.

See above for what we anticipate will be the same guidelines as they are referred to as "Joint replacement'' in guidelines.

Ambulatory Surgical Center:  Total knee is being allowed to be done in ASCs.   ISSUE:  Hospital finance -take a good hard look at the pricing.   Revenue/cash hit from a) change from inpt to outpt and b) hit from moving to ASC from the hospital.  Payers are also using 'site of service' for prior authorization for outpt services - like imaging.  If the prior auth is done for imaging for my outpt procedure, the insurance plan may approve it but not to your facility.  Is your pricing comparable to a free standing Imaging Center?  The payer is going to the cheapest!

Medicare  Advantage:  What are they doing about their Inpt only list?  Check your contract as it will be important to clarify, in writing:  What is their guidance on allowing an inpt for a procedure/joint that is no longer on the inpt only list?  Do NOT allow the catch phrase:  "We allow what Medicare does" as that is just another way to say - denial for inpt.  What criteria or guidance are they using?  Get it in writing as Traditional Medicare is using the 2 MN rule and the CMS guidance from 2017.  Never allow verbage like - Medically necessary procedures. What does that mean??

**Medicare Advantage Most Common Issues**

This was tough but I believe I have a couple of the 'hottest' issues.

1) Can't change a pt status after discharge - 'just like Traditional Medicare.'  Shot me now!!

Let's tackle this in multiple steps:

      a)  When sending records :  ALWAYS know the clinical guidelines the MA plan is using to support an inpt. EX) United is using MCG/posted on their webpage.  What are your other plans using?

      b)  When sending records:  Include a cover page outlining why/how it met the clinical guidelines they are using.  United:  MCG -met inpt in these categories.  Tell them how and help them do the right thing by demanding the inpt.  ALWAYS require documentation as to why it didn't meet inpt.  Never just send and ask for their ruling.  The MA plan is paid a per member/per month from CMS to manage the patient's care. They do not get additional funds for care-like an expensive inpt.  Track and trend all abuse when inpt was clearly outlined.  Then be prepared to submit a formal written complaint to Medicare.   On our webpage/below there is a list of CMS reps to file complaints with the MA plans.  They will require you make an effort to resolve directly with the MA prior to submitting a complaint.  BUT SHOW PATTERNS...SHOW ABUSE....and HOLD THE MA PLAN ACCOUNTABLE. (PS Some accounts are more gray but still sending a cover letter outlining WHY an inpt - then you have clearly shown how you tied it all together..)

      c)  If no contract, Medicare's 2 M N rule applies/Traditional Medicare so yes, better watch closely as sending records - why?  Traditional Medicare does not require this... and then you do have to make a final pt status decision while the pt is still in house.

      d)  If there is a contract - then the MA plan does not get to have it both ways:  require records to be sent, no mandated timeline for giving a decision, then no mandated time to have a pre-denial call (think peer to peer) or disallow anyone talking to the payer but the provider with 'direct knowledge."  And then the pt is discharged while the 'discussions' are occuring and now the payer says - too late!  You don't get to go back and change status as the pt has left.  WRONG!  Happy to abide by 2 MN rule, no records sent and then we will live with internal prior to d/c.  Get your UR nurses trained on action items. (PS  Thanks to some great Physician Advisors who have rallied around having the patient complete  CMS's form 1696 - Appointment of a representative. THe patient appoints the internal PA to represent them. Dr Baker/SC.  WOW!)   Use it...

2) Think long and hard about giving the MA (or any payer) access to your records.  Yes, you don't have to submit records.  But -wow!  The feedback from multiple sites who have done this:  The insurance plan 'sees' the ER to floor, sees all the care provided over the next day or two and then rules - OBSERVATION as the pt is improving.  WHAT!   The inpt occurred when the pt was in the ER and could not be safely discharged.  This is the power of having UR in the ER -first touch.  Clearly outline why the pt needs to be an inpt -from the ER -not hrs later--not when the hospitalist makes rounds or sees the pt hrs later --but right when the decision 'not to safely discharge is met.'   Are you giving away inpts?  Are you in a continual 'battle' to try get and keep inpts?  Saving time with sending records is resulting in more obs..  scary!

**NEW & UPDATED CLASSES**

Yep, plenty of new & updated classes on our webpage. (See link below)   All are free... get and use to continue in your commitment to educational excellence.

NEW  Attacking Medicare Advantage Plans - take your power back.  This class also has a section as to why patients are moving to MA plans---'it is all about the money, baby"

NEW:   Living the Patient Experience..  very personal while incorporating an onsite Patient Financial Navigator program  (***Hop over to the Patient Financial Navigator Foundation webpage for more free classes.)***

NEW:  CDM Excellence - hot spots

NEW: Pharmacy Challenges

UPDATES:

Revenue Cycle Impact of Disruption- lots of updates in this one.

ER & Hospital based clinic- Strategies for success

OR, Anesthesia, Recovery and Supplies plus a work paper

Drug Administration - the uglies

Top Audit Risks and lessons learned from charge capture audits

Inpt vs Obs - adding tips for total knees and hips

**COME AND SAY HI...** I am happy to invite you to join me at the OK HFMA: Triple Crown meetings in OK city and Tulsa on Jan 22&23rd.. WAY FUN!

Compliance 360's quarterly FREE webinar: Feb 5th        "Hot updates while a guest hospital presenting how to build and use a Payer Contract Matrix!"

Be watching for additional conferences and webinars in 2020.. We won't be bored!!

Happy to chat with you about speaking at your facility and/or your professional association.  It is always a joy!

**\*\*\*\*\*\*\*\*\*HOT OFF THE PRESS  \*\*\*\*\*\*\*\*\*\*\*\*\***

"**Majority of Americans would pay higher taxes for health coverage for everyone** : survey by Commonwealth Fund, the Howard TH Chan School of Public health and the NY Times. 12-12-19

According to a recent telephone survey, 93% believe that all Americans shoudl be treated equally regarding the quality of health care they receive; only 16% believe that the current healthcare system does this.  56% of Americans think that the government is responsible for making sure that everyone has health care coverage.  59% believe higher-income people should pay higher taxes so that everyone could have health insurance and a majority - 53%- would personally be willing to pay more.  The survey of more than 2000 US adults.

**Closing thoughts for this holiday edition:**

As 2019 comes to an end, reflection can be a good thing...  Healthcare has been my passion for 41 years.. (yep, started when I was 12)  It is a joy to provide assistance in multiple ways - but mostly to be to say - this is how healthcare works - to the scared & overwhelmed families in our communities.  The country desparately needs us - who have knowledge of healthcare from the inside - to educate and help clarify the 'noise.'   Stay educated, stay informed and keep it simple -as our leadership is essential.  Healthcare is personal. Healthcare is local.

Thanks to each of you for allowing us to be a part of your healthcare family. It does take a village!

Best wishes for a dynamic and peaceful 2020..