February 2016 Infoline

Hi and Happy Feb!  It is super mild in Idaho...we seem to have had our tough winter early.  Spring - here we come! ( I know, I just jinked it!)

**Crazy times---let's start the discussion --Mgd healthcare plans**

 WOW - it is hard to believe the magnitude of the challenges we are facing with the mgd care plans.  (You will wish for Traditional Medicare audits!)

A few key elements to review:

* The contract has all the power!  If it is not in the contract, they should not be able to do it.  Who is training the UR team about how to deal with payers?  New language and support team from the revenue cycle.  No silos!
* Having said that, research closely the language for:
* What is the definition of an inpt?  Some are using IQ, others Milliman, others using traditional Medicare, others use the generic 'medically necessary stays.'  WHAT??
* It is highly important to have clarity in the language of the contract.  Commerical Mgd care is significantly different than Medicare Part C/Medicare Advantage.  Part C DOES NOT f follow Traditional Medicare.  It is 100% contract driven.
* We have some Part C plans being 'creative' with using CMS guidelines.  BIGGEST ABUSE (remembering there are many out there) --**denying ALL re-admissions within a 30 day period**. They even sent out a CMS reference that does NOT say this as justification.  It doesn't matter if the DRG is different, different DX, different reason for readmission - denied.  All size hospitals, all over the county are getting these.    They said CMS denies, so do they.  Not true - as the payment is made, but the data is collected for the identified readmission dx and reported the next year with penalities for high %s.  (A site indicated the UR person had told the provider that ALL his readmissions for ALL Dx any reason are being denied. Said it was a new Medicare rule...misinformation~  Who is training in your facility?)
* **TO DO**:  Immediately demand a call with the Contracting Director for the payer.  Start yelling and 'nicely' discussing the incorrect denial.  Do Peer to peer calls. (Another Part C plan told the site that CMS did not allow Peer to peer calls any longer!! WHAT??  Not true.)
* **TO DO:**  Call other hospitals in your area...a single hospital is not going to get as much attention as multiple ones joining together with a plan of action.  INVOLVE the hospital association...track patterns of abuse.   And YES - CONTACT CMS and report the abuse of the Mgd Care Medicare plan.  There are contacts for all plans...
* **TO DO**:  Immediately evaluate the contract language.  We don't usually negotiate-what is an inpt - but it is long past due to begin.  If you don't have a contract, then CMS's Traditional Medicare rules should apply but contact your MAC to get the regulatory guidance.  We have many many hospitals /smaller mostly, being bullied by these abusive practices.  (Another ex: one of the largest plans: "We won't negotiate as we have a national contract... says medically necessary admits..."   Guaranteed a denial with what appeal rights?)
* **TO DO**:  Confirm the appeal rights of all commerical plans and definitely the Mgd Care Medicare plans.   Confirm with CMS, not the plan!!   (A site was told they could only appeal back to the original insurance company who denied.  1 level of appeal!  Not true...all levels of appeal within Medicare.  But what about non-Medicare plans? Contract driven...)
* **TO DO**:  EX: The inpt status was in dispute until after discharge.  The facility finally agreed to downcode to obs. The Part C plan said: you can't bill as OBS now as it is post discharge. They are quoting CMS/traditional Medicare rules and telling them to bill bill type 121.  The revenue codes for obs hrs/762 and drug adm/260 are excluded from the list of covered 121/inpt denied claim. THIS IS NOT AN INPT DENIED CLAIM. This is a disputed status that took until after d/c to resolve.  HUGE!   (They win on all fronts by delaying until after d/c..sneaky devils!)   **IDEA:**  **Create a "Variation from Order Form for Non-Traditional Medicare payers.-use for all commerical, Part C Medicare, others.  The form should include the language:  "Thru communication with the (payer name), the inpt order is being changed to obs as the payer will not authorize inpt and the facility agrees not to appeal or further challenge the change in status.  The account will be changed to obs for billing purposes."  Signed by the UR doctor or director.   Important to have in the EMR - for coding clarity, audit clarity, historical reasons plus all follow up work.  The doctor's office should be told plus the pt -easy to follow note as the outpt of pocket changed from inpt to obs.  Bill obs hrs and all outpt services.  This will be from the initial first point of contact. Yes, another issue to include in the contract language.**

In a recent free webinar with Compliance 360, the same question was asked for the 3rd year:  Who else besides the RAC have you seen an increase in audits and denials?  76% growth/Jan 2016    This is the new world of battle grounds...  and the provider community is not prepared, I am afraid. Documentation is still key, but knowing the rules/contracts is paramount!

(***TEASER ALERT:  In our fabulous Utilization review/Physician Advisor Boot camp/July, we have dedicated 1/2 day to the issues related to the new world of Mgd Care abuse.***

***We will have sites telling their anguish and what they did about it/action!  We will have attorneys helping with how to challenge the contracts!  The role of a PA in knowing the issues and how to do Peer to Peer... powerful!   Exciting but painful! We will also have all the Part C contact names/access, but your MAC should have it or your regional CMS office.  Don't suffer in silence.)***

**AHA's fight over RAC Backlogs gets new life from Appeals Court.**

**(Thanks, RAC SUMMIT folks and others for sharing.)**

The federal appeals court has revived a lawsuit brought by the AHA, which centers on the controversial Recovery Audit Contractor program. Due to the backlog in RAC appeals, OMHA announced a temporary 'suspension' of most new request for ALJ hearing concerning payment denials in Dec 2013.  In May 2014, AHA, Baxter Regional Medical Center in Ark, Knoxville,  TN based Covenant Health and Rutland (Vt.) Regional Medical Center filed suite concerning the backlog. They brought the matter to compel HHS to meet the statutory deadlines for ALJ reveiw of  Medicare claims denials.  The claims were dismissed in 2014, but the US Court of Appeals for the District of Columbia reversed the dismissal on Tues.  The appeals court remanded the case to the lower court and instructed the court to 'consider the problem as it stands now - worse, not better."   As of Feb 2015, the decisions ALJs were releasing had been pending on average 572 days.  The AHA Is pleased with the outcome of the appeal.  "Today's decision confirms that the agenda (HHS) has a clear duty to comply with the congressionally mandated deadlines...and it refutes attempts by the agency to excuse compliance because of the RAC program, noting that congressional mandates trump discretionary decisions, ' per Melinda Hatton,  AHA general counsel.  (<http://www.beckershospitalreview.com/finance/aha-s-fight-over-rac-backlog-gets-new-life-from-appeals-court.html>

TEASER ALERT:  **at the fabulous Boot camp, we are creating a cool MOCK ALJ hearing along with all the participants - MAC rep, attorney, internal denial mgt staff, 3 PAs.  Each will present what they do to prep and then actually have a hearing with a retired/ALJ by phone - real thing!.  WAY COOL!**

**WHAT to watch for:**

    UR/Physician Advisor Boot camp  (Endorsed by ACPA)- 4th national--SAVE THE DATE

    July 20-22nd

    San Antonio, TX

    Co-produced with RAC SUMMIT

    We are 'inches away' from posting the final agenda.  Both webpages -AR Systems, Inc and RAC SUMMIT - have registration information.

Key areas:  Pre -con on CDI; 2 day bootcamp with tons of interaction with faculty/experts in their areas; a **NEW POST BOOTCAMP** idea will also be offered... NEW NEW NEW

Focus areas:  regulatory updates, implementation ideas, better practice ideas, daily work flow, attacking the inpt status, Managed care anguish, unique case study discussions and DENIAL PREVENTION - internal processes with ACTION plans.  Unique to a bootcamp setting...

    Pricing for groups/more of a team approach; pricing for smaller hospitals.

    In room or live streaming/web.

    Join us ..anyway you can...as the interactive learning experience is fabulous!

    NEW:  Shortly we will be launching a 'free' outline of how to build an internal **PT FINANCIAL NAVIGATOR PROGRAM - ATTACKING THE HASSEL FACTOR**."

It goes beyond what a business office does - it speaks to all the patient concerns and confusion with navigating the healthcare system.  We can do better and we should!

It will lay out HOW TO DO IT--with very low costs--with reporting to the PT ENGAGEMENT folks... (As a physician recently told me - you are returning the ***soul*** of the organization.)

We are looking to partner with a hospital to grow/pilot this in Idaho...but regardless, it is so doable...with the knowledge of many fragmented pieces pulled together as the resource center for the pts...  Think about how you can do this!   Might need your site for a pilot!     YEAHOO!

(This will be free just as all the other training material on our webpage is...it is all about the education! )

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***Come and say hi!  The groups ask me to alert you to when I will be presenting.  Happy to**! \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

March 14th        Texas regional HFMA            Attacking the 2 MN rule; Top audit finding for Charge Capture and pt status -finding and keeping your revenue

March 16th        CT HFMA                             Attacking and top audit findings

April 7th            Ohio hospital group               Inpt vs obs -why is it so hard?

April 8th            KAPAM/Kansas                   Top audit findings

April 14th          Montana HFMA                     Attacking

April 21st          VHA audio                            Anguish with Mgd Care audits

April 28th           GA HFMA                            Top audit findings

April 29th          IL IMA                                   Attacking

Thanks, again, for the privilege to be a part of your professional life.  So many of you are willing to share your stories...as it always has and always will take a village!

Have a great one!