AR Systems, Inc.
"The Healthcare Navigator Company"

Education
Compliance
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February 2021 Infoline Newsletter

What's New

Welcome to Vaccination February! Happy healthy Feb! Yes, plenty of rollout anguish that is now being addressed thru baby-steps.
And then –Payer's Gone Wild! (Exciting new class) Yes, in addition to the Pandemic still raging thru the US, the payers are beginning audits, prior-authorization challenges and yes, Traditional/Original Medicare leads the parade with massive regulatory changes effective in Jan. Let's look at what is happening as we tackle the new year.

Perspective- COVID-19 Update

Public health emergency/PHE extended another 90 days/April. PHE has to be done every 90 days. CMS waivers are still effective during this period.
1 in 12 Americans have had COVID. (Dec it was 1-17.) 454,000 deaths and counting. "Long haulers' – recovered but have post-acute healthcare symptoms – 10-15% reported. (think healthcare costs, job impact) US accounts for 25% of all cases worldwide. USA represents 4% of the global population.
Stats: Testing fees range from $245/ARK to an average of $140.

Uninsured stats: 37% of 35-44 yr. old's lost health insurance In 2020. Total uninsured rose from 27.5M in 2017 to 30M in 2019 to approx. 40M at the end of 2020.
President Biden 's Executive order re-opened the Federal Exchanges/Marketplace between Feb 15-May 15th for special enrollment period. The state exchanges are encouraged to do the same.
Uncompensated care stats: $660B since 2000. 2017 $38.8B; 2018 $41.38B; 2019 $41.68B still waiting to hear for 2020.

Hospital's lost $20B with the pause in elective surgeries. Median hospital operating margins dropped 55% in 2020vs 2019. (Kaufman Hall)
1-4 rural hospital are vulnerable to closure.
Question: How transparent are the hospitals and practices in outlining the real costs and losses due to COVID in the past year? How easy is it to follow for the average American? How much outreach is being done to explain the real costs against charges against real payments? No , it is not that complex. There is considerable backlash about all the federal funds to hospitals and yet, the patient is still billed, collection efforts, etc. Re-think what true

consumerism is… Now is the time if there ever was one…

VACCINE ROLLOUT: As more Americans are being eligible to receive the vaccine, it is important to be very clear on 'charges to patient.'
Under the CARES ACT, there is no charge to the pt for the vaccine. Patients are being asked for their insurance cards. The cost of the administration of the vaccine is being charged to all insurances. The insurance companies are required to pay. "Providers are prohibited by agreement with the US Govt from billing patients for the vaccine or its administration, including balance billing.' CARES ACT
Don't forget to help all your uninsured patients to get assistance for COVID -related /primary dx under HRSA provision/file thru Optum.

Payor's Gone Wild

It is exciting to be offering this new class: Payer's Gone Wild-with all the never-ending payer updates and their operational impacts. Traditional Medicare leads the pack but you won't be bored by the other payers either. *Note: The new class is now posted on our webpage along with the multiple other free classes. If you need more information, please drop me a note. FUN!*

Traditional/Original Medicare
Audits are back! RACs are BACK! In Aug, 2020, CMS stated: "CMS expects to discontinue exercising enforcement of medical review audits – regardless of the status of the PHE." Any chance they could just say – we are going to begin enforcement audits again… RAC has many targets, not the least of which is total hip and total knee as inpt-especially 1 MN stays. Supplemental Medical Review Contractors/SMRC have multiple current and closed projects posted -including a finding of 25% error rate on spinal infusions. (Hint- anyone guessing why this procedure has now moved to a prior-authorization requirement? Crap!) MACS are doing targeted probes including the identified 5 procedures/outpt/prior authorization requirements/normally cosmetic. Better get your 'A game' going again-in case you were getting bored. Learn from the audit findings and turn it into pro-active education. (SC 300 bed : have had multiple knee and hip requests from the RAC. Ill 88 bed: have had cardio pulmonary denials and hip/knee requests from RAC.) www.cms.gov/research-statistics-data-and-system/monitoring-programs/medicare-ffs-compliance-programs/recoery-audit-program/approved-RAC-topics)

Phasing out the inpt-only surgical procedures by 2024 . Wow! This is a significant financial hit and one that each CFO should start assessing – payment as outpt, like procedure charge from the ASC when the procedures move to the ASC/11 in 2021 and working closely with the ortho surgeons/general surgeons and the internal team: UR for surgery/yes you definitely need one assigned, pre-op team, joint team and documentation revisions in handoffs from the office notes to the hospital's permanent record. Many 'missing' pieces today to support inpt. (Take a look at our class: "Inpt vs obs -why I love the 2MN rule PLUS total joint anguish.' CMS has a guide on what needs documented – a 2-step process: one to justify the procedure and a 2nd one to justify inpt. The 2MN expectation is needed with a plan to support inpt using the CMS guidelines as a toolkit. 1 MN stays will continue to be a focus of audit. Check out the PEPPE Report too.) In our joint audits, we continue to see

large segments of missing documentation to support 1 or 2 /above in the hospital record. Consider allowing the office note to become part of the record; the pre-op /joint clinic to include the CMS screening and always have the UR surgery team as the safety net – check for it all being present. Audits are here!

Physician documentation changes to office E&M. Biggest change since 1995/97. Approx. 60% of all practices are now owned/contracted with hospitals/health systems.
The EMR needed revised to a) reflect a place for ALL time to charted for ALL activity during the 24 hr day for ALL providers involved in the care of the pt 's visit /HUGE CHANGE and b) new medical decision making requirements.
This was part of the Patients over Paperwork directive. It is estimated to free up 2mins per visit. AUDIT RISK: take a look at your bell curve for 2020. Then watch carefully the bell curve as sampling is indicating that there could easily be an increase to 99204/99214 with no increase in documentation. Also, time is a great gift/option but who is completing the charge level? Not at the end of the face to face as there is still additional time potential – until midnight that day by any provider/mid-levels too. Which was used for each visit: time or MDM? Internal /concurrent auditing ideas: as we are addressing this, we are doing a comparison-type audit. 1)Validating against what was charted and billed. 2) Comparing against the 1995/97 – up, down or same? 3) Comparing what was used to level with the 2nd option. Which more adequately reflected the level of care done? (If you need help with this, let's chat. This class is on the webpage too. More darn fun!)

Big surprise with new E&M: The RVU was increased for the office-based providers and reduced for the proceduralists. Big hits and big wins! The conversion factor originally had a 10% reduction -as this entire process was BUDGET NEUTRAL /no new money – but by eliminating and postponing use of the new G codes, 'funds were found' and now the factor is closer to 7% reduction. And 2nd surprise: Do you own /contract with a provider and pay them based on RVU? What about payer contracts? Take a look at the information within the new E&M class -as it likely that the primary care providers will see an increase in their payment/based on RVU & CV WITH NO NEW VOLUME. Wow – not sure CMS/DC really understands the full impact -this is a big consideration!

Readmission penalties: CMS fined 2545 hospitals for high readmission rates. 83% of 3080 hospital evaluated. Likely have cuts in all Medicare payments ranging to 3%. Remember- CMS looks at the year for designated common dx, now adding hips and knees. CMS traditional guideline for combining into 1 account: same hospital, same day, same reason. It is not a 30 day rule for combining. The Medicare Advantage plans like to say – just like Medicare – when they require you to combine 2 admits in a 30 day period. Nope, and ensure your UR team knows this. Lots of misinformation on this one.

End of Surprise billing: We have discussed this multiple times over the past year but starting in Jan 2022, there will be guidelines for when a) the payer and the out-of-network provider within an in-network hospital have to arbitrate to resolve their payment and b) that the pt will not owe more than they would have if in-network. Time to get this well understood in your customer service dept. We will continue to provide insight as this is rolled out. Many changes like an "Advance EOB" -provider and payer. Never a dull moment! (Take a look at the 3-part series I wrote for the regional newspaper in the Patient Financial Navigator webpage under 'Healthcare Buzz. Always be the patient to better understand this!)

Prior Authorization requirements for payers/providers starting 1-1-23 . There is plenty of

dialogue around this one but with 14 hrs spent of each week in a provider's office/per AMA's 2018 survey completing prior authorizations – many times for ongoing med management – there is plenty of information to share. Biggest concern: it did not impact Medicare Advantage plans..and then variation if not all payers have to follow. Baby steps… anticipate more clarity.

Transparency is live! Hard to believe, but yes, the past administration went ahead with implementation with all legal requests to delay rejected. CMS has stated they are looking at random hospital webpages and seeing plenty of non-compliance. Be the patient and try to work thru 'the easy to access, easy to understand' price estimate section. Just tried to do it for my Dex Scan. Had to have the actual CPT to do it? Really, what patient knows the CPT? The order for my Dex scan/present in my individual record did not match any of the descriptors listed so I called. Have a ways to go to get to EASY TO IMPLEMENT. When tried to get allowable, had to call insurance as my insurance didn't list them? Said I had to have billed charges to get CPT allowable. Really, as that is not how that works either. I ended up going to 4 sources to try to get it and in the end, it was wrong for a single test. We are on the same journey for my husband's major shoulder outpt surgery. Just told us to meet the deductible. Nope, as there is a physician, anesthesiologist, rad interp, pre-op charges and other related charges too. Still plenty of work to be done. Will keep trying 'to be the patient' as I access other hospitals' webpage for complete charge/allowable/out of pocket $ based on real insurance validation. Baby steps.

Other Payer's Gone Wild

United has purchased ChangeHealthcare and thus now owns Interqual/McKesson is part of ChangeHealthcare. Yep, effective 5-1-21 moving to IQ, no longer using MCG. This will be highly interesting to watch as I would love to think they did this to better review clinical guidelines and appropriateness of inpt status. (It must be 2021!) United owns many hospital-support services by owning Optum.
United published that their 'site of service' determinations – looking at hospital last after ASC and imaging centers – has netted approx. 60% savings. (CFOs: is your pricing 100% comparable to these free-standing entities? Unfortunately we have more costs but to the patient – it is all about the money! And to the payer – it is all about the profit.)

United and Humana have now lifted suspensions for prior authorizations for inpt to in-network SNF referrals, effective 1-31-21. (Thanks ACPA leadership team!)

HOT OFF THE PRESS

United Healthcare- Huge
Effective July 1, 2021, diagnostic tests completed at a facility = free standing lab or hospital outpt= must be a Designated Diagnostic Provider /DDP provider. Providers have until Feb 28th to meet certainly quality and efficiency metrics to become a DDP. If the in-network provider is not a DDP, then the claim will be denied. Pts will have to pay out of pocket for testing even if in-network. Many surprise bills!

New payers in the game: Watch closely as many employers are doing their own employer-based clinics; starting their own MA plans and are taking the 'front door' of outpt revenue

from the hospital thru doing their own testing. Walmart, Walgreens, CVS, Disney, Amazon, Apple, Sam's club members, insurance plan employees & other large employers. Stated: Working with the complexity of the insurance plan and the provider community, much less cost and easier to manage hiring their own mid-levels and MDs. Watch for more large employers to do the same.

Amazon,JP Morgan, Berkshire's healthcare venture group – Haven – has dissolved. They will continue to be inventive on their own.

SITE OF SERVICE: pay close attention to this as it continues to result in outpt procedures done by another provider besides the hospital. EX) The doctor asks to have an MRI done at the hospital. Prior auth requested. Approved but with the site of service as the free standing imaging center. If it is still done at the hospital, it will be denied. Wow! Watch closely and communicate same to the pt.

Lastly-"Navigator" to assist patients with denials or claim rejection by the payers

When we think about denials, we realize that the provider community is really the only ones who know what the payer 'meant' and how to challenge it. Unfortunately, we may have lost the true consumerism aspect when providing internal navigators to help with downgrades, denials or other reductions in payment. Anyone ever had one of these? Which patient understands what it means when a payer says – 'this is not medically necessary?"

Real examples:
1) Pt had burns on his lower leg. Required special wraps for after care. After 1 month, insurance stopped paying stating no longer medically necessary. He was still getting debridement covered, but not the take home wrappings. He called – provider said have to call your insurance. No help. Pt called his insurance agent as she is who he bought the Medicare Advantage thru. She called insurance, said nothing to do but pay for it. He was angry and frustrated. WRONG! I reminded him that it was medically necessary for after-care but no insurance agent knows how to address this type of denial (or any denial, actually) – she was just trying to help. Who should have helped the patient? Impacts all aspects of his follow-up care.
2) Pt has a 'hanging' shoulder/very minimal rotation. Doctor orders MRI to see how much damage is done. Insurance denies authorization – not medically necessary. Pt said – what now? Provider office said to talk to hospital and imaging centers to see what they could do - about pricing without insurance. Free standing imaging said – without insurance- about ½ price. Hospital/no discount. No one offered to help with the appeal to the insurance. Finally pt called and said – how will the doctor know what is wrong, surgery, etc. without the MRI? Then the big question – what if it is paid for privately, but a surgery is then needed. No, the insurance will not pay as it was not deemed medically necessary to begin with. What patient can possibly navigate thru this? Where are the true healthcare Advocates to assist the patient? Can't work, consistent pain – what next?

Let's look at true consumerism -which is way beyond setting up cool webpages – as this is a normal occurrence with major impacts to the patients. Always excited to hear how your organization is providing the other arm: Great patient care and EXCEPTIONAL financial

navigator services..

Dynamic Educational Opportunities

I WOULD LOVE TO HAVE YOU JOIN ME FOR SOME COOL UPCOMING VIRTUAL EVENTS:

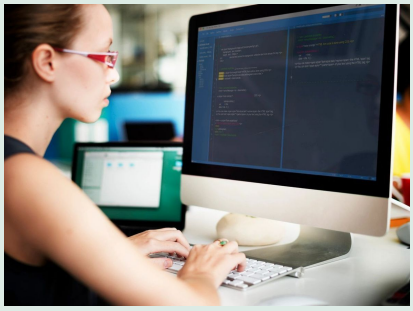
Feb 11th Round- up – Western State HFMA event Payer's Gone Wild

Feb 18th OK HFMA Payer's Gone Wild

March 19th AL AHIMA Understanding the Revenue Cycle PLUS Impacts of the new physician E&M coding change

Remote Coding Options

Do you need help with "Just in time remote coding'"—maybe one patient type, maybe maternity coverage, maybe employee dealing with medical issues, maybe vacation coverage- or a longer/more permanent partnership with no minimums and 24/48 hr guarantee turnaround with ready to code accounts? Here anytime you need us-large or small hospitals and employed providers… Love it!



VIRTUAL LEARNING LIBRARY

NEW NEW NEW – ARS Is thrilled to announce an enhanced educational opportunity – Interactive Virtual Training has arrived! In addition to the no-cost powerpt classes, ARS can create a site-specific learning experience that includes subject experts in many diverse topics. For more details look at the new webpage section: Virtual Learning Library. Drop me a note and let's get connected.

While you are on the webpage, take a look at the multiple services we are excited to offer -which includes specific ones for Critical Access hospitals. From coding and documentation integrity audits with up to 2 hrs of education with the telephonic presentation of findings, to remote coding /all size facilities/no volume limit/24-48 hr guarantee to diverse general site-specific education – We are here! With over 200 years of combined experience from our auditing and training teams –we have you covered. Drop me a note and we can chat.

Final Thoughts

Happy healthy 2021 to you all!
Stay safe, lead by example and we will get thru this very very difficult time. (If you have

been impacted by COVID -19 infection or death, please know my prayers are with you. Our family all wear masks all the time. We have lost 1 family member (including his mother/hospitalized/unable to be with her son at all and father) and 1 close friend. Plus due to working outside the home – 1 high risk adult child & her spouse. Her daughter working in LTC= all in Idaho/one of the highest positivity rates and one of the lowest in getting the vaccination 'in the arm.' A daughter in NY had all the symptoms but did not rule positive - working remotely but son came home from college, even though he worked to be compliant too. Many extended family members with my son-in-law's family who do not wear masks/multiple hospitalized. The new strain is highly contagious so please remember -it is a silly little mask. This will end…if we can change the pronoun from 'I' to 'We! Best to you all, always!

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Kind regards,

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