January 2015 Infoline

HI and HAPPY 2015!  Hard to believe it is already here!  We have lots going on so let's get started.

**NEW AUDITS - RACs are BACK thru Dec 2015  (and beyond...lol)**

**Note:  HHS released the new fee for service error rate:  10.1% 2013 - rose to 11.8% 2014- end of Nov**

As the industry 'beefs up their game' to prepare for more audits, a couple hot topics are appearing on the 'new issue' list.  BUT still no 2 MN pt status audits.

**Wastage**

Last month - shared the need to ensure compliance with the a) documentation of WASTAGE for all single dose vials so the entire vial can be charged and b) the inability to bill for ANY wastage with a multi dose vial.

HINT:  Many areas are impacted - RT, Pharmacy, Nursing, Imaging, anesthesia.  All have to follow the same rules.  Also, Pyxsus or another like vendor - nursing charts the wastage into this stand alone system. Is it part of the documentation of the permanent, legal record?  We have yet to find one that it is.  UGUUG

HINT:  Create 1 location/use an unused field in the EMR. Label it:  Wastage -with ALL impacted areas charting the SINGLE DOSE VIAL wastage to this location.  Otherwise, only the actual ordered amt of the drug can be billed.

(NOTE: In our charge chart audits, we continue to see this as a #1 audit variance.  The OIG has audited wastage, now the RACs have it... Very fixable.)

**KX modifier**

KX modifier impacts the rehab outpt dept.  There is a $ cap for Medicare pts. Once that cap is exceeded, the KX modifer becomes an issue.  The doctor has continued to order medically appropriate care but now risk has began.  It is the 'functional limitations ' that are still not met- Kx modifier is telling Medicare same.

HINT: The rehab staff need to carefully and completely chart the -why still skilled care?  What functional limitations are still present that keeps the pt from being discharged?  Why can't they do the rehab 'at home' vs skilled with the therapist?  Many do not chart this - they simply continue charting the time elements and the care - but not this additional element.  This element has been educated on by the MAC , but probably not as clear as was needed.   Easy to add this additional element to the existing pt care documentation.

**General issues** - remember that the RACs CAN audit '**appropriateness**" of the service...  like Cataract is medically necessary.... keep watching their new issues list.

**NEW RECOVERY AUDIT PROGRAM IMPROVEMENTS- WOW!**

Go to <http://www.cms.gov/rearch-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-porograms/recovery-audit-program/downloads/RAC-program-improvement.pdf>

It outlines the 20 improvements with the RAC program.

    Some big ones:  Only allow a 6 mon lookback for pt status audits if the hospital got the claim in within 3 months of DOS. (Think MAC can still audit during the re-opening period/4 years)

                             Only have 30 days to complete the complex reviews   (Both allow for the 1 yr rebill period to occur)

                             RAC must maintain a 95% accuracy rate  (The indept RAC Validation contractor 's recent report:  Connelly 92.8%  (who had won the Region 5  DME/Home Health/Hospice but is now on hold due to Proformant's challenge)   HDI  97%     CGI   96.8%     Performant  99.1%      (Don't have to agree but these are the % that are given to Congress , CMS, etc.)

**Focused Probes by MACS**

3 areas to include:

    1) Probe and Educate findings.   RAC SUMMIT  WPS and Novitas shared their error rate from the 1st and 2nd round P&E/as of Nov 2014 PLUS the highest areas of variance.

(***To see the full report, it is part of the updated Probe and Educate class on my webpage***.)
    Highlights:     WPS's audit sample    26-27% audit variance in 0 and 1 MN stays             Novitas    55-57% audit variance in 0 and 1 MN stays

    Highest reason for both:  Documentation did not support 2 MN expectation.  Reason for admission that will take 2 MN.

    HINT:  Build in 'ques' for each inpt order.  Why does this dx for this pt need 2 MN  (or an additional MN after the 1st outpt MN) - what is the PLAN for the 2 MN stay?

Then if they recover faster/respond to treatment better than anticipated - absolutely include that in the discharge note.

    2)  CCS/MAC specific:  Cataract/highest volume of outpt surgeries

They have a Local Coverage determination which essentially outlines what 'medical necessity looks like for cataract surgeries.'  It must be documented by the surgeon prior to the surgery so the hospital and the surgeon have clarity on the WHY medically necessary..  If all the elements are NOT met by the pt, then the surgery is not done.  THIS IS CALLED PRE-CERTIFICATION by hospitals.   UR must work closely with surgery scheduling to ensure/validate this is present every time PRIOR to surgery.  They probed:  Kentucky   85.6% error rate    Ohio   88.7% error rate        It is not optional...

    HINT:  Why do you care?  Where one MAC goeth, others followeth.  (Required elements:maturity of the cataract disease process, visual acuity, and ability to perform activities of daily living.)

    3)  NGS/MAC specific:  3 MN stay (leading to a SNF or swing bed referral)

Recent letter to the NGS hospitals indicated a marked increase in 3 MN and thus a need for a probe.  Another MAC/Noridian has done this type of audit previously

    HINT:  Documentation as to 'why still an inpt receiving clinically appropriate care for all 3 MN" is HUGE.  The documentation tends to move away from clinically appropriate to 'preparing to transfer.'  Although discharge planning documentation is very important, it is not the reason the pt needs a 3rd MN in a hospital.  WOW!   AUDIT daily to ensure CLINICALLY appropriate for all 3 MNs.  Our historic audits indicated a 60% audit variance on the 3rd MN...  All fixable.

**HUGE INCREASE IN MEDICARE MGT CARE DENIALS  (and yes, all payers are auditing. Recent Jan 2015 webinar with Compliance 360 - Biggeset growth in Audits?  67% in commerical payer audits/denials.... WOW!  Time to improve the pt story...)**

Golden rule - Part C/Mgd care does not have to follow any Part A/Traditional Medicare rules

Many hospitals are reporting massive 'hits' with lots of interruptions for 'what consititues an inpt.'

Some hints:

    1) treat all Part C as though they are a COMMERCIAL Payer. Call for pre-certifcation.  Discuss criteria they are using for inpt decisions.  Dispute if they are not 'honoring the pt order.'

    2) immediately work with contracting on getting the clarification of 'inpt' into the contract.

    3) it is extremely hard to 'win ' with the plans -as they DO NOT HAVE TO FOLLOW Part A.  What does your contract say about determining inpt?  It must be very clear.  (Though you appeal thru regular Medicare processs when disputing a denial.)

    4) Track and trend losses or delays in payment or blantant abuse.  Business office and UR - present to the CFO and contracting... without data, hard to effect change.

EX) United -letter said we will be using clinical guidelines AND 2 MN.  Hospitals will never win!  (Later 'clarified'??  Really?)

Humana , Aetna -others?

EX)   Hospital sent me a note on Condition code 44 for Part C.  \*Unless it says CC rules must be followed - there is no such thing for Part C/Medicare. CC 44 is a Part A rule.

**\*\*\*\*\*\*HEY SAVE THE DATE\*\*\*\* our 3rd annual Physician Advisor and UR boot camp\*\*\*July 22-24, 2015**

**We are thrilled to co-produce this operational focused dynamic bootcamp with the RAC SUMMIT.**

Watch for the full details next month but for now - save the date.  We will be in San Antonio having 2 pre conferencess (one for UR, one for PAs) plus 2 days of operational focused sessions - taking us thru the steps of an internal PA program and the first point of contact with UR.  Case studies, networking breakfasts, lunches and dinner.  Faculty who are committed to ensuring your success.   LOVE IT!

PS We will also be broadcasting the conference via internet feed  ...just like being with us...

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**ICD-10 Readiness - it is all about 'awareness ' training, payer interaction, and tons of provider office interraction**

As we prepare for the Oct 2015 go live (still on, but still push back from the physician industry)- don't forget to have a positive, can do message ...

The hospital is doing the mass majority of the training of the provider community -and as it is being done - focus on the 'enhanced pt story.'

Additionally, go to our webpage and pull down another one of our FREE classes - "ICD-10 Impacts everything in the revenue cycle - think beyond HIM."

\*It walks thru the payer impact, how to engage the office staff more, how to win internally with dynamic roll out plans.

As we continue the site-specific boot camps, we are looking for the 'awareness' of all the dept heads (as every areas with medical necessity edits will be impacted) , admitting, pre-certs, contracting, PFS, denials prevention, UR, and other areas=- Including HIM...all necessary for a transparent transition.

***HINT: For remote coding support- let me know as we are contracting to do 'just in time coding' or coverage coding or practice for the coder coding - all at the same price as the ICD 9 historical coding. No price increase for ICD 10 ....  Audits include 'ICD -10 readiness' for all hospital and coding validation audits.  A bit of value added for our great hospitals and employed/contracted providers.***

***Let me know and we can chat... but don't wait too long.***

\*\*\*\*\*Come and say HI at these groups where I will be presenting. They ask me to let you know.. happy to! \*\*\*\*\*\*\*\*\*\*\*

Jan 27th            LA HFMA                ICD -10 Changes Everything in the Revenue Cycle

Jan 29th            Tri-State HFMA        Attacking the 2 MN rule - Plus Probe and educate findings/lessons learned

Feb 3                CO HFMA                Webinar: ICD 10 Changes Everything

Feb 12th            So Ill HFMA            Optimizing Charge Capture to find lost charges  PLUS  ICD -10 changes

Feb 19th            Joint Ohio Mtg         ICD -10 changes

Mar 12-13th        CO HFMA               2 day -  Mini Medicare Boot camp - 4 reimbursement classes taught

March 19th         AAHAM TX             Mini-Medicare boot camp - 3 classes taught

March 26th         SD HFMA               Still finalizing

March 27th         NEB HFMA             Optiming CDM to find lost charges

April 10th            ILL AHIMA              Attacking the 2 MN rule;  ICD -10 changes everything

April 16th            SD AAPC                Attacking the 2 MN rule; ICD -10 changes everything

April 23rd            OK HFMA               Still finalizing

HAVE A GREAT ONE!   Keep smiling...and yep, it is ok to 'kick something' some days!  HA