June 2015 Infoline

HI and happy 4th of July. Hard to believe that June is over!  DARN!

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*Still time to register for the very fun Physician Advisor and UR Boot Camp in San Antonio\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

2 Pre-cons; 2 day boot camp where we learn from extremely talented faculty.. networking breakfasts, lunches and dinners... Case studies plus 100% operational focused.

PLUS payer input on the probe and educate findings...  Don't miss the interaction with the faculty (17 talented folks) while we learn how to create a dynamic, powerful internal network and better practice ideas for PA and UR.

DATE:    July 22-24th

PLACE:  San Antonio, TX

Go to our website or the RAC SUMMIT as we are co-producing it with this create team.

Onsite or live streaming are options.  Would love to 'see ' you there.  HAPPY TIMES

PS Some of the fun faculty are all about re-enacting the Alamo..which is right across the street!  HA    We do have fun while we work hard!

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**Med-PAC's Recommendations to Report to Congress, FACT SHEET, June 2015**

Be sure to read this report, especially page 1& 2.

WOW!  Highlights:  SHORT STAY POLICY ISSUES

1)  Withdraw the 2 MN rule  (And replace it with??>???? Nothing was recommended which leads us back to the 'judgement of the physician' which is where the RACs first came from.)

2)  Focus on short stay inpt stays with the highest rates with a penalty for excess rates of short inpts. 1 day inpt stays account for 13% of total inpts in 2012  --(Before the 2 MN rule. GADS High areas for audit as we are back to -  why was the hospitalization even necessary at all?)

3)  Look back for RAC to coincide with Medicare rebilling rule -1 year and contigency fees tied to denial rate.

4)  Part B/Self adm meds to be packaged during outpt obs -but budget neutral = meaning no new payment but not pt responsibility either.

5) Count 2 MNs in obs toward 3 inpt day for SNF. (If we have 2 MN in obs, we should have converted to inpt prior to the 2 nd MN and have an inpt anyway!! )

Missing this time - no recommendation to create a new short stay DRG program.  But if we eliminate the 2 MN provision - and a heavy focus on 1 MN stays = how are we not going to have massive audits?  Be careful what you ask for!  Stay tuned

**Discharge clarified:**

Thanks to Dr Salvatore, DE, CMS has replied to his question and he shared it on RAC RELIEF:

    Discharge is defined at 42 CFT 412.3 (a) as 'formally released.'  Formal release is defined by CMS survey and Certification Group as 'when the physician's order for discharge is effectuated."

    So essentially this is not when the order was written   and not when the pt actually left the hospital, but when the RN effectuates the discharge by doing the discharge instructions, etc.

This has been used in billable OBS hrs but also for inpt/condition code 44.

**Lost Inpts: Still struggling**

Still many lost inpts with hospitals struggling to let go of the old language - 'doesn't meet Interqual or Milliman."   This is not the definition of an inpt for Medicare pts - never has been, never will be.  Also, the biggest lost revenue continues to be - never, ever, ever, ever -leave a pt in an OBS status a 2nd MN if they need 'in hospital' care.  Thanks to Dr Hirsch /Accretive for sharing with us a reminder from the Final Rule, pg 50946:

    "The decision to admit becomes easier as the time approaches the 2nd MN, and beneficiaries in necessary hospitalizations should not pass a 2nd MN prior to the admission order being written.  "  IPPS Final Rule 50946

CONVERT, CONVERT, CONVERT, CONVERT if a 2nd Medically appropriate 'in hospital ' MN is needed...regardless of Interqual or Milliman. The provider clarifies why a 2nd MN....then inpt.

Another lost inpt:  Transfer ins.  If the pt had the 1st MN in the initial facility in ANY outpt setting, count the MN toward the 2 MNs in the receiving hospital and bill as an inpt benchmark. Use the 72 occurrence code span date of the initial hospital visit/outpt date.

**ICD -10 Payer Testing/Issues**

Hey as we continue to prepare for ICD -10, here are some pearls for payer issues:

    1) Will they accept BOTH ICD-9 and ICD -10 claims POST go live?  If so, how long?  (Watch for Medicaid as the hot potatoe!  Need at least the look back period..EX: Idaho = 3 months)

Ensure all contracts have language that requires both to be accepted.  Try for 1 yr to submit both.

    2)  Why 1 year?  To allow for correct primary payer to be resolved ..always 1st. This takes time

    3)  Test EACH PATIENT type. There will likely be new PAYER edits as we send thru much more specific dx codes.  (Emphasis - ER and inpt surgery!  Big hits!)

Watch them thru the edits and the return to providers/RTPs.  We may have coders working hard and yet we can't get them out of the business office due to payer edits.

\*\*\*\*\*\*\*\*\*\*\*\*\*\***HEY COME AND SAY HI OR JOIN US ON A WEBINAR** \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

The groups ask me to let you know. Happy to!

July 13-14th        WA CAH webinars        ICD 10 changes everything;  Top at risk items identified in audit:  Charge capture and Pt status (NEW CLASS)

July 15th            Texas Hospital Assoc    ICD 10 changes everything in the revenue cycle

July 22-24th        BOOT CAMP

July 27-29th        Idaho Rural Network      3 locations - training on Pt status and UR better practice concepts

Aug 10th            Compliance 360            FREE webinar - Pt status updates/audit findings./lessons learned

Aug 11th            Hospital assoc of PA     Attacking the 2 MN rule - finding your lost inpts.

Aug 20th            Idaho HFMA                  ICD-10 changes everything

Sept 14th           NTT conference             TBD

Sept 18th           Utah HFMA                   TBD

Sept 25th           VHA                             TBD

THANKS for always sharing... it does take a village....

PLUS be thinking of ways to pay it forward in this excellent healthcare world we all have the privilege to work in... little things do matter!