June 2018 Infoline #2

**\*\*\*\*\*\*\*\*SUPER EXCITING NEWS!   The 6th National Physician Advisor and Utilization Review Boot Camp is only 5 weeks away. WOW!     2nd EARLY BIRD DISCOUNTING EXPIRES ON June 22nd!   HURRY!**

**We are partnering with the RAC Summit team again this year to bring this 'get it done' focused boot camp. \*\*\*\*\***

**We are the only conference group that offers LIVE streaming directly to you as an option to the onsite.  Super cheap as we have not raised our rates in 6 years.**

**Check out this way cool agenda - and don't miss out on the Early Bird Discount.**

        Pre-Con:   **"What does disruption in healthcare look like?"** From patients, to physicians, to payers to new delivery system potential to national focus...  including many unique changes to adapt to the constantly changing environment.

        Main:       ' **Attacking Payer Denials - Chapter 2.  Lessons learned and strategies for su**cess."   Fabulous faculty will include operational focus by PAs and UR team leaders; payer input regarding new dialogue and hot at risk issues; Total Knees will take center stage with education and case study luncheon discussion; with regulatory updates, payer denial stories and how to be successful internally and with the payers.  Non-Contracted Rules with Medicare Advantage plans Plus National update on Part C plans - more hot topics.  WOW!  Did I mention tons of opportunities to network with the faculty?   Can't wait to see you all there-in person or on the web!

WHEN:        Weds-Fri, July 25-27th

WHERE:      Hyatt Regency Los Angeles International

PLUS:          Live streaming/like being with us; group pricing; early bird discounts, CME credits.

to get the full agenda and to register:   <https://racsummit.com>    or    our website.             **REMEMBER 2nd EARLY BIRD DISCOUNT ENDS June 22nd.   LIVE WEBSTREAMING  OR  ONSITE..  GROUP DISCOUNTS.**

**HEY JOIN FINALLY FRI, June 22nd with John Montaine and Ernie de los Santos' team as they tackle how to make the payer contracts work ...more win /win vs lose/lose.**

**John will share more strategies at the Boot Camp but go to** [**https://mailchi.mp/appealacademy.com/registration-for-finally-friday-live**](https://mailchi.mp/appealacademy.com/registration-for-finally-friday-live)**to join them for this cool session.**

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**Updates:**

**Total Knee Ideas: as of Jan 1, 2018 - CPT 27447/APC grouper 5115- removed from the inpt only list.**

As we all continue to deal with the somewhat conflicting CMS guidance, there are two pieces of helpful directives when creating documentation 'template' ideas.

By building 'always' templates for the Ortho surgeon and the primary care provider to use - it will provide much more consistent documentation to support - why an inpt?

1st:  Need to have documentation to support the medically necessity of even having the knee surgery.  Look to:  "CMS Releases Major Joint Replacement Booklet"   Medicare Learning Network ICN 909065 May 2017."   Elements to include in support of the medically necessity of surgery, at all... are included.  Great check off sheet when ordering and UR validating the documentation is present.   RACS can still audit this.

2nd:  Then move to the question - inpt vs outpt.  Med Learn Matters SE1236 has some great check list/template areas that need to be present when supporting - why an inpt and look to the 2 MN presumption when ordering/ scheduling as an inpt.  Special focus on 'patient risk, procedure risk, intent for treatment."  All will greatly support the rationale for inpt.

3rd:  In recent total knee audits, some interesting outpt total knees were present.  Things to assess when determining - safe to do as an outpt with extended recovery/no unplanned event.

2nd knees:  younger pt/all three were under 70; already had the 1st knee replacement with the 2nd knee scheduled; had the home set up done, had a caregiver ready, had already had outpt rehab or Home health with the first knee/good experience, had no medical factors that could impact their recovery.  ALL HUGE FACTORS with determining at the point of scheduling:  outpt.

4th:  Then if the outpt DOES have an unplanned event, look to the 2 MN benchmark determination - and explore converting to inpt 'as the 2nd MN approaches."

**REMEMBER -**this is for Traditional Medicare.  Watch as the other Medicare Advantage plans/many are already only authorizing outpt and commerical plans - ALL DONE AS OUTPT.

The fight is on to get an inpt - but remember - the rationale behind 'why an inpt for Traditional Medicare ' can and should be used for other payers.

**UPDATES/HEALTH CARE BUZZ - a ton to report to hang on**

1) "DOJ won't defend ACA, argues individual mandate is unconstitutional."  June 8, 2018

Hidden in this is an alarming addition: "A group of GOP -led states filed a federal lawsuit in Feb claiming the ACA's individual mandate is now unconstitutional because the tax penalty the Supreme Court upheld is no longer in effect.  They also argue the ACA provisions guaranteeing coverage to people with PRE-EXISTING conditions can't be separated from the mandate and should be invalidated."  (WOW!  It never ends...   Still amazes me that we mandate/fine drivers without liability insurance but our bodies are not as important as our cars...  Pre-existing conditions had no protection for coverage prior to 2010.   What group would want to allow restrictions to Pre-existing coverage? Never underestimate the power of lobbying groups.)

Morsels:  24% of adults said their healthcare was harder to afford over the past year.  (Commonwealth fund, May 10, 2018)

46% said they would not have the money to cover an unexpected $1000 medical bill.

              4M Americans lost health coverage from 2016-18.  The uninsured rate among working age people is 15.5%, up from 12.7% in 2016.

              1 in 5 adults living in the South are uninsured, up from 16% in 2016.

              5% of adults plan to drop coverage because of the individual mandate repeal.

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"Payers propose hefty ACA exchange premium hikes."   Healthcare Dive   May 9, 2018

2)  "The Veterans Affair's Mission Act will provider over $50B in federal investments to privatize a portion of the VA's healthcare system and improve historical inefficiencies." June 7, 2018

Pres Trump signed the Act to set up a Veterans's Community Care Program that provides new standards for delivering veterans's care and allows the VA secretary to furnish care for veterans out-of-network and eliminate administrative burdens & adds IT services for Veterans.   The VA Mission Act could face a gridlock as lawmakers are expected to contend on the best way to finance the law. "

3)  "New Medicare Advantage rules hold big potential for population health"  Healthcare Dive  June 13, 2018

"Improving health outcomes using population health management has raised visability around nonmedical conditions that impact health outcomes.  Payers will now be able to work with companies like Uber and Lyft to provide transportation, for example, as part of a more complete set of benefits for the quickly growing MA population.  CMS issued a final rule in May giving MA plans more flexibility in determining the types of SUPPLEMENTAL benefits they can offer chronically ill enrollees, including non-medical benefits. The new policy, part of the broad 2019 Medicare payment rule, means plans like UnitedHealthcare and Humana aren't harnessed to a set of supplemental benefits, but can tailor them to the specific needs of individuals."    (Anticipate 40% of Medicare pts to be on MA plans by 2020. If 40% of the Medicare population can get all these supplemental benefits, why can't 100% of Medicare beneficaries and move all to these packages?  Still can't get anyone to answer that except - we can't afford it??? What?  See below for BONUSES)

NOTE:  MA plans are paid a per-member, per-month fee to manage the patient's healthcare.  They are paid more when the pt is sicker.  There is a great incentive to offer supplemental benefits - home meals, healthclub memberships, home visits, air conditioners for people with asthma, home renovations to prevent falls, and other like items.  Keep the patient healthy and out of healthcare providers.    PLUS THE MA PLANS ARE PAID YEARLY BONUSES for their Star Rating.  The Rating is done thru communication with their enrollees who rate the service. KEY = Care Coordinators assigned to the enrollee.  Weekly calls with chronics conditions, networking to prevent further healthcare issues, etc.  5 star is the highest rating.  Check out the plans you work with to see the 'ratings.'   Huge amts of funds to pay the bonuses - came from the ACA.   (Did I say something about lobbying groups?)

OIG :  Inappropriate Denial of Services and Payment in Medicare Advantage"  June 2018

"Capitated payment models are based on payment per person rather than payment per service provided.  A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, healthcare services in an attempt to increase profits for managed care plans.  We will conduct medical record reviews to determine the extent to which beneficaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, we will determine the reasons for any inappropriate denials and the type of services involved."   Report  # OEI-09-18-00260.  Expected issue date:  2020    <https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000299.asp>   (Thanks to Nina  Youngstrom, Report on Medicare Compliance.)

(Why aren't the complaints from the providers included in the star ratings?'  Let's be proactive...  and ALWAYS file complaints with CMS on all excessive denials, delays or inappropriate use of coverage criteria...and if you are not contracted, the MA cannot force you to use their criteria or accept their rates.  We discuss all this and more at the Boot camp.  File compliants - use our webpage to find the Payer-specific CMS contact for filing excellent examples of abuse.  SQUEEK!)

**ABUSE:  6 hospital health system in upstate NY.  Had a payer/MA PLAN send a 1200 record request for 'Risk Validation Audit."   3 months later sent a 2nd request for 400 records. Same reason.**

**What the heck?   Risk Validation audit - it says they are required to do this by CMS. WHAT IS THIS?  A DRG coding validation audit based on what?  And without results, a 2nd request.  Or possibly a way to 'data mine more dx codes to increase their payment from CMS?"**

**CHALLENGE THE PAYER:  First always look to the contract.  Second - demand to see what they are looking for and why.  Third  - no and heck no.**

**FINDINGS:  When discussed with contracting, there is a provision that allows for 10 records per site per request.  So a total of 60 records; not 1200.  SURPRISE!  When we discuss the ABSOLUTE need for the denial team/PA team/UR team to know what is in the contract - this is a huge example of why.  INSANE this is allowed. Hospitals fight back.**

**TURN THIS PAYER INTO CMS ASAP!!!!**

**Another morsel - Here is the statement from the Medicare Managed Care Manual, Chapter 4, Section 10.16, Medical Necessity:**

    "If the plan approved the furnishing of a service thru an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity."

(Thanks, Dr Baker - one of the dynamic faculty at the boot camp..and shared thru RAC Relief.)

**Lots more on MA abuse next month and at the Boot camp....**

4) "Trustees warn Medicare Finances are Worsening..."   "Social Security/SS combined trust fund reserves depletion"  June 2018

Annual Trustee report: "The report from program trustees says Medicare will become insolvent in 2026...three years earlier than previously forecast. Its giant trust fund for inpatient care (Part A) won't be able to cover projected medical bills starting at that point.  (Think baby boomers - by 2030ish -25% of the population will be 65 or over!! WOW.  Are there enough current workers to contribute to the Trust Fund to pay SS and Medicare Part A?)  "The report says Social Security will become insolvent in 2034 -no change from previous year's projection.  More than 62M retires, disabled workers, spouses and surviving children receive SS benefits. The average monthly payment is $1294. Anticipate 75% of SS $.   In principle, the US is supposed to be paying forward its Social Security/SS and Medicare obligations by building up trust funds to cover future costs.  That money is invested....but when the money is actually needed to pay benefits, economists say a government so deep in debt could be hard pressed to make good. "  (Part B is ok as premiums are paid.  Part A does not have monthly premiums; it is based on worked quarters.)

5)  "Value -Based Care Generates  Medical Cost Savings of 5.6%"  Change Healthcare, June 18, 2018

Change Healthcare recently released a study on healthcare industry's transition to value-based care.  (**NOTE:  WHO KNOWS WHAT VALUE BASED CARE ACTUALLY MEANS**?  When asked, many providers relate to the payer determining what is appropriate for the pt= therefore, value based is payer/insurance driven??   Check out our "Disruption means? ' class as there is a ton of excellent info from a recent AMA survery:  14 hrs a week for doctors to do all the payer required prior-authorizations.  Is this VALUE?  Time to question what words mean...and how it is judged as the 'answer to driving down the cost of healthcare.  Another scary one:  Outcome based payment systems!  Again, Insurance payers making those decisions??  WOW!)

    Value-based care strategies generated medical cost savings of 5.6% on average

    Nearly 80% of payers reported improvements in care quality after the transition

    Pure fee-for-service currently accounts for 37.2% of reimbursement

    21% of payers are capable of rolling out a new episode of care program in 3-6 months.

**GUEST AUTHOR-   Angie Martin, Sr Manager, Great Plains Health Alliance/CBO, Wichita, KS- CMS CHANGES IMPACT DRUG ADMINSTRATION**

CMS implemented changes to NCCI edits for ***non-OPPS*** providers on April 1, 2018.  The edits involved ADD-ON procedures where a specific HCPCS/CPT is always perforrmed with primary service, on the same day.  ***This caused denials for drug administration sercies when the encounter spanned past midnight.*** The remittance will show a claim adjustment reason code of B15 for the denied line.

Hospitals report drug administration services as a 'per encounter' service.  This means that only one initial service (96365, 96374,or 96360) can be reported for the encounter unless there were two separate sites.  If a subsequent coder or additional hrs CPT codes such as 96366 is reported on date of service that is not the same as the initial service, the line item charge for 96366 is denied.  **CMS has discussed this with the NCCI committe and they will be changing these edits back to 'per claim' edits but the fix will not be implemented until Oct.**

CMS is encouraging your to work with your MAC until the fix is installed.  One of the problems is that it is unclear if ALL of the MACs have been notified.  The MAC can bypass the edit and process/reprocess the service.

Link to transmittal:  Subject - NCCI Add-on Codes for non -OPPS providers effective 4-1-18.  [*https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2018downloads/R20440TN.pdf*](https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2018downloads/R20440TN.pdf).    (Thanks a ton, Angie, for sharing.   GADS!)

\*\*\*\*\*\*\*Hey, do you need help with **remote coding**? Just in time coding?   All patient types.  All size hospitals and providers.  No minimums.  Guaranteed 24-48 hr turn around.  Cost per chart for ease in budgeting

**Happy to connect and share more about our flexible remote coding services...\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Have a great one!  Love sharing with you and learning from each of you.  Happy Summer!  Hope to see you all in July at the Dynamic Boot Camp in LA  or via live webstreaming.**

PS  Historical Info Line are always on our web page...plus powerpt classes.... plus articles..... plus Pearls.

All free... Enjoy!

**Last thought for the day:  Lean into the next grand adventure of your life...today!  YES!**