May 2016 Infoline

Hi and happy almost Mother's Day!   Enjoy the special weekend...

YES**- the 4th National Physician Advisor and UR Boot Camp is ready for registration.**  Early bird registration ends soon so don't delay.

We would love to see you in person or via live webstreaming..either way you get to "see" your super, dynamic faculty.  Happy faces while we share better practices thru the daily journey of a PA and UR.

GOAL:    Get it right the first time!   From daily operations to hot spots for UR to learning from case studies to ALJ mock hearing and finally, tons on attacking the Mgd Care denial problem.

When:    July 20-22, 2016

Where:   San Antonio, Texas

Look at the RAC Summit webpage/co- produced with this great team... or go to our webpage under bootcamp.  ([www.arsystemsdayegusquiza.com](http://www.arsystemsdayegusquiza.com))

**BONUS:**  We have developed a very exciting formal **PA Onsite Training program**.  Learn more about it on our webpage or thru the registration for the boot camp.  Discounts apply.

Hands on, formal education with networking and support after the onsite.  Yep, I will be there too!  A great tag team!

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**Lessons learned**

**Many great facilities are sharing their lessons learned from different audits.  Here are some highlights as we learn together.  It takes a village!**

1) CGS/MAC's posted an ER focused probe: B000172015  (Thanks, Karen R/Ohio)

This issue targets ER services for triaged patients who were not seen by a qualified health practitioner extender.  The facility is not entitled to ER services payment for these patients as these services were not provided incident to a physician's service. (No ER doc, no ER facility = appears to be how they will data mine for these.)   2/2/16

2)  KEPRO QIO findings are starting to come back.  Some similar 'findings' as earlier reported from Lavanta.

(Thanks, Gail/IA)  KEPRO selected 10 cases from May-June 2015.  No Occurrence span code 72 was on any (they have started using it now.)  4 cases did not meet IQ; 6 did meet.

(Although we know there has been 'interesting dialogue' from the QIOs about clinical guidelines even though CMS has stated repeatedly that it is not a determining factor when determining inpt.)  Very surprised to have all approved. Areas for improvement:  The why for 2  MN was to be in all the H&Ps/some did, others did not as it was not a required /hard stop field.

One of the cases did include a note why the pt was being discharged earlier than anticipated. 1 case was an inpt only and should not have been included.   ( NOTE:  They were surprised because they had some pretty high denial rates with the RAC.)

Another KEPRO note:  "They appear to be struggling with understanding the 2 MN benchmark. Some of the comments said the pt did not have 2 MN as an inpt; but the record clearly showed the 1st outpt MN and a rationale for the 2nd MN.  We hope to help educate them and get these overturned."

THOUGHT:  We have heard from multiple sites that the QIOs 'appear' to be a bit 'green' on the 2 MN benchmark.  Feels like we are training them... Wonder -what is their background?  Did the MACS work with them?  Was there a handoff process?  GADS!)

3) Mgd Medicare Part C :  Remember, these are private insurance plans that DO NOT have to follow any Traditional Medicare guidelines.  It is essential to either have a detailed contract that outlines 'what is an inpt' or get clarity from CMS on what to do when you are not contracted and ensure the payer/part C knows it.

(Thanks, Elaine/LA)  "Our Mgd Medicare has developed an audit named: "Clinical Review Audit."  In this one, the reviewer removed Dx Codes that they deem 'not to meet criteria' , usually CC or MCCs ( which would directly impact the DRG payment/Surprise!!)  For example, they might remove AKI because the patient did not meet the 'AKIN Criteria'.  Our MDs clearly documnented the diagnosis and were able to provide refuting sources for the appeal.  This has happened for acute respiratory failure, sepsis, pneumonia, severe protein calorie malnutrition and more.  So the payer is removing dx that are clearly codeable because of the documentation by the physician.  They are doing this to reduce payment.  Our only avenue is to appeal but it goes right back to the Mgd Care plan...How is this allowed?"

Remember - there are HIPAA standard transactions which all covered entities/payers are required to follow accepted coding rules.  Have you told them you were going to report them to CMS who is the papa-bear of all covered entity abuse?  There use to be a dedicated group within CMS but doubtful anymore.  Still the payer 'thinks they can get away' with it -so challenge them.

AND REMEMBER TO HAVE GOOD ABUSE EXAMPLES TO REPORT TO CMS's MGD CARE TEAM.

Thanks to many great folks on RAC RELIEF, we have been able to post to our website the contact names to alert to the abuse of the Mgd Medicare plans.

If you don't squeak, there won't be any change.  Get them and start reporting -with good examples.  Involve legal if it doesn't resolve.  How many long OBS LOS are you having with the Medicare Part C plans?  If you have a growth in obs - where is it coming from? Traditional Medicare-sure hope not= 2 MN benchmark.  Look to the Mgd Medicare plans.

4)  More Mgd Medicare Part C:  There are daily notes from multiple sites with the blantant abuse from the mgd Medicare plans.

We will definitely be addressing this at the **boot camp** but hints:  
    Track and trend any 'disputed' status - doctor ordered inpt, Medicare Part C said Obs only.  Why?

    Track and trend any deleting of documented Dx so the account is downcoded/less DRG

    Track and trend - critical access hospitals.  How are you being paid by Part C?  No contract - then normal per diem/inpt or % of billed charges/Outpt. (CO site said - paid the medically necessary rate?? WHAT???)

    Track and trend any full denials.  Most commonly seen with 'readmissions within 30 days."  They said -just like Traditional Medicare.  Wrong, but who in the hospital knows to challenge this?  
    Report both of the above to the UR Committee.  Ask for their leadership and help.

    Report both of the above to contracting.   Is there a contract?  does it speak to the above items?  Many hospitals operate in silos with everyone working hard but very little shared information.   Good practice to have regular meetings with contracting & CFO- sharing the wealth.   Define terms carefully.   Always involve coding and UR.

**UPDATES**

* Go to <https://www.cms.gov/outreach-and-educationa/outreach/npc/downloads/01-14-14-2midnight-transcript.pdf>  (Thanks, Dr Engel/U of U)  still way too many questions about clinical guidelines/IQ or others.  We still have UR teams who 'can't let it go/Think Frozen song" and are allowing "doesn't meet clinical guildlines" to drive Traditional Medicare inpts.  Easy read. Find those lost inpts and use the 2 MN rule...don't make it harder than it is.
* Reviewing Short Stay Hospital Claims for Patient Status:  Admissions on or after Jan 1, 2016.   CMS's website has great reference material pre and post Jan 1, 2016. (Thanks Dr Hirsch/Accretive and Dr Salvatore/DE)  Always excellent to have easy access to historical reference material.  Prior to Jan 1, 2016 - <http://qioprogram.org/sites/default/files/20151109-reviewinghospitalclaimsforadmissionmemo%20final.pdf>.    On or after Jan 1, 2016- <http://qioprogram.org/announcements>.    All about the QIO too.
* Medicare Part C and D Oversight and Enforcement Group within CMS: Dec 29, 2015 - Notice of Imposition of Civil Money Penalty for Medicare Advantage & prescription drug for Humana, Inc.  CMS has made a determination to impose a civil money penalty in the amt of $3,100,900 on Medicare Advantage/C and Prescription Drug (MA-PD) and identified PDP contract numbers.  Good read...  Of course it tells them how to appeal.
* MOON /Medicare Outpt Observation Notice sample form is out.  (THanks Dr Locke with great comments by Dr Hirsch and others/RAC RELIEF)  It is part of the 2017 IPPS rule which is not out yet.  There is no OMB # nor an approval date so it is not recommended to use yet.  Inpt final rule should be finalized by Aug 1st .  See the sample form on our webpage under value added/free stuff with the other free classes, etc.  With the 2 MN benchmark - let's hope we have very few examples to give this notice...
* CMS issued their Bundled Payment outline on April 1st. Just saying....   They just make it easy sometimes! HAHHA   Good reading...time to get ready as 800 hospitals are included.  NOTE:  **DR JOHAR is going to share their /OHIO** experience  at the Boot camp as they are identified as one of the 800.

Thanks again to one and all for allowing us to share with you each month thru the Info Line...for over 20 years.  And to each of you for sharing your story with us so we can help others. Wow -one of us must be getting old! HA

Keep smiling!