AR Systems, Inc.
"The Healthcare Navigator Company"

Education
Compliance
Commitment

August 2021 Infoline Newsletter

What's New

Hi Happy healthy summer! Certainly hope you are all doing excellent. It has been unbelievably hot in Idaho, drought and yes, wild fires. So difficult for so many. Best thoughts to all..

I was hopeful I would be able to share 'nothing but great news' on the COVID-19 'attack plan.' But unfortunately, every day brings a new surge in positivity rates with 97% of hospitalization & deaths from unvaccinated patients. Very hard to watch as more suffering from his horrible virus. As with the influenza flu yearly vaccine, we know we can still get the 'flu' -just not as severe. COVID-19 is similar so being cautious when we are around large groups, being diligent with unknown vaccinated-status, and continuing to encourage those around us to study the science of the vaccinations – as I am sure I echo others- we want our healthcare workers not to have to deal with this over-and-over again and yes, like many others, we want to return to a sense of 'health safety' that vaccinations can provide. Hope for a much better report next time.

National stats: Good news: Recent increase in vaccination rates. Getting closer to 70% with 1st shot. Let's follow the science and get there and more!
Deaths: 618,585 approx 350 daily. Delta Variant is far more transmittable ….

Long haulers/Long COVID - continuing medical condition requiring medical intervention – months or years. New medical bills? New fears of the unknown.

Over 4 million children have tested positive for COVID. Unknown lifetime health issues? New medical bills to add to the fear.

Let's Tackle Medicare Advantage

It is forecast that MA /Managed Medicare/Part C will reach 40% participation in 2022. To truly understand 'why' 65+ people are electing to move from Traditional/Original Medicare to MA plans (primarily commercial insurance plans) it is important to do a little google search for plans in your zip code as plans are sold per county. Counties right next to each other can have different plans. Also not all plans are sold in all counties. Some plans don't include all the 'special/additional benefits'. It is important to learn and then gain an understanding of why. HINT: Cap on out of pocket, dental/eye glass/hearing aids, and some have transportation & fitness gym coverage. Why not join? In-network limitations are the biggest

drawback, but again – look at the $ savings and getting a new doctor may not be the deal breaker. The biggest problem with the MA plans is the ongoing challenges with the PROVIDER community. Massive repeat prior-authorizations, delays in making decisions: inpt vs obs, arbitrary changes on their webpage/posted and allowed due to contract language, continual 'not medically necessary denials' with questionable rationale/or unknown, stripping documented dx to reduce DRG payment, and other little goodies – all resulting in a continued strain with OPERATIONS and the MA plans. Unfortunately, the contracting team may be unaware of the real COSTS of MA contracts and thus are not including the revenue cycle team (including all aspects of care mgt, Physician Advisors, and PFS) in the OPERATIONAL components of the contract. Let's ensure there is 'tracking and trending/TNT' of patterns by each MA plans as otherwise it is just 'stories.' The Administrative Cost of each contract is keenly aware to the operational team but may not be known to the contracting team. Time to TNT and join the Contracting Team…even in large health systems.

Looking for patterns resulting in disputes with inpt status:

In a recent great onsite project, we were looking for the patterns associated with the MA plans denying inpt and then telling the hospital they had to either do CC 44/bill outpt 131 but has to be done prior to discharge or bill outpt/inpt claim 121/after discharge decisions. There are plenty of 'clarifying the current process that should occur/flow " but there were two large patterns identified . (Unfortunately not unique challenges.)

1. Each payer gets to determine their definition of an inpt. (Ex: Aetna clearly stated they follow MCG and here is what it said. Humana eluded to the 'mysterious' clinical guidelines/CG and then

listed what had to be present. Although there is conversation not to use the CG when defending an inpt, this may not be the best path as ‘we do what the payer does’ so we all start on the same page.

2. Each payer faxed their ‘initial determination letter’ with no timelines for making this determination. When asked, some

said
they
get
up
to
7
to
14
days
to
make
this
decision.
WOW!
Where
does
it
say
that
in
the
contract

Biggest pearl found with project: Tracking and trending replies to requests = 4 days on average. (Direct access to records did not have any impact on the timeline to reply. Other hospitals have found giving access resulted in many more obs and no decision until discharge/NO WAY!) Then the letters told 'the patient' that if they were still in a bed, the hospital could convert to outpatient obs. Another letter said that if the doctor wrote an order after this decision, the hospital could ask for a P2P call – scheduled within 14 days . Again, after 4 days to make decisions, then ask for P2P/2 more days and grandma has to still be in-house 6 days later to be able to convert back to obs , if agreed. WOW! No and heck no! This is a huge contractual issue but one that MUST be addressed.

Payer Wins: *Be sure to realize, these are some of the strategies used… not ok!*

If account goes to status dispute – no timeline to reply = can't bill 131/outpt all services if grandma has been D/C

If account goes to P2P call and then inpt is approved but obs was the only order on the record = payer says, can't convert to inpt either as pt has left.

If inpt downgrade to obs is accepted, but there is no obs order prior to discharge= can't bill anything but 121/ancillary services.

Provider Wins:

Ensure that the language 'We follow Medicare Guidelines' that is included in all MA plan communication is clearly understood with OPERATIONAL Addendum to all contracts.

EX) ABS hospital – If Medicare Guidelines are followed, then the 2 MN rule is used. There will be no submission of records for determination, no independent guidelines used outside the 2 MN rule, all determinations for inpt done internally. Otherwise, coverage rules for patient benefits mirror Traditional Medicare, but the MA plan does not get to create their own guidelines and then dictate that that the hospital 'cannot change status after discharge'.

Attorneys may need to be involved especially when the losses of inpt tracking is provided. NO way should there be any acceptance of 'after discharge/can't do anything but ancillary' directives from the MA plans. They always win if they delay, delay, delay.

Create a Payer Matrix. Wow – there are so many pieces of these operational issues that appear to be unknown to the operations team. Readily available and updated.

Keep a log of 'questionable dx' for inpt status' as the disputes result in obs vs inpt. Provider education on documentation and yes, sometimes they were just obs… (Hate it when that happens! LOL But updating of information, patterns, plus reading the letters from the payers, helps us become as knowledgeable INTERNALLY as the payer is about you.)

Abusive patterns or inability to work with MA plans on coverage issues .

Approx. 5 yrs. ago, CMS issued a list of contacts for MA plans to file complaints. There was some surprise on CMS's part (CMS oversees all MA plans) of the level of complaints- even without many providers even knowing the complaint process was available. Ground rules: Always try to work out any dispute directly with the plan. If it cannot be done or additional like cases occur, file the complaint. It cannot be over rates… Track and Trend by payer and share this abuse with the contracting team. Why contract? What is the win for the provider?

Thanks to Dr B/South Carolina, below are the new CMS complaint contacts, per region. This is a change from previous contacts so thanks a ton! It takes a village, for sure!

CMS Complaint Contacts:

Region 1 Boston ROBOSORA@cms.hhs.gov
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Region 2 New York RONYCORA@cms.hhs.gov
New Jersey, New York, Puerto Rico, Virgin Islands

Region 3 Philadelphia ROPHIORA@cms.hhs.gov Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Region 4 Atlanta ROATLORA@cms.hhs.gov
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Region 5 Chicago ROCHIORA@cms.hhs.gov
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Region 6 Dalla RODALORA@cms.hhs.gov
Arkansas, Louisiana, New Mexico, Oklahoma, Texas

Region 7 Kansas City ROKCMORA@cms.hhs.gov
Iowa, Kansas, Missouri, Nebraska

Region 8 Denver ROREAORA@cms.hhs.gov
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Region 9 San Francisco ROSFOORA@cms.hhs.gov
Arizona, California, Hawaii, Nevada, Pacific Territories

Region 10 Seattle ROSEA_ORA2@cms.hhs.gov
Alaska, Idaho, Oregon, Washington

Regulations Updates:

Pause on elimination of the Inpt only list for Traditional Medicare. CMS/RACs are still auditing total knee and hip but looking forward – there is a 2nd look as to the safety factor of moving all to outpt (and then earning an inpt) and moving many to free-standing surgery centers. Stay tuned as the discussion period is underway. *And yes, huge financial loss to move from inpt DRG to outpt APC. And what are the other payers using? Are MA plans using CMS's inpt only list? So are they also moving all to outpt? Wow-without the 2 MN rule to help justify the need for inpt/current guidelines from CMS – how will you ever WIN an inpt surgery with an MA plan? Significant contracting issues.

Surprise billing interim final rule. The goal of this was to take the patient out of the out-of-network financial risk conversation when being treated at in-network provider. I am sure everyone is reading and learning as we prepare for the full implementation next year. My take away: There are some great pieces being outlined -with much more accountability with the payer, rather than push it all to the provider. The nuts and bolts of how to do the arbitration if in dispute, still working on. And I am hearing how the providers can ask the pt to allow them to balance bill the pt for out-of-network claims – more protections being built in to disallow any intimidation attached to this. Wow! This one has been a while in coming but if we are 'listening to the patient where they are ' – they have no idea of all the professional fees they may get attached to any hospitalization. How could they possibly have known they weren't in the hospital's network? Time to work on that piece too!
BIG WIN: In July notice from HHS/CMS, it states that no payer can do a post-discharge denial/recoup funds and make the patient liable. This would be in violation of the surprise bill legislation. There may likely be challenges but I will savor this WIN for the patients and the providers… *CMS surprise-billing rule outlaws retroactive ED denial policies. July 7, 2021 All about the layperson protection.

Transparency new penalties. Since Jan, the requirement to post easy-to-access information for any patient seeking information on upcoming procedures, etc. has been required. After plenty of preliminary work -and yes, right thru the 'lost year of COVID', the hospitals were to have it ready to go on Jan 1, 2021. If not, a daily penalty of $300. The goal was to inform the patient of their charge and their allowable, payer specific. Inside healthcare, we knew it would be hard to meet this and especially since patients don't know their CPT code and the complexities of 'entering the business of healthcare – scared and our work is foreign to most. Also we hear that patients are not even using the portal. WHY? Has the hospital done community outreach? Public service announcement? Social media blasts about how much we care -so here is what you can get at any time – and here is who you can call with questions? Meeting the obligations of the law is different than meeting the vison of the law.
Yes, new heavier penalties are likely. The larger the facility, the higher the daily penalty. The RUB: Posting contracted rates with each insurance play. Next year, the Plans are to post their rates with providers. We will definitely be watching this one. *What other industry requires the competition to post their rates with all their vendors? Nuts!

Recent Publications

Hopefully you are already subscribed, but the July 19th issue of "**Report on Medicare Compliance**" newsletter included an interview we did on: *Surprise Billing Rule Banks ER Denials Based on Final Diagnosis Codes.*' We also included why are hospitals sending daily/every 2 day records for concurrent review when a)the patient was already approved for inpt and b) DRG payment is for the stay, not the day. Contracting issues – no additional records unless outlier or referral post-discharge and absolutely NO 'per day' denials within the DRG. More NUTS!
Nina/ Managing Editor always does a great job!

Patient Financial Navigator programs: Hfma national publication
It was exciting to finalize the article : "*How to engage with patients where they are by balancing automation with the human touch.*" It will be published in **hfm's Sept issue and previewed in HFMA's Financial Sustainability Report**. Excited for the 'messaging' along with lots of implementation ideas for every hospital. Love it!

Payer's Gone Wild and yes, Payer's (Still) Going Wild!
It is exciting to be teaching this 'never-a-dull-moment' new class to many professional organizations –both virtual and baby-stepping back to safe-distancing live. (Note: What a grand opportunity to incorporate BOTH -a hybrid meeting! Think of many healthcare professionals you can reach thru desk-top ed/would never get approval to travel for ed! Now the mission of outreach educational can truly be met. And we know how!! The silver lining of the Pandemic.) Hottest classes right now: "Payer's Gone Wild", "Attacking Medicare Advantage Denials – Taking Your Power Back" and the long-time favorite: "Inpt vs Obs -why is it so hard PLUS Total joint anguish – it is all about the 2 MN rule" Yes we *teach to individual providers too…*)

HOT OFF THE PRESS

Post -Discharge denial of ED visits
United Healthcare is delaying rolling out their ER Emergent post discharge audit. "UHC $320B could be saved in next decade by reducing ED Visits." June 2021.
• As with anything, the true challenge is ensuring the layperson could possibly know their ED visit was not emergent – base on UHC's definition. UHC is following Anthem BC's example -just a little different. Humana is also looking to finalize how they are going to only cover 'emergent' dx. There are legal challenges but ultimately, the patient is left trying to pay a denied claim when they had no idea 'what the emergency dx would be at the end of the visit.' Another contracting issue..

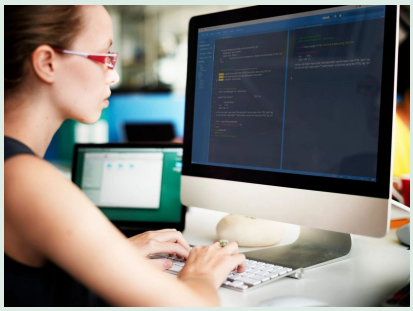
Site of Service - *Back by Popular Demand*
Recently, I was asked the one thing I was most concerned about that will impact the Revenue Cycle… (besides the above items, LOL)

And once again, Site of Service Prior-Authorizations it first with the post-discharge arbitrary denials added as a 2nd high risk. Why? The hospital/health system has a contract with the payer. But so does the free-standing surgical center and the free-standing imaging center and every other hospital. So the payer WINS always as they can look around and find the best rate for the request and authorize the service but not to the hospital who requested it. WOW! United has even stated that they will be looking at outside the hospital for all outpt services…unless certain criteria/high risk are identified. Begs the question: Why are you all contracted when there is no loyalty from the payer to direct patients to you? You are simply giving discounts from billed charges and getting what in return? This is especially hard to figure out when you are the only hospital in rural/closest is 40-50 miles away. Where are they directing but to you? And MA plans can't sell in your community without a community network -which is the hospital? Take some power back and re-assess: pricing as hospitals will loose and with everyone knowing each other's rates= there are no secrets. And have the conversation about directing of patients because all the 'great rates' won't matter if you don't get the pts. On the other hand, I heard a physician's group speak about the Transparency issues with massive control of pricing when hospitals are merging, buying practices = what is the incentive to change when you control the market? Are you ready to have this conversation within your own walls , in your community, at home? Oh yeah, this stuff is fun!

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 summer of 2021 to you all! Be kind to each other. Lead by example. Keep it simple while you do outreach with your community. Delta variant surge of the deadly COVID

virus is unfortunately in most of the states. ‘Be the change we want to see.’ Thank you for being part of the AR SYSTEMS’s Village! It matters.

Where is world is Day?
Yes, some face-to face chapter educational sessions but lots of remote … love them both! Join us!

Aug 19th Idaho HFMA *“Payer’s (Still) Going Wild”*

Aug 26th MS HFMA *"Payers ..."*

Aug 27th NM rural hospital network *"Payers..." +++ "All the other fun regulator stuff"*

Sept 16th IA Fall AAHAM conference *"Payers …"*

Sept 23rd Western Reserve chpt *"Payers..."*

Oct 6th NJ HFMA *"Attacking MA Denials – taking your power back"*

Oct 21st UT AAHAM *"Payer..." or "MA – STD"*

Oct 19th CoPam *"Attacking MA"*

Nov 1st Region 9 HFMA *"Payers..." & "Attacking MA"*

Info line Subscriptions

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Info line Signup

Kind regards,

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