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FACTS & FEATURES

AHA SERVICES
Guiding Healthcare Solutions

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The Final Countdown to ICD-10

The countdown to ICD-10-CM implementation is well underway and many healthcare professionals have yet to start preparing or are still not sure where to begin.

ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consists of a diagnostics classification system. ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity in the United States. It also provides code titles and language that compliment accepted clinical practice in the U.S. The system consists of more than 68,000 diagnosis codes.

ICD-10-PCS was developed to capture procedure codes. This procedure coding system is much more detailed and specific than the short volume of procedure code included in ICD-9-CM. The system consists of 87,000 procedure codes.

Together ICD-10-CM and ICD-10-PSC have the potential to reveal more about quality of care, so that data can be used in a more meaningful way to better track the outcomes of care. ICD-10-CM/PCS incorporate greater specificity and clinical detail to provide information for clinical decision making and outcomes research.

While this is a major transition for both providers and payers, the steps involved and training required are quite manageable with early preparation. In order to assist hospitals through the many areas necessary for a successful transition, AHA Services has assisted in developing an ICD-10 Toolbox for participating hospitals.

Coder/Clinical Documentation Improvement (CDI) Clinical Assessments and Training

Baseline Assessments: Evaluation of each coder's baseline proficiency in medical terminology, anatomy, pathophysiology and pharmacology with department summary and individual reports by coder.

Coder Clinical Concept Courses

ICD-10-CM/PCS training courses in medical terminology, anatomy, pathophysiology, and pharmacology with detailed study guides.

ICD-10 Readiness Testing and Gap Analysis

Evaluation of ICD-10-CM/PCS clinical knowledge in medical terminology, anatomy, pathophysiology and pharmacology.

Physician Training

A unique physician training module that addresses the physician's practice as well as the hospital's goals. This is accomplished through a humorous presentation from a national renowned speaker who is also a surgeon. This program has received rave reviews all across the country and is one of the most effective ways to train physicians and other staff members.

Physician Education

Seminars and training focused on the needs of the physician and/or their staff. Can be from

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one hour to six hours in length and can be tailored to the various specialties to assist them in preparation for ICD-10 implementation. Onsite or remote-based training.

Remote Coding/Coding Outsource

DocuVoice coding partner(s) can deliver the best coding solutions tailored to your specific workflow with guaranteed quality and turnaround times. It is committed to providing fast, accurate, cost-effective remote coding for any healthcare provider, in any location, for any patient type.

Computer Assisted Coding

Computer-Assisted Coding is defined as software that suggests codes to human coders for validation. The process increases productivity while allowing for better revenue capture through more thorough coding. By utilizing natural language processing (NLP) technology, the CAC tool presents NLP coded charts to human coders to validate the results before processing the codes to billing. CAC can increase productivity, decrease variability, and identify problem documentation for a quick return on investment. This is especially important during the transition to ICD-10, as it is expected that coding productivity will decrease during the initial implementation.

Documentation Gap Analysis

Documentation chart review to determine if current documentation is sufficient to support the increased need for specificity in ICD-10 coding.

Encoder Software

DocuVoice encoder provides a medical coding software solution that empowers medical coding professionals to deliver their best performance. Its encoder gives medical coders the intelligent tools and support they need to navigate the complex and evolving world of healthcare coding with confidence, including ICD-10, ICD-9 and CPT codes. Through intuitive function, clean presentation and up-to-date medical references, the encoder "thinks" and works the way medical coders do. The result is greater efficiency and more accurate coding that improves your workflow and bottom line while helping to ease the transition to ICD-10.

Physician-Assisted Medical Chart Documentation Reviews

DocuVoice works from an entirely new model and puts specially-trained physicians on a team with the coder. This provides the coder with insight to additional diagnoses and procedures that are addressed in the chart. Fifteen minutes for each review day is scheduled to discuss the physician's findings with your coders. The synergy of the clinical knowledge of the physician and the regulatory knowledge of the coder results in more accurate coding of the encounter with prevention of erroneous up-coding and correction of costly under-coding.

Coding Review Services

Comprehensive Coding Review Services for inpatient and outpatient hospital services, physician chart review and gap analysis to determine strength of chart documentation. These services will enable healthcare facilities and providers to adequately prepare for the ICD-10 transition and to focus education efforts based on the identified needs.

Charge Master Updates

Accuracy in maintaining your facility's Charge Master (CDM) is crucial; even a minor error can result in financial loss in the generation of patient revenues, as well as violation of Federal, State or other regulations.

CDI Training

Building and maintaining a Clinical Documentation Improvement Program is essential in preparing for ICD-10. DocuVoice provides coding and documentation training for your CDI team.

To schedule a webinar to discuss ways that DocuVoice can assist you, please contact Bob Stewart at bob@docuvoice.com.

Better Employee Value

Better Value Every Day

As the only national not-for-profit vision company, VSP gives your employees the best value for their eyewear.

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Plus, as of January 1, 2014, your employees automatically get an extra $20 to spend on featured frame brands like **bebe®, Calvin Klein, Flexon®, Lacoste, Michael Kors, Nike** and **Nine West.**[2]

Exclusive Member Extras

Only VSP members can save more than $2,500 by taking advantage of exclusive rebates and special offers, including:

- Rebates on the most popular contact lens brands
- Special discounts on preferred frame brands
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- Nike-authorized prescription sunglasses–average savings of $325

Employees also save up to $2,600 with TruHearing® on each pair of digital hearing aids.

Contact Emily Morris, 800.638.2626, to see more ways your employees can save.

1. Based on applicable laws, benefits may vary by doctor location. 2. Featured frame brands include Airlock, Altair, Anne Klein, bebe, Calvin Klein, ck Calvin Klein, Chloé, Diane von Furstenberg, Dragon, Emilio Pucci, Flexon.

The Cycles Continue

BancorpSouth Insurance Services, Inc.

Medical professional liability for hospitals and other healthcare providers has been subject to numerous underwriting cycles over the past 40 years. These cycles are typically characterized by multiple years of premium reductions accompanied by an expansion of underwriting carriers and more liberal policy terms. Loss ratios eventually rise to an unprofitable level typically resulting in sharp and abrupt premium increases and a significant decrease in the number of insurance carriers.

Healthcare providers in Arkansas and nationwide currently find themselves in the midst of the soft market segment of the current underwriting cycle. At least 10 carriers currently offer hospital medical professional coverage in Arkansas and premiums have steadily declined since 2007. This is in sharp contrast to the 2001-2003 hard market period when only three carriers remained in Arkansas following the exodus of at least four major carriers due to a number of factors, including carrier insolvency.

It is difficult to determine when the next hard market period will emerge. However, there are several factors hospitals should consider in the management of their carrier and broker selection to achieve the best protection and lowest cost over the long term:

1. Does the proposed carrier have a long history of providing professional liability coverage to Arkansas hospitals during both the hard and soft periods of the market cycle? History has shown that certain carriers will be absent in the hard and more difficult periods only to reappear once improvement in the market has occurred.
2. Is the broker or agent highly experienced in Arkansas medical professional liability with a long history of assisting hospitals with their coverage needs through all phases of the market cycle? Almost any agent with a license can obtain a professional liability quote during a soft market period only to be left without access to viable carriers when the market firms or the individual hospital hits a rough patch in its claim activity.
3. Are claims handled by highly experienced medical liability adjustors based in Arkansas that understand the dynamics of the Arkansas legal environment? Many carriers handle their claims with out-of-state adjusters with little experience or knowledge of Arkansas. The improper handling of claims can result in excessive loss and expense that can ultimately drive up premiums, not to mention the potential reputational damage to the healthcare institution.
4. Does your carrier have a significant market presence in Arkansas and a greater spread of risk or is this a one-off account in the state? Carriers with limited market presence in the state can have a greater tendency to apply negative underwriting actions resulting from poor loss experience to an individual hospital than a carrier that views their risk exposure as spread among numerous accounts in a program state.

The Healthcare Division of BancorpSouth Insurance Services and its predecessor agency, Ramsey, Krug, Farrell and Lensing, has a 25-year history of serving Arkansas hospitals, doctors and other healthcare professionals. Its 12 dedicated staff members are highly trained and experienced in areas of healthcare liability and property underwriting, local claims and risk management.

Please call the BancorpSouth Healthcare Division Service Team at 501.664.7705 for more information.

Making Sense of Compliance... Compliance Dashboard

Does Compliance Really Matter?

Yes...it's the law. There are many requirements an employer has as a plan sponsor the most important being fiduciary oversight. Plan documents, ERISA notices and ERISA disclosures are just a few of the necessary items required. Any participant can sue the plan for noncompliance with ERISA, which can lead to fines and damaged employee relations. In addition, more and more lawsuits are being brought over claim denials and benefit reductions. These lawsuits often hinge on a compliance issue, whether it is documentation, eligibility, or a plan notice reliable process in place to ensure your plan is in compliance with the law.

How Compliance Dashboard Can Help

Compliance awareness is the key to staying on track with ERISA, HIPAA, Health Care Reform and other federal regulations. Hagan-Newkirk's Compliance Dashboard service takes the time to learn about your benefit plans and your company, so that it can customize its compliance process to your specific organization. Then your responsibilities on the compliance calendar are scheduled, providing you reminders when a requirement is due. Using on-time email alerts and automated compliance tracking, employers receive the information they need, when they need it.

Benefits of Compliance Dashboard

- Reduce Workload—A solution that will help reduce the employer's workload by automating the compliance process.
- Lower Risk—Tracking and documenting the employer's compliance efforts as well as serving as an education resource.
- Relieve Anxiety—Pushing information to HR staff so that responsibilities do not fall through the cracks.
- Increase Competency—Continually educating HR staff on compliance responsibilities and giving them a resource center where they can learn about the laws and mandates that govern their benefit plans.

For more information on Compliance Dashboard call 501.823.4637 or go to www.hagannewkirk.com.

Press Ganey Acquires On the Spot Systems

As your partner in transforming healthcare, Press Ganey (PG) continues to deliver innovations that reduce patient suffering and improve the patient experience across the care continuum. During the past year, Press Ganey introduced solutions to capture the voice of every patient, increase employee and physician engagement and provide targeted analytics. Today, PG further advances its efforts to improve the patient experience through the acquisition of On The Spot Systems, a point-of-care technology company that enables organizations to capture real-time patient feedback.

With the addition of point-of-care surveying to Press Ganey's other existing modes, it is able to capture patient feedback at every point in the care process and helps providers increase patient engagement before, during and after patients are in their facilities. This solution can be adopted in any care setting, with surveying offered via any tablet or mobile device, to support performance improvement through better coordination of care within the organization and across the care experience.

Strategically utilized in concert with the full product suite, the Patient Voice Point-of-Care tool expands patient feedback and continues Press Ganey's efforts to shorten your improvement cycles. The web-based, software-as-a-service (SaaS) solution can be rapidly implemented and supplements your existing patient experience efforts with customized surveys for even more targeted performance improvement. An advanced alerting feature automatically routes patient feedback by email directly to your team for immediate investigation and ultimately, resolution.

As part of the PG actionable reporting tools, the point-of-care solution offers dashboards, word clouds, scorecards and trend reports that can be exported or scheduled for delivery by email. Consistent with Press Ganey's other services, patient comments are captured to better pinpoint service recovery and augment improvement efforts.

Press Ganey is committed to driving the industry forward in 2014 by investing in solutions that address the needs of its clients and make the healthcare experience better for patients.

Press Ganey welcomes your input regarding other innovations that would enhance your efforts to improve the patient experience as it works with you to transform the industry.

Visit www.pressganey.com or contact or contact J.D. Ort, 877.697.5718.

CMS 2-Midnight Rule

FLORIDA HOSPITAL ASSOCIATION
Management Corporation

On August 19, 2013, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FY) 2014 final payment rule for the Medicare inpatient prospective payment system (IPPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes proposed and adopted by CMS and legislative changes previously adopted by Congress.

To address concerns about appropriate inpatient hospital admission decisions and recent increases in denials of short-stay inpatient claims by federal claims review contractors, such as Recovery Audit Contractors (RACs), CMS is adopting its proposal, with some modification, to implement time-based admission guidelines. As adopted, CMS is specifying that inpatient hospital claims with lengths of stay greater than two midnights after formal admission following a physician's order will be presumed generally appropriate for payment under Medicare Part A. CMS is expanding its proposal to allow for patient time spent receiving outpatient services (emergency, observation, and operating room services) to count under the two-midnight threshold.

CMS said: *"We are specifying that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, we are specifying that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate."*

Under the newly adopted policies, claims that meet the time-based guidelines will be presumed generally appropriate for Part A payment and will not be the focus of federal claims review contractors. However, CMS would presume that hospital services spanning less than two-midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician's order or the service involved an inpatient-only procedure. CMS has estimated that this policy will increase inpatient payments by about $220 million. To maintain IPPS budget neutrality, CMS is using its "exceptions and adjustment authority" to apply a -0.2 percent reduction to the federal operating, hospital-specific, and federal capital rates. Complete details on the inpatient admission guidance policies are available on *Federal Register* pages 50938-50954.

CMS also said: *"...the beneficiary's required 'level of care' is not part of the guidance regarding inpatient admission decisions."*

This means that commercial screening tools such as InterQual will not be used by the contractor to determine whether the inpatient admission status was medically necessary. The approval or disapproval of an inpatient admission comes down to physician documentation of the physician's "expectation" of the need for continued medical monitoring and treatment past 2-midnights. Therefore, the documentation should reflect:

- Two-midnight expectation or inpatient-only procedure
- Physician order/rationale is the key
  - Requirement that the order specify "to inpatient," "for inpatient" or similar language
- CMS also states, however, that in "event that explicit identification of the admission as inpatient is not specified, the admission order [may still satisfy] provided that the intent to admit as an inpatient is clear"

The admission order:

- Must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital and is knowledgeable about the patient's care and current condition
- Must be furnished at or before the time of admission
- Must be signed, dated and timed before the patient is discharged from the hospital
- Date and time is still the time when the inpatient admission begins

The factors that lead a physician to admit a particular beneficiary based on the attending physician's clinical expectation must be clearly and completely documented in the medical record. This should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation <u>must be documented in the medical record</u> in order to be granted consideration.

A beneficiary who experiences an unexpected recovery during a medically necessary **stay should not be converted to an outpatient** but should remain an inpatient if the 2-midnight expectation was reasonable at the time the inpatient order was written, but unexpectedly the stay did not fully transpire. The Physician Admission Certification Statement must authenticate the practitioner order, which includes specific reference to "inpatient" admission, and certifies that the services are appropriately provided as inpatient service in accordance with the two-midnight benchmark under 42 CFR 412.3(e). The certification should include the reason for inpatient services, either:

- Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study, or
- Special or unusual services for cost outlier cases under IPPS
- Estimated time required in the hospital

(Continued on Page 6)

2-Midnight Rule (Continued from Page 5)

- Plans for post-hospital care, if appropriate, and as provided in 42 CFR 424.13
- CAHs: the physician must certify that the patient may reasonably be expected to be discharged or transferred within 96 hours
- The certification must be completed, signed, dated and documented in the medical record prior to patient discharge. The inpatient stay should not be considered to commence until the inpatient admission order is documented

Certifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff. Verbal orders must be authenticated prior to patient discharge. The CMS Guidance provides that following discussion with and at the direction of the ordering practitioner, the order may be documented by a resident, physician assistant or registered nurse as long as that documentation of the order is in accordance with State law, hospital policies and medical staff bylaws.

The timeframe used in determining LOS expectation begins when the patient starts receiving care in the hospital and **includes** time in observation, emergency department, operating room or other treatment area. The time is the cumulative time spent at the hospital beginning with the initial outpatient service (being seen by a physician). Time spent before the formal admission order may be used in making an admission decision and the time spent before formal admission does not count for SNF qualifying stay.

For more information contact Barbara Flynn, Denial Management Services, 407.841.6230, barbaraf@fha.org.

Arkansas Hospital Risk Management Seminar

Friday, May 2, 2014

8:30 a.m. - 3:00 p.m.

Sponsored by BancorpSouth Insurance Services

Location: BancorpSouth Insurance Services
8315 Cantrell Road, Suite 300
Little Rock
501.614.1180

Registration information and meeting agenda to follow at a later date

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February 11 Beyond ICD-10: Are You Ready for What's Next?

February 12 HFMA's e2 Learning: Educate Staff to Elevate Performance

February 20 How to Develop and Maintain Supply Chain Transparency and Control

March 4 A Vendor Guide to HFMA's e2 Learning: Generate Results for Your Clients

View all upcoming live webinars

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HFMA provides webinars available one calendar year following the live webinar date and year. Most On-Demand webinars are free for HFMA members and $99 for non-members, unless otherwise noted.

Available until May 30, 2014:
Reimbursement Model Transition Planning: From Fee-for-Volume to Fee-for-Value

Available until June 6, 2014:
Challenges with Transitioning to Accountable Care

Available until September 24, 2014:
Understanding the Impact of Consumable Costs that Exceed their Capital Investments

View all on-demand webinars

Introducing KnowledgeWeb for PDS Users

As you know, Professional Data Services (PDS) has been acquired by iVantage Health. One of the resources that is available to ALL employees at your hospital is the **KnowledgeWeb**. It is part of the iVantage services to its clients so there is no additional charge to participate in or access the KnowledgeWeb.

The iVantage KnowledgeWeb is an online collaboration platform to help managers improve quality, cost, patient satisfaction and financial performance. Department managers, administrators, managed care analysts, nurses, and staff participate in ongoing conversations around ideas and challenges to build a comprehensive best practice library.

Insights are gathered from hospitals via emailed surveys and questions, and interactive web conferences. The results from hospitals nationwide are summarized and archived in the KnowledgeWeb - all searchable and downloadable for iVantage clients.

Go to kw.ivantagehealth.com to complete the **PDS Educational Needs Survey** (using the login and password emailed to PDS users from Jyoti Osten in December 2013). This will help build the **Revenue Enhancement Knowledge Community** to best meet your needs.

All PDS users should have received a login and password to access the KnowledgeWeb. If you are a PDS user and did not get a login or would like to learn how to share this valuable resource with people throughout your organization contact Jyoti Osten at josten@ivantagehealth.com.

Please contact Jyoti Osten, iVantage Health Analytics®, with any questions at 760.815.0763, josten@iVantageHealth.com. .

AHAWCSIT Congratulates Twelve Hospitals Recognized for Outstanding Performance

The AHA Workers' Compensation Self-Insured Trust (AHAWCSIT) is proud to recognize twelve of its member hospitals for outstanding performance and commitment to workplace safety during the year 2012.

These members achieved a combined average incidence rate for medical only and lost time claims of 49% or less of the Bureau of Labor Statistics (BLS) incidence rates for hospitals (the nationwide rate for hospitals is 6.8).

Controlling costs of workers' compensation can result in dividend payments to members of the AHAWCSIT.

Congratulations to:

- Johnson Regional Medical Center
- HSC Medical Center
- Arkansas Methodist Medical Center
- Ouachita County Medical Center
- Little River Memorial Hospital
- Delta Memorial Hospital
- Drew Memorial Hospital
- McGehee Hospital
- Magnolia Regional Medical Center
- Ashley County Medical Center
- Chambers Memorial Hospital
- Dallas County Hospital

Keep up the good work!

Contact Tina Creel, AHA Services, Inc. to obtain information on how you can become a member of this very successful group at 501.224.7878.

The Marketplace Enrollment Call Center, a Valuable Tool for Your Employees, Friends and Patients

As many of you know the "Call Centers" as provided by the Government to enroll Americans onto the insurance exchange has been met with less than stellar reviews. People all over the country have experienced problems with the enrollment as well as with calculating their subsidies. Others have experienced navigators who have given them incorrect information while still others have experienced fraud. But, as we all know, one bad apple can spoil the whole bunch, and that seems to be what's happening with the navigator program as the reports of fraud and abuse have made the public leery of the process. It's clear that having a licensed broker to help people know their options and enroll on the exchange is vital.

Fortunately, AHA members and friends of AHA Services can continue to utilize The Marketplace Enrollment Call Center. The biggest difference between The Marketplace Enrollment Call Center and the government's hub is BancorpSouth's Call Center is staffed with licensed insurance professionals who can answer questions, help calculate any subsidy, recommend the plan that is best suited for them as well as assist them with the enrollment process. Yes, individuals calling into The Marketplace Enrollment Call Center have encountered similar problems with the actual enrollment but instead of waiting while an unlicensed navigator tries again and again to create an account for them on the Healthcare.gov website, they are still speaking to a licensed agent who is able to provide them with quotes and give them an idea about their ability to qualify for a subsidy. They can also have a follow-up call made to them in the event the system is experiencing technical difficulties, a service not available elsewhere. Additionally, they can be shown private plans in the event they do not qualify for a subsidy.

It's important to remember that for coverage starting in 2014, the Open Enrollment Period is October 1, 2013 to March 31, 2014. For coverage starting in 2015, the proposed Open Enrollment Period is November 15, 2014 until January 15, 2015. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events.

The toll free number to call to begin the enrollment process is (855) 649-7023.

Should you have any questions about this or anything regarding the Affordable Care Act, please contact Mark Meadors, 501.614.1192.

New Survey Shows Increased Use of Locum Tenens Physicians

Each year, Staff Care, the nation's leading provider of locum tenens staffing services and an AHA Services preferred provider, conducts a survey examining the use of locum tenens physicians nationwide. Staff Care's upcoming *2014 Survey of Temporary Physician Staffing Trends* tracks the number of hospitals that have used locum tenens physicians over the previous 12 months, why they have used them, and what types of physicians are most in demand as locum tenens. The survey also looks at physicians who work on a temporary, locum tenens basis and reveals why these physicians choose to work temporary assignments.

Last year, Staff Care's survey indicated that some 75% of hospitals and medical groups had used locum tenens physicians during calendar year 2012. According to Stephanie Hawkins, Regional Director of Territory Sales with Staff Care, the 2014 survey will show that 90% of hospitals and medical groups used locum tenens physicians in calendar year 2013.

"A growing number of healthcare facilities are using locum tenens physicians, for a variety of reasons," Ms. Hawkins notes. "These include filling gaps created by physician turnover, maintaining services while facilities are seeking permanent doctors, and providing coverage for physicians on vacation or CME."

Copies of Staff Care's *2014 Survey of Temporary Physician Staffing Trends* will be available in mid-February, and Arkansas Hospital Association members can obtain a free copy of the survey report by contacting Stephanie Hawkins at 469.524.7445 or by email at Stephanie.hawkins@staffcare.com.

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Stephanie Hawkins, 469.524.7445
Kurt Mosley, 214.392.3936

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