BEST PRACTICES MINUTES
November 9, 2015 RIC/RAC Meeting

FACILITATORS PRESENT:
Ms. Jane Knight
Ms. Karen Northcutt

MS. KNIGHT: Good morning. I'm Jane Knight with the Alabama Hospital Association, and I am sitting in today for Wesley Ashmore, who is back at the office at a Medicaid Steering Committee and couldn't be with you today. We're excited that you are brave enough to swim or crawl, however you got here in this terrible rain, to be here today. And at least we're nice and dry in here.

I'm the vice president for membership, and I visit with the hospitals' CEOs, and I do the education for the rural hospitals. And as we meet with new CEOs, we always tell them how great the RIC/RAC program is and how it's just grown to be one of our best committees. And we really appreciate your commitment to it and participation. And I really am excited to be here and see and hear and learn. And one of our best resources is Karen Northcutt with Medical Management Plus, and I'm going to turn the program over to Karen. And we appreciate their service to the association.

MS. NORTHCUTT: You're welcome. And I was thinking riding down here this morning , it's been since the year 2002 officially that we were coming together. And we were in the small conference room at the Hospital Association. It started out I think we had about seven the first meeting. It went to about 13 people. And then it grew from there. So it's been really great.

We've got some new people from Cahaba coming today, Adrianne Nabors and Paula Motes, so that will be different. Because I don't know them either. So this will be a new one for me too. Just to remind everybody, try to be nice because it is their first time out. I did have one chance to actually meet Dr. Mitchell, the medical director at Cahaba, about two months ago. I think he's been very, very busy starting out in Dr. McKinney's spot right now. So hopefully, we can get him in one of the future meetings.

I did want to go over, as nerdy as I always am, of course, the final rule, which came out the day before Halloween. Surprise, surprise. So it usually is full of good things to understand and know. They did not change a whole lot from what was proposed in July, but I did want to go over the main issues. And for those that don't have to deal a lot with the Medicare outpatient population, just to give you a little primer, Medicare pays ambulatory payment classification, APCs. And if you hear OPPS, which it's called, it's outpatient prospective payment system, prospective meaning that you know what you're going to get paid when the bill goes out the door. And prospective also means that Medicare knows what they're going to pay you.

We have the IPPS, inpatient prospective system. Inpatient prospective means I know what I'm going to pay you, you know what you're going to get by one lump sum, a DRG.

Medicare has been striving since 1999 and the year 2000, with the inception of the OPPS, to get to a level where they want an episode of care. So at the year end of 2015, I think that we're finally making that to be a very prospective payment system on the outpatient basis. And I want to really cover what packaging is and what packaging is not. Raise your hand if you know what packaging and bundling is. Okay. Great. Great.

Packaging basically, in the early days, when we coded all ancillary services, drugs, surgeries, rehab, everything has a code to translate to Medicare what you get paid for, and

Medicare had a payment rate assigned to that code. Over the years, any codes that are identified with another service, Medicare has started packaging those ancillary services, those types of procedures that are associated with a procedure or service. So about three years ago, Medicare, for most clinical lab services, packaged those lab services into an emergency department visit, a clinic visit.

The next year they took pathology and they said, okay, you're pathology now, bundle this service with your surgery. We used to get paid separately for the pathology. Now it's included in the surgery.

Last year, they also packaged many, many items in the emergency department, such as your basic diagnostic radiology, your lab, your respiratory therapy breathing treatments. So we had quite a significant shift last year in the ED without much of an increase in what they paid us for those ED levels.

Somehow Medicare had calculated it that it was going to be okay. And so I guess everybody has survived another year.

This year, the big change is for observation services. I'm going to just go over briefly what the requirements are to receive separate payment for observation services now and what that will be in January.

Now, if I have a level four or five ED visit or I am a direct admit from a physician's office and I'm in observation services eight hours or greater, then Medicare pays us a composite rate for that entire episode of care. And basically, the ED level is packaged into that payment for the observation as well as the lab, the simple radiology, respiratory therapy treatments. Those are all packaged into the observation now.

What has finalized, which was not in the proposed rule, is a gift, if you will, in some cases. Because they are going to allow any level of an ED to qualify for observation composite rate if they are provided observation services.

What we've seen a lot of is a patient would be a level three and also goes to observation. In that case, because we had a level three ED billed instead of level four, the patient did not qualify and the hospital did not receive a composite rate for the observation services.

So those that operate on a true bell curve where you actually have a lot of level threes in your ED and they go to obs, those now all qualify for observation. So that's a gift for those who did not have a level four or five with their observation visits.

The increase on observation composite rate is going to be around $939 over last year. But here's the caveat of what is now packaged that was not packaged this year. All infusions and injections are packaged into the observation composite rate. So therefore, if I came to the ED and I had infusions and injections and we continued to code them during the observation service, these are now packaged into the obs. So we will not receive any extra payment for infusions or injections, unless that patient just went to the ED, had infusion and injection, and went back home.

So anything where the patient turns into an observation service, the infusions, injections, are packaged, your ED payment is packaged, all your ancillary services are packaged. And the significant change, as well, is the CTs and MRIs are now packaged. So basically anything that you do to that patient for the medical patient is going to package into that

composite rate for the observation service.

The second caveat is if you have a surgical procedure, a surgery basically is going to be paid and not the observation. So basically, we can't have both. You're going to have one or you're going to have the other.

Does that make sense to everybody? So, again, outpatient prospective payment system has now taken on a very true meaning of outpatient prospective payments.

One pet peeve I do have about this whole packaging is the fact that -- and just to understand -- those that have to work with the correct coding initiative edits, the CCI edits, the MUE edits, all the edits that are required for the hospital to modify to make sure that we're correctly billing these services are going to trump the packaging. So Medicare is still going to say, if you don't modify your claims, we will noncover those line items even though they're packaged.

So a lot of times, we're going to be spinning our wheels, modifying codes that, at the end of the day, package. So just to tell you that everybody is suffering the same brain damage because at the end of the day, it's like, so what, let's just noncover them and let them go. But there are some cost report ramifications on that because now you're showing noncovered services which you cannot claim versus if you modify this, it's a covered service; it's just not separately paid. So that is the trick on the packaging side.

I did want to say too one of the significant things that was finally printed was a HCPCS code for the low dose CT lung cancer screening. We've been waiting for that code since February when Medicare passed the national coverage determination for lung cancer screening. It is G0297. The code is available January 1st, 2016. And at that time, you can actually retrospectively bill to February 5th, 2015. So the code is not going to be ready. I think there's been some articles written out there that says, yes, you can retrospectively go back and bill for this. They didn't tell you, though, if you go to the final rule, you can't bill that new code until January 1. So don't try to bomb your claims now. Medicare feels like you'll have plenty of time for those early claims to file those.

Also just make sure when you read the local coverage determination, that you also look at the registry, did you get all the right information prior to billing these claims to get those in the registry. So a side note, you are going to get a whopping $112.49, and that is unadjusted. So nobody in this room gets 100 percent of these adjusted payments.

So just as a note, I think some of the CT people -- I think it's very good service. Maybe Medicare will come up in price on the payment rate in the future after they have enough data to work with. I thought at least they would get it to the payment rate for a CT. They did not.

But anyway, that is one of the cheap things as far as the CPT codes that are valid. They did also -- someone had a question earlier about the Advanced Care Planning, and there's a new code for that as far as making sure that you have appropriate forms filled out. You know the time it takes. They would not comment specifically in the OPPS as to what the requirements are for that. So I think we really won't know the requirements for that service, for the nonphysician practitioner to perform this. They do have a payment rate of $54 for that, but we don't know how to use it yet. So I'm sure with the instructions -- usually they come out at the end of December. We'll know that instruction.

One of the other things that I did want to mention too is the OIG came out with I think is

a very, very important statement regarding self-administered drugs on October 29th. And I think it's very significant for everybody in the room. As far as our understanding and what the threat was in the past, self-administered drugs for outpatient Medicare is not covered for Medicare to pay for that. But everybody has always worried that if the hospital does not bill the Medicare beneficiary for the self-administered drugs, then they would be violating a kick-back law. The only printed one statement in the past regarding billing self administered drugs was, we don't regulate the billing policies of the hospitals, but it could implicate other statutory or regulatory provisions, including the prohibition of inducement to beneficiaries.

So the OIG has looked at this, and I think there has been so many complaints by the beneficiaries and the hospitals, about self-administered drugs, the OIG has come out with a statement that it is okay to waive or discount self-administered drugs to a Medicare beneficiary in a hospital outpatient setting.

They have four points, and you can get this out on the OIG website. I'll go through the four points quickly. I've got some hospitals that do bill the beneficiary. I've got some hospitals that have taken the liability, basically, for that service and noncovered these.

And in the early days, hospitals would bill and would not change any of their billing practices and just bill it, for those that know what I'm talking about under a 250 revenue code as covered, let them go. Because Medicare was not going to pay us anyway.

So now I think, again, because we have such a composite rate with the obs and the complaint rate with the self-administered drugs by the patients, they do now have a statement.

This policy statement applies only to discounts on or waivers of amounts for Medicare beneficiaries that owe for noncovered SADS, self-administered drugs. Hospitals must uniformly apply their policies regarding discounts or waivers on noncovered SADS. That means that they are going to do it without regard to the beneficiaries' diagnoses or type of treatment.

So, basically, if you decide to waive or discount these, it's across the board to all Medicare beneficiaries regardless of their situation in the outpatient setting.

Hospitals must not market or advertise the discounts or waivers. So you can't say come to my hospital because I'm going to waive your self-administered drugs charges to you. And then the hospitals must not claim the discounted or waived amount as bad debt or otherwise shift the burden of these costs to the Medicare, Medicaid programs.

So, if you are going to waive these copays or waive the amount that you're going to get paid for the self-administered drugs, then you would have to bill them and make sure your billing program is going to bill them as noncovered and provider liability. So it's going to put it in the right bucket for your cost recording services. It's not a covered service, therefore, you can't claim it as a cost. It's a noncovered service.

You're going to either shift that cost to the beneficiary and charge them for it, or you're going to take liability for that and not claim that as a true cost to the hospital.

We've been waiting on clarification for this since the year 2000. So it's a little slow, but we finally have it. If the OIG says it, at least they won't come after us. And with this statement, I would say that any other regulatory department would not say it. And I do believe that the beneficiaries, AARP, every other organization, have been loud and clear that they do not want to pay for it. I was talking to a pharmacist the other day of the laborious actions that have to be taken for the patient bringing their own drugs in and making

sure momma's sack of pills actually is what she's taking. And that purple pill in that other bottle with that yellow pill really is a R24 and this is round oval and what it is.

The liability of hospitals that have patients that bring their own drugs in is great under that scenario. It takes a lot of effort from a pharmacy to get it right, and all the reconciliation needs to be performed.

So taking that aside and having to actually be able to not fear waiving these payments is another story. Of course, again, the hospital is going to have to look at what the loss of actual reimbursement is for those that actively pursue and collect from the beneficiary and waive that against the poor person in the audience that actually has to answer the phone and talk to the beneficiary. Those that have had to do that -- and this may be a blessing in the future, that you might not have to do that anymore. And so I hope that that is good news, at least from the legal standpoint, that we do have permission to do that.

On a lighter note, we have one more rule. October 29th seemed to be a good week for proposing things, stating things, putting the final rule out for Halloween. But they released a discharge planning proposed rule. It's a biggy, biggy. Any of you that are involved in the discharge planning, social work, basically where that patient is going to go post-acute care setting, where they -- call it the PAC now. It's their initial work at PAC. So the PAC means post-acute care: Where is the patient going? Do they know what they're doing? Just because you reconciled momma's drugs and gave them a list, printout, and they left the hospital, do they know what they're doing? Do they know that they can pick up their drugs? Do they have any drugs at home?

Again, this is Medicare's way of assuring that readmissions are going to be even lessened. And they want to make sure that the patient has direct involvement in their caregiving.

The big kicker on this is that -- and I just want to say that I don't know who all and what the good plans are, but they're going to -- if you go to the proposed rule on CMS's website, there are standards for the discharge planning process that are going to be very widened on the hospital side. There's whole sections within the Code of Federal Regulations that are going to be modified or revised completely. Those sections are going to be under 482.43, under the Discharge Planning section. And then, basically, you're going to have to have a written process, which everybody does now; but it's going to be a very specific, what is your process, your medical staff, who is involved, who takes on the plan. The big issue now is it's going to apply again to inpatients, which we know we're going to do a very good job with that, but it's going to apply to all patients receiving observation services.

So, again, that discharge planning that you do so intently on the inpatient side is now going to apply to those patients in observation.

So are we hearing something prospectively again? As it's turning out for those short stays that used to be inpatient, that now are outpatient with observation services, what they are finding out is we're not planning well for them, they didn't stay long enough, or we didn't get to them.

So all patients in observation services will have the discharge plans that are the same as the inpatient side. It's also going to be applied to patients undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used.

This came out the 29th. And if you have any major comments once you read it -- it goes into great lengths about how this is going to change your planning process, they're taking comments for 60 days from when it published in the Federal Register, which is published on November 3rd. Read it and start putting your thoughts out there to make sure.

Because of all this, it always says to me is we're now going to increase staffing. And they think this is the second wave of a patient-centric healthcare system, where the patient has all input. They know what they're doing to stay well.

Again, we already dropped that ski several years and we're slaloming now to say in the past, fee for service, we want that patient in our hospital; that's how we make money; that's how we pay the bills. Now we want to treat the patient, treat them well, quality care, and we don't want them back.

So all I can say is at least we have an aging population. So I think there's going to be more in the pipeline. So with more in the pipeline, if we can keep those that are good and not that sick out of the hospital, then we'll have beds for those that are truly sick and need to be there.

And, again, from the proposed rule for OPPS, I do want to say, they're backing off on the two-midnight rule. Now, we're just as confused as ever. They are going to allow the physicians to have more input. And if that patient really didn't stay or is not expected to stay through two midnights, then maybe sometimes on an individual basis, it's okay that the doctor did that.

So again I'm going to give the prize to case management and those that have to deal with this on a daily basis, I think I would probably have no hair because I would have pulled all of mine out. And then all I can say is we can do the best that we can do. The doctor is trying to treat the patients. We're trying to give quality of care.

So, in general, we got composites for obs. Most things are packaged into procedures and/or visits. We've got a new discharge planning process that's coming soon, and we have something that we all need to go back to our hospitals and see how we need to, as a facility, address the self-administered drug situation that we've been dealing with.

Any questions?

AUDIENCE MEMBER: In light of the second comment you made about an individual where momma needs to be here, at the Medicare compliance formum recently, there was a big question to reinstate, either to enter a qualified screening criteria. Do you know anything that says we need to go back to those, justifying it that way or is it still have an inpatient order and the physicians stating why the patient needs to be in the hospital?

MS. NORTHCUTT: As best as I can read from the proposed rule and the final rule on that issue, they did not bring up the screening criteria to be the justification for it. I do believe that screening criteria help assist a physician in making a very valid medical determination. But I don't think that Medicare is going to actually ever go back to that, because they think that it's in the physician's head and in what they are treating. So, again -- yeah. I could be wrong and

they could print it tomorrow that, yeah, you can go that way. I have not seen it in federal lingo yet that we could.

AUDIENCE MEMBER: Regarding the QIO reviewing our claims, do you know if our appeals will go to the QIO or will they go to Cahaba? Who will we be appealing to?

MS. NORTHCUTT: I believe it is going to go back to Cahaba and then come back to you as far as that goes. And then I guess you go to the second level as always.

AUDIENCE MEMBER: Now that the two-midnight rule and both Educate is over, are they still going to not audit the patients who expire or transfer or sign an AMA?

MS. NORTHCUTT: Yeah. That is still part of the rule.

AUDIENCE MEMBER: Okay.

MS. NORTHCUTT: So really looking for the one-day short stay that really meets the qualifications. Inpatient-only procedures are still going to be excluded from this as well.

AUDIENCE MEMBER: The managed care companies also have to comply with that rule, those available?

MS. NORTHCUTT: Well, there's a Medicare fee-for-service and then there is a managed care population. And on this particular one, I believe that it's only going to be for the fee-for-service Medicare. Those that were falling under the jurisdiction of Cahaba, as far as these rules that are being published.

Then the two-midnight nonrule is applicable as far as if you can distinguish what it is. I think one of the things that I see that are going to throw more people into the mix or more hospitals into the mix is it's basically getting that order on that second day. I came in today, I don't have an inpatient order till tomorrow, and then I leave the next day. Even though the intent, if you look at it in the intent and they met and they stayed two midnights, that is going to fall out from a billing calculation, basically, because it looks like a one-day stay on the bill, when, in fact, they spent two midnights.

And so those I feel are going to be the highest threat for review, will be those that we're not getting that order till the next day. In a perfect world, if we can have a case manager for every six patients in the hospital -- how does that sound? Then I think that you could follow them around and know that I don't have an order for this patient and I've got to get an order today, hospitalist, or the doc has made up their mind they're going to be inpatient, let's get them done.

If we had that, those two midnights, those two days are going to not put you at a threat level. And that will be the same case manager that's trying to get that discharge plan written for that observation patient that you didn't even really know they were obs and now they're obs and they're leaving the next morning at seven.

So, again, I think there's a lot of issues to work out on which one that you want to hit that's going to make the most sense. Again, if I had my wishes, it would be if we could get that inpatient order written as quickly as possible in order to prevent you from having to go through the brain damage of the review in general.

AUDIENCE MEMBER: Cahaba was doing a good job of kind of not looking at the ones you're referring to right now because of the OCS72. Do you think the QIO will pull those still? Even if you put current code on that claim?

MS. NORTHCUTT: I don't know. I don't think that they're going to pull as many. I think the QIO is going to be pretty selective. Again, I think it falls back to staffing, just to be perfectly honest. So it could, with that occurrence code, at least prompt them to think this is valid. We're going to grow that out.

All right. That's all the good news I have today. I knew on a dreary Monday, I might as well just go ahead and top it off now. It didn't look like I put too many people to sleep, so I guess that's a good thing.

AUDIENCE MEMBER: You scared them.

AUDIENCE MEMBER: You had spoken about removing some procedures from the inpatient only list. Did those procedures go through on the final rule?

MS. NORTHCUTT: Yeah. The proposed inpatient procedures did go through as being off the inpatient procedures list. I think really the second level disks are probably the main ones that have thrown you in a quandary. And, of course, being prosthesis removal and replacements. Who knows?