BEST PRACTICES MINUTES
July 21, 2014 RIC/RAC Meeting

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: Good morning. We have Karen Northcutt to start off our meeting today with some Best Practice information.

MS. NORTHCUTT: We have a good group here. And I definitely think that we've got a good agenda today. I was just going to pontificate a little bit on what is going on. And we usually call this best practices or what's new during this session. And what's new is we got a gift the day before the 4th of July, and it was my favorite reading. It's the proposed outpatient perspective payment system for Medicare.

So the proposed rule came out July 3rd. I was just going to go through some of the highlights of what was proposed. If you'll remember last year, when I was sitting here about this time, Medicare had proposed that a lot of bundling and packaging were going to take place. And they went through all these proposals, and then they held back for this year most of the packaging.

Now, what they did package this year was laboratory services. So if I came in the emergency department and I had lab done, then our lab was bundled. If you have an outpatient procedure, that is bundled.

So what they had proposed and what they did last year was just a beginning of this packaging. What is proposed this year is they're going to package your pathology. That is going to be significant with all of your surgery cases.

When I talk about packaging, it doesn't mean that you can't bill it. It just means they're not going to pay you for it. So I always love that. You can bill it. They're just not going to pay you. I say that a lot.

And so pathology is now going to be packaged. And there are about 500 HCPCS CPT codes that are going to be packaged. And for the majority of those, it's your diagnostic radiology, so your chest x-rays, those simple diagnostic type of x-rays, a foot, a hand. Plain x-ray, that is going to bundle into your ED level or into your service that you have.

Also, a big one is EKGs. Those are going to bundle. So I'm just saying what you would normally see in the emergency department if you came in. You rule out chest pains. We've got our components. We've got our EKGs. And all of that now is going to package into the visit.

They did not change what the definitions of your ED levels are going to be. So they had proposed last year that they were going to go to one level, and then they argued through the rule that maybe they'll have two levels. So they couldn't come up with anything. So they proposed not to do anything about it.

So as you know, this year we have one level for your clinics. And we still have your own definition of your five levels and your critical care in the emergency department.

The next thing that they did last year and proposed and they want to adopt it this year is there are 29 comprehensive APCs. And what does that mean? That means that there are over 200 CPT codes that are going to flow into 29 different APCs. These are surgeries that have a device associated with them. So it's going to be your pacemakers. It could be your cardiology. So anything basically that you're implanting, those are called comprehensive APCs. And what that means is everything associated with that surgical event is going to be paid one payment rate.

So again, now we've got the lab cut out. We've got our diagnostic x-ray cut out. Anything else that's going to happen during that event is going to bundle to one payment. So there was a lot of argument about that as well, because you've got certain cases where in cardiology, you might have two stents placed. And they were saying that we are only going to give you one payment rate for that.

So the argument is out there that they might actually give us a higher weight to actually pay us additionally if you have two very significant device-related procedures. So I do believe that some of the proposed pricing did go up. We hope that it's going to compensate for everything that is actually going to package into those comprehensive APC rates.

But those are really the biggest issues that they addressed this year, so they kept quite a bit alone. Because I want to mention something that you probably should already be doing with lab starting July 1, just to make sure. There was an argument with the NUBC (National Uniform Billing Committee - they're the ones that write all the billing code regs) and CMS. And CMS adopted a bill type that the NUBC said, no, you can't really use for this service.

So in general, what Medicare did from January to July is if the only thing I have on a claim is lab work and the patient was actually there when you drew it, then we had to bill it as it was a non-patient laboratory, a 141 bill type. So we finally got all the systems ready to do that, and now they've changed it back July 1 to if lab is the only thing on the claim and you've drawn blood, the patient is there, we have to bill it as an outpatient hospital, a 131 bill type. And each line item of the lab has to have a modifier, L1, on each line. So that's a pain. It's an edit, and somebody has got to touch the claim again. But again, if you don't have that on the line item, then they're going to pay you zero for the lab. So it does help to actually stop the claim, look at it, and get it on there.

And again, I say that because the only time we're really going to get paid for lab anymore is that way. If you have anything else during that service, then you're pretty much not going to get paid for it. So I just wanted to make sure that we had that.

I do want to say that in the proposed rule, they have an interesting concept for anybody that has not dealt with two midnight rule and physician certification. Has anybody ever heard of it? Yeah, yeah. Okay. Nightmare.

In the proposed rule, Medicare is saying that the certification basically is obvious that through the progress notes, through the inpatient order, that the

physician's documentation should support what the physician's intent is. So, of course, we've never had to have a certification form, per se, and that they, CMS, should be able to follow the patient from order to discharge and see that that two midnight expectation was there and why the patient was an inpatient.

So in the proposed rule, they hung something on that is inpatient, I always love it when this is the outpatient rule, but then they hang something on the inpatient rule to the outpatient rule. So, then, we won't know this until the outpatient rule usually comes out, usually the day before Thanksgiving. So we'll know that then whether they adopt this. But what they want to do is change the certification process to only be extended to long stays and cost outliers. So what they're proposing is the physician will have to certify any stay that is greater than 20 days. So that's kind of the change in the process. I know. We were supposed to certify that we've got a short stay DRG payment, and now we're going to have to justify why they're here 20 days and greater. So they've gone all the way down to the other end of the building, if you will, as far as how this is going to flow.

In saying that, we do have one thing that I want to clarify too along with that certification process is those hospitals that are doing the Part A to Part B rebills through a self-audit. And what I have read and what I'm seeing now is that many still don't have a process down for actually notifying the patient that their status has changed. CMS did clarify again that it is the responsibility to follow the conditions of participation that the patient actually has to be contacted after that discharge of the status change.

They do say too that the physician should be knowledgeable of it, and we hope that they are. But through this self-audit, it's kind of disconnected between who's notifying the patient, who told the physician, and where do we keep that. But they did want to remind beneficiaries their benefits have changed and any other liabilities that they would have. So I did want to clarify that and make sure that you were actually doing something with that.

Some of the other issues are on the agenda to discuss today with Cahaba. One of them is respiratory therapy. Several have asked to make sure clarification is there. I don't know how well it is clarified in our packet.

Respiratory treatments are still going to be paid, not packaged. So this makes it even more important, is the fact that the CCI (Correct Coding Initiative) manual came out and said that respiratory treatment you can bill basically per encounter. And per encounter in most people's mind is I came to the hospital, it is an encounter. I came to the emergency department, it's an encounter. A NCCI representative has clarified the respiratory treatment issue. I think it has muddied the water a little more. And what the people at CCI have said is that the treatment is actually how many times the patient is encountered. So if I'm respiratory therapy, I come see the patient. I give a treatment, and I go back, and then I come back and give another one.

Now, they say that that is a separate encounter if the intention is not to have a medically necessary encounter. If the physician orders aerosol times three, that's considered now one episode, because the treatment was given in subsequent sessions without reporting that basically that they got better or basically they need another treatment. So that muddied it even more because now I don't know what an episode is. I can see their point that maybe they don't need three treatments, but the doctor has already ordered it. And so you're going to fulfill that. Now it muddied it even to the point that they're saying that that would be a separate episode if you reported back to the physician.

THE SPEAKER: So do we need the 76 right now? We're doing the modifier for each one of them, right?

MS. NORTHCUTT: That's where I was hoping for a little clarification today. So if we go through that with Cahaba, that's why doing that. Because on their answers here, they do say that an encounter in the emergency department is one episode.

So if we go with what they had said, is that if I had two breathing treatments in the ED, it's considered one episode. And they said if you're in observation and you had three different encounters, then that's going to be three. So I just wanted everybody else to be as confused as I was when this comes up. But it is an issue because you do have to modify it. You're actually doing the service. And it becomes very hard to explain to respiratory therapy what they should do and how you're going to bill it and whether we're going to have a billing edit at the end of the day that we're only going to bill one.

THE SPEAKER: Karen, just one more clarification on the lab. The OPPS rules. I was just wondering was there any changes or are molecular and the drug tests still excluded from the bundling?

MS. NORTHCUTT: Yes. Right now the drug screening is not packaged. Which I'm just floored. But the drug screens are still not bundled yet. And I started thinking, well, maybe they think it's a screening service or a preventative service or something. Because it's just very odd that we would have that. And as you know, any Medicare patient that comes in with altered mental status or anything, they're pretty much getting a drug screen.

So whatever reason, you're safe on those right now. That's one of the few that we have left.

THE SPEAKER: So are you saying if the doctor orders respiratory treatment times three and I've been going back and putting the modifiers by two and three, so do I continue to do that or no?

MS. NORTHCUTT: That's why I'm hoping to get some clarification from Cahaba, if you read the response from the people at CCI, if you really look at it and try to make something out of it, it does make sense, but it does not explain an episode. So each time the health care professional goes and has this breathing treatment, then they consider it an encounter. But they threw the medical necessity piece in there, which is the hard part. They got better. They got worse. We're going to give another treatment. So that documentation, trying to support why you applied the modifier, which makes me nervous either way to put it on now. And I wish I knew exactly the answer, and that's what I'm hoping to get some clarity on today. I do have a feeling, though, that they're going to say it's per episode based on what I read in your packet today.

THE SPEAKER: But the episode could be PRN, right? I'm just saying.

MS. NORTHCUTT: A PRN episode. Yeah, yeah. So I can see where you should be providing a treatment, seeing if they're getting better, and then if they're not, then you're going to do another. That's more interaction than breathing treatment times three.

So, when you really look at it that way, you can see where they're coming from, was it really, truly medically necessarily when you don't even know how they responded to the last treatment?

THE SPEAKER: Karen, in 2014 add-on codes were bundled in 2014, right?

MS. NORTHCUTT: Yeah. Well, we still had some add-ons. But now all the add-ons will be bundled into that comprehensive, the APCs. The thing that they did not bundle, which I was very happy about, is on the infusion therapy. So the add-ons are safe right now on the infusion, IV pushes and injections.

THE SPEAKER: So most of those add-ons will be bundled?

MS. NORTHCUTT: Most of them were bundled this year. The composite rate for observation did not change. It's still $1,287. And that includes the payment for your ED Level 4 or 5 critical care visit. So again, just a reminder, there is no payment when you bill the observation code. All the payment is going to be remitted back on the emergency department level.

And I do want to say, just because I saw this the other day and it was heartbreaking, I had a hospital, and it was new to me, out of Florida. And I had reviewed a lot of their files. And what they had done was bill the hours for observation per each date of service on different line items, and thinking that Medicare was going to pull that up and read all of those and actually pay us on that.

But what was happening is if they came in and you had three hours of obs the first day and then you had 17 the next day, Medicare was reading the first day and it was three hours. We don't get any more money for observation unless we're eight hours or greater and they're going to read that first date of service.

So on many cases where they had everything right, looked great, met observation, they did not get the composite rate.

Make sure that all your hours are billed on one line on the day that the order is written and observation commences.

THE SPEAKER: What did you say the reimbursement was for that?

MS. NORTHCUTT: For the composite rate, it's $1,287. So if you're a Level 4 or 5 or you're a direct admit from a physician's office or you come from a clinic and go to an observation service, then they will pay us $1,287. That's going to include your ED payment. Now your lab is bundled, that EKG is proposed to be bundled, and now most of your diagnostic x—ray will be bundled. Also, that payment rate will be reduced by your wage index. So that's the maximum. Unless you live in San Jose, and then you get more than the APC payment rate. But most of us are going to get around 86 percent on the wage.

MS. WHATLEY: Thanks Karen, we appreciate this information.