BEST PRACTICES MINUTES
July 13, 2015 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt
Ms. Debbie Rubio
Ms. Vrinda Kosgi

MR. ASHMORE: We're going to begin today with Best Practices with Karen Northcutt and Debbie Rubio with Medical Management Plus.

MS. NORTHCUTT: Debbie is going to start off with some issues that I think people were trying to clarify about the LCD (local coverage determination) redeterminations and the development. So to get started, I'll turn it to over to Debbie.

MS. RUBIO: And Karen is going to talk about the proposed rule, so I'll try to be real quick about Cahaba's LCD process. As Karen said, some people had asked for some further information on this. And so I'm really going to concentrate on draft LCDs, the comment period and then the reconsideration process. And I think everyone realizes an LCD that Cahaba publishes defines the indications and conditions for medical necessity of certain services to support the coverage of those services.

Really, everything that I'm going to talk about today, you can find on Cahaba's website, www.CahabaGBA.com. And be sure you're on Part A, which is for hospitals. And then under the quick link section, there is an LCD that you can click on and go to the web page that contains all this information. It has a lot of the descriptions and links to other pages and links to the policies.

When Cahaba first starts with the policy, they publish it as a draft policy. There is at least a 45-day comment period. So this is the time, if you have concerns about the policy, to submit your comments. And you can do that one of three ways. There's an e-mail on that website that you can just click on and enter your comments on that e-mail and send it. There's also a fax number and a mailing address, if you prefer to send your comments in that way.

Once Cahaba has received all the comments, reviewed those, they may make changes to that draft policy based on the comments they receive; but then they will publish a final draft; and there's a notice period of 45 days for that finalized policy. So you still have time to be prepared within your facility before that policy becomes effective.

Sometimes, though, even if you read the draft, you may not really realize the impact of that policy until it goes into place and you start receiving denials. And at that point, it is not too late to give feedback on the policies.

You will give feedback on finalized policies through the reconsideration process, which is also on that page that I told you about. You can get a link to that page. Again, you submit those comments the same way, through e-mail, fax, or written comments.

When you do a reconsideration, you need to be very specific. It has to be submitted in writing, you want it to say exactly what you want to change. So you need to say the language that you want added, the language that you want deleted, and new diagnosis codes that you would like to be considered. Plus you need to provide some justification for that.

You do not just say I want it or because I said so or because you are receiving denials. There needs to be some medical literature or something that supports the change that you are requesting.

Now, once you submit a reconsideration, Cahaba has 30 days to decide if it's a valid request or not. If it's not, they'll let you know. If they decide it's a valid request, then they have 90 days to decide what they're going to do about your request. If they do not change the policy, retire the policy, whatever, then they will also let you know, send you a response to what they have done there.

That is just very briefly how the LCD process works. There continues to be more and more all the time and reviews based on what the policies say and don't say. So does anyone have any questions about the LCD process?

Also, I want to point out, and we may talk about this during Medicare's discussion, that the Probe & Educate Program was extended again through September 30th of 2015. So some of you that thought your hospital was through with the Probe & Educate Program are again receiving requests. That's because of that extension that was in Medicare Access and CHIP Reauthorization Act of 2015.

One other thing that people had wanted us to mention is that if you are billing for screening mammograms or vaccines, like flu, pneumonia, for hospital inpatients, those need to be submitted on a 121 type of bill.

Now, let's hear from Karen about the proposed rule.

MS. NORTHCUTT: Medicare came out with the proposed outpatient prospective payment system rule right before July Fourth weekend and I am going to try to summarize it.

There were quite a few things that were tucked away in the proposed rule. The one good thing is they did not have significant changes this year as they did last year, they were doing a lot of clarification, what went on last year. And last year as we know, Medicare is trying to make an outpatient visit or an episode, a bundled payment. They've been working at it.

This is the 15th year of APCs and in the past, for just about every CPT code, HCPCS code, Medicare had a separate payment for each code. Then gradually over the years, they have bundled codes and say this code is associated with this code, so we're going to pay you this much and not pay you separately for different codes.

The year before last, Medicare bundled just about all laboratory tests. That was the first thing on outpatients. If you had a visit, either in the emergency department or observation, then they bundled laboratory. This past year they realized that they messed up and they overpaid in excess of a billion dollars for laboratory services that they did not package in 2014 that they thought they did.

And I was always wondering when it was going to catch up with them, because they

were supposed to package all pathology then and they were supposed to package drug screens. Well, they went ahead and paid it all out.

So this year, as you'll see, they are making a 2 percent adjustment off of the major calculations for APCs this year to compensate for the billion dollar mistake that was made the previous year. So just as a side note, if you read that and you see that there is a 2 percent decrease and a conversion factor, basically, in the whole payment system, they adjusted that down. So that was one mistake that they made.

But they went on packaging last year. And as we know, most simple diagnostic tests, all respiratory therapy treatments, most all labs except molecular pathology, were all bundled into your ED visit with your EKGs, all of that bundled into the payment for your ED visit or your observation visit.

This year we have what is called a comprehensive component payment for observation. And as we know, just for a slight primer, for observation, if a patient comes in the ED and they have a level four or five visit and they go and have observation services eight hours or greater, then Medicare pays us what's called a composite rate. They pay us for that observation and they took the ED and bundled that into the payment.

This year, observation has its own composite. And it will still follow the same rules of how you qualify for that composite rate; but everything bundles, except for preventative services, into one flat rate.

So, for example, if I come in the ED, altered mental status, fell down, cut my head, they sew my head up and then I have a CT scan -- which was not packaged last year -- and let's just say I had a shot, all of that will bundle into one payment rate for the entire episode of care when observations services are ordered. And there is going to be a modifier that you can put if there is a different physician that orders a different service. But that's going to be very, very rare as well.

The good part is, is that the increase in the composite is around $900 from over last year, but you have to remember that your drug administration is now packaged into that one payment and your significant diagnostics, which are going to be your CTs and MRIs.

So at the end of the day, if I'm in obs and I'm there coming through the ED and I'm there 30 hours, then the unadjusted payment rate is about $2100. And that's going to cover payment for everything.

So that is the biggest deal that came on the APC side. There are some issues that they wanted to address as well on modification and how we modify laboratory. And as anybody that has to do billing and understands how that goes, right now we're having to modify lab if it's the only thing on the claim and the patient actually presented for venipuncture. And we had to put modifier L1 on that claim. So they are changing that for us and making it better for us and making a different status indicator for those labs. So if that's the only thing on the claim, on a 131 in January, we won't have to modify those anymore. So that was a good thing that they did.

I did want to say that one thing that was very tucked away, I think it was on page 585 out of 697 pages, they did come out with a basic ruling that is going to be effective

October 1. I always love things that they tuck into this. And one of the things that will become valid is that starting October 1, it's called a new medical review strategy. And they are actually changing the medical review policy. This is going to dovetail into something else that's new but for short stays, the QIO will be the one to review those. They're going to do samples of post payment reviews. And it's not going to be the RAC to start with. And it's not going to be the MAC.

So the QIO, which is going to be KEPRO, is going to audit all of those short stays. And then they're going to educate you. And then they are going to identify those that are aberrant and those that did not learn from their education. And now they're going to turn that data and those volumes over to the RAC. So it's going to go from the QIO and now the RAC. You still go through the appeals process through Cahaba. So this is going to be a whole change from the short stays.

AUDIENCE MEMBER: Are you saying short stays as in one day or two midnights?

MS. NORTHCUTT: Anything less than two midnights. This is very important because of the other proposed rule that was hooked onto the outpatient rule. Number one, we have this starting October 1. But they are proposing that they are going to broaden the definition of the two-midnight rule and make it even more ugly and messy.

So, basically, it's gotten so gray now. But, at least, we had a hard and fast rule of the anticipation of the doctor that they're going to be there through two midnights, everything is good. I think we're getting it. Well, they said, you know what? Well, we're going to have some doctor discretion in here and the doctor might think that they need to be an inpatient based on signs and symptoms and/or the risk of adverse event and that the patient may not be there two midnights, but I feel like they need to be an inpatient.

So in those cases, when the docs now have some indication that they have more leniency, I suspect that we'll have many more one-day stays.

So it's going to be the QIO that is now going to be the one auditing you. So, again, I don't know how you break it to your docs. I don't know if you even tell them. And we've gone through all of this brain damage for Medicare to come back and say that that there could be some times when inpatient would be ok without an expectation of two midnights.

Now, they did say you should not have any minor surgeries or anything of that nature as an inpatient . So the old days where the cath lab patients, patients getting stents, spent the night and were one-day stays, I think that's still not an inpatient. I don't know how sick you have to be for one night or the risk of adverse effect that you would all of a sudden be okay for inpatient.

But that was the big varied points in this outpatient prospective payment system. So we're talking outpatient. And here we are talking about a two-midnight rule that's proposed to be more lenient. And we're talking about who's going to audit you. That is fine. So the QIO transition will start October 1 and that is final.

They took off about seven inpatient-only procedures and four of them are spine

procedures, two are penile implant procedures. So what I was looking for were all the stents, and they have failed to take those off the inpatient only list again. So those are one of the one-day stays that I always see are carotid stents, but they are safe on the inpatient-only list.

AUDIENCE MEMBER: Will we hear from the QIO? Are they going to send it to RAC leaders?

MS. NORTHCUTT: I think that from what I can gather, the QIO is going to educate you. And then if you're not educated and they start seeing a high volume, that's when they're going to refer to the RAC. So they don't really say, but hopefully they will come out with some instruction instead of the long Federal Register on how this thing is going to work. I have a summary that we have done about the two-midnight proposed changes and the QIO that I will send to Peggy to distribute to you.

Put that on your website or whatever you want to do on that. Because it kind of lists what the functions are. As everybody knows, August 2014 the QIO actually split into two different entities. And so one is really about quality and one is under the medical reviews, higher weight DRGs. So they are two separate and distinct entities as well under the QIO. We've got numbers listed for the QIOs.

Has anybody gotten anything from Kepro? Do they sound familiar to you? I think it will be the same. I don't know where their requests come for the post payment where it's going to go. I don't know who to contact yet. I'm sure we'll hear a lot in the future about that.

I did want to say, too, that a proposal that just came in yesterday, kind of interesting at best, is really going to affect Dothan, Montgomery, and Tuscaloosa. The comprehensive care for joint replacement for acute care hospitals furnishing lower extremity joint replacement services, the CCJR, are lucky enough to be selected to participate and that's mandatory for 75 different geographical areas where Medicare over the next five years is going to practice bundled payments for joint replacements, hip and knee. So anything lower extremity joints.

Now, what they're going to do is they're actually going to look at a 90-day episode of care. And that's going to include the inpatient hospital visit for the surgery, all post acute care, whether it's home health, the SNF, the acute inpatient rehab, and physician.

They are going to hold the hospital liable for quality outcomes and for excessive payments for episodes of care. They think that the hospitals are going to be the ones that are going to be able to control this.

So what they are going to do is they're going to give the hospitals involved in the geographic areas three years' worth of data that shows payments for these episodes of care within that geographical region. And they are actually going to allow you to come up with what you think your target price for that episode of 90 days is. Then at the end of each year, they're going to see what your actual quality outcomes are and what the actual payments were. They have not really said yet exactly how this is going to work.

In the second year of the program, they are actually going to give you an incentive, repay you if you actually went under your target price. If you go over your target price, then they're going to take money back from you.

So this is very significant. They have a lot of demonstrations where this was voluntary, but this is not going to be. So you are going to be the guinea pigs for the state that are going to get to practice this. So I look forward to hearing how this is going to go.

Since they just proposed this, you have until, I think, September 9th to actually make comments. It came out in the Federal Register last Thursday. And CMS has a FAQ sheet out on their website as well. But for those interested parties they are holding the hospitals directly liable for care in the total episode. How well are they if going to outpatient rehab? Did the patient go to a SNF? Are they spending too much money in the SNF? Are they better? And controlling the physicians' services within that. They are going to take out chronic illnesses. This is going to be specifically addressing the replacement.

So if you have a revolving door patient with other chronic diseases, I think those are going to be considered an outlier and won't be part of what this payment process is.

So those were basically the big surprises that came out within the last three weeks that I know of.

AUDIENCE MEMBER: And I guess the physicians have no role in this? I mean, their payments are not going to be bundled?

MS. NORTHCUTT: They're going to pay the physicians, the home health agency, the SNF and the hospital. They're going to pay everybody. This is kind of a pretend thing, if you will, over the next five years, except for they are going to actually pay you an incentive or take money back. So, yeah, the docs aren't going to get dinged, the SNFs, the home health. Everybody is going to get their money. But the hospital, being the only ones that really are the directors of this service, are going to be affected monetarily within the next five years.

AUDIENCE MEMBER: And can you say what that was again, please?

MS. NORTHCUTT: The CCJR, Comprehensive Care for Joint Replacement - comprehensive care for joint replacement for acute care hospitals furnishing lower extremity joint replacement services.

AUDIENCE MEMBER: Seems there was a special blip on it, right?

MS. NORTHCUTT: Yeah, there's a special blip on it. That came out Friday. And it's going to be DRGs 469 and 470.

AUDIENCE MEMBER: The affected hospitals, will they get like a letter, a greetings letter, or you just have to read it in the Federal Register? Do you know?

MS. NORTHCUTT: I think that you definitely need to read the Federal Register. It's very lengthy. It goes into how they calculated, what they did, and it is very in-depth into how they're going to notify you, how they're going to get you your data, the data for the geographical region that you're in. And they're supposedly going to give you your data so that you can make decisions on it.

This is the proposed rule and we've got until September 8th, September 9th, before the comments close. And then they'll have another probably 45 days. So really the sad part is for this to start this early and we won't have a final rule probably until October.

So if you want to argue or comment, please read the rule and put your comments in. Because you will definitely be affected. There's going to be an assignment of somebody within the hospital that is now going to really have to manage; specifically, if you do a high volume of joints, to actually look at it.

So just in consideration of who's going to manage this and who's going to herd the cats. CFO probably needs to know that too.

AUDIENCE MEMBER: Has any thought been given to how this is going to impact patient choice in post acute care providers?

MS. NORTHCUTT: They are going to allow beneficiaries to have patient choice. How are you going to arrange it is an interesting thing. They've got a whole list of requirements - you know, the patient, the beneficiary, still has choice. If they want to go rehab in Florida, I don't know if they're looking at because they've got out of the geographic region, that that's going to not play into it. There are quite a few outliers that they're going to consider.

AUDIENCE MEMBER: I would think it would be more local. If you know a particular entity provider is not as good quality as another provider, the outcomes are not that good, if you happen to know that what can you do?

MS. NORTHCUTT: They're saying that the hospital is the best director of the care. So, to me, it's always about choice and giving the beneficiary choice and that you can't act like you're favoring one agency over the other when, in fact, if you are directing this care, just in my own opinion, I would definitely suggest highly this agency that does such a good job with lower extremity joints. So I don't know how the SOWs is going to look on that. But they did want to make sure that the beneficiaries still had choice. And I don't know if it's just blowing air and saying that because they had to, but that one was definitely in there.

It's going to be interesting. Everything is going to be a bundle, just like on your TV, Internet, and phone. It's all going to be a bundle.

AUDIENCE MEMBER: Do you think this is going towards being final?

MS. NORTHCUTT: I believe, because they do say quite a bit within this proposal that they have succeeded in demonstration projects across the country on similar episodes of care. I think that they think they know what they're doing enough to give you the data that you need.

And I know that they are determined that we are going to go to accountable care organizations. We are going to function as one between physicians, all post-acute care providers, and the hospital.

I didn't think that it would be so severe that they would just say the hospital is going to direct this. We've done so well at being able to direct the doctors in the past, I think an excellent job at everything that we've done on admissions, medical necessity, having them order stuff that they don't need to order. So I think this should fall right into place with that as far as I can tell. That's the good, if there is a good thing.

I think from a physician's standpoint, the follow-up care is what they're looking for. They were already held under a global surgical period. So from a physician's standpoint, either you want to see the patient early, make sure they're progressing, and then the patient can go bye-bye -- I apologize, you're good, you're taking up some office space -- or those that really want the patient to come back and back and back. Is that medically necessary for them to do that? When are they discharged from the surgeon?

And I think that they're going to the SNFs, because we got 21 days. I think that's going to change, as anybody that deals with Medicare advantage programs. Rehab for them is a lot shorter in SNFs than fee for service Medicare. It's amazing how you can extend that if you're a SNF.

How do you determine appropriate length of stay with that skilled nursing facility, how long does it take them to rehab? And under what circumstances would a knee replacement ever go to rehab? Are they going to go straight to outpatient PT/OT? How is that going to look? Or are they going straight to home health?

So, again, trying to get all of these different parts and pieces together and functioning as one is challenging - you know, whoever gets that job in the hospital, bless them. That's all I can say on a Monday morning.

AUDIENCE MEMBER: I guess I just wanted to reiterate. Because if you think of anything else just to see that everybody goes in there and puts a comment that this is ridiculous or something like that, just comment.

MS. NORTHCUTT: Yes. Read it and comment. Whatever piece that you feel. And, like I say, this was just thrown out there on Thursday. It's pretty significant, though.

AUDIENCE MEMBER: But everybody needs to comment, especially Tuscaloosa, Montgomery, and Dothan, and everybody else just to see if we can make a difference.

MS. NORTHCUTT: Yes. You know, I'm from Birmingham. I don't know why it didn't get hit. Maybe they think they are closer-knit communities. You know, and Dothan, I know you can ride all the way around the circle. They got one hospital over here, we got one hospital over here, and you can go straight through the city to both, or you can go all the way around the circle.

So it's like whoever you're closest to on the circle is really where you're going to go. So I know about that now, where the SNFs and where is the home health and where is the outpatient rehabs in all of this.

And if the doctors are practicing at both facilities, do they keep them longer at one than the other? Why is that? You know, do they start rehab quickly? Your knees are going to probably post-op two hours; they're probably going to have you walking down the hall now. So it should be interesting.

AUDIENCE MEMBER: Who is responsible for coming up with the price? I mean, say Jackson Hospital in Montgomery does the surgery in the OR. And then the patient goes to HealthSouth Rehab there in Montgomery. Is HealthSouth supposed to give Jackson Hospital their charges?

MS. NORTHCUTT: No. They actually are going to pay HealthSouth. So here's the deal. For the first five years, they're going to pay their individual entities whatever they're getting. So that's where they're collecting the data. The only penalty is going to be after you develop your target price for the management of that. Basically, that's where they're going to take money back or give you incentive money. But they're going to pay HealthSouth, they're going to pay the hospital, and they going to pay the doctors.

AUDIENCE MEMBER: Okay. But my question was more about that management price. Is the hospital responsible for coming up with that price for nonrelated parties that will be charging?

MS. NORTHCUTT: That's right. Supposedly, CMS is going to give you all the paid data for that geographic region for each entity for this particular service. So you will have access to all the data. They said that some of it will be PHI scrubbed but that you will be able to follow a patient and actually see HealthSouth, what they paid them, what they paid Sports Rehab over here, so that you can actually see it based on the DRGs selected.

MR. ASHMORE: Thank you, Karen, and Debbie.

(Continued discussions after the lunch recess)

MR. ASHMORE: United Healthcare is not with us today, but they did provide answers to our submitted questions. We're not going to go over those as you have them in

your packets. But, Vrinda Kosgi from Baptist Health in Montgomery is going to share her joint operations program that she has with United that can be beneficial for some of you at other hospitals.

MS. KOSGI: I know we all have issues with United Healthcare, but this helped us some, and I just wanted to share that. So if any of you wanted to go select United Health, you can do that. And also what we've seen as -- from the student company perspective, we've not been getting as many examples as we expect because we do all have issues, I'm sure. I'm going to talk about some of them that we were having, and we have brought it up with United Healthcare through this joint operations meeting that we've started having since last year.

They come down to our facility, and we are given a chance to go over all the issues with them. And they take it back and try to resolve them, and it's a little bit more proactive, and has helped us.

And some of the issues that I just wanted to mention that we were having, and I think some of you also must be having were 835 EOB mismatch issues. We've had this issue for about five or six years now. It hasn't been resolved yet. But some of the issues which used to take a long time and lots of effort on our end are kind of getting better, because we basically send a list of all our issues now in a specific format to Linda Fetsch on a weekly basis. And she forwards those issues to their MSA team to resolve.

They process it for us separately other than the routine kind of claim processing. It's getting done faster, quicker. And another issue that is on our list is reallocation of refunds, where our vendor is sending refund checks to them. And they're recouping again on their remit.

But we're addressing every issue that we have via weekly e-mail in a log to Linda Fetsch.

Other issues I wanted to mention was Billing Type 137 denied as duplicate, UHC inpatient claim vaccine charges, provider credentialing. Those are things that we are having issues with.

And then we're also having "false out of network" responses for our facilities. And they gave us some sort of a workaround. There's a workaround for everything, so we're trying to push them to do the root cause analysis on all these issues. And I think it would help if more providers get onto this and report the same kind of issues so that they can fix their systems. I think it would help, I just wanted to share that with you, to try and contact Linda Fetsch to do the joint operations meeting and set up a process. Last year it got better with some of our issues, so we stopped having the meeting.

And then this year, when we had our yearly meeting, it was again a stack of issues. So I would suggest that you start having bi-weekly meetings so that the response time from UHC is basically being tracked on all issues. And then Linda provides her comments as to where it is with MSA to us before the next meeting when we go over those issues together to see what's going on.

But we have requested a root cause analysis on some of these issues, which are

common and they are mostly system issues.

I just wanted to spread this word out so that more providers are getting into the joint operations meeting with them so that, hopefully, we can bombard them with the same issues again and again and push them to do the root cause analysis. We can go faster than we are right now. Thank you.

MR. ASHMORE: Thank you, Vrinda.

MS. NORTHCUTT: Before Blue Cross starts, I did want to say that from the OPPS proposed rules, there were two other things that I just wanted to mention. And for those that are looking at their radiology on the CT scans and the updates to the XR 292013, which means your upgrades, your CAT scan machines have to meet certain qualifications in the future. And Medicare is in on that as well. They're developing a modifier for you to actually modify the CPT code for the CAT scan that you performed, if your scanner is not the approved scanner now. And they're going to reduce your payment by 5 percent next year and 15 percent in 2017.

So I've heard anywhere from pricing of $300,000 to upgrade these CT scans machines to even more than that. Just to be aware that there will be a modifier created for that, and you will have to get with your radiology department to see if all of your scanners are updated. And if they're not, how are you going to know which machine your Medicare patient used for their CT of their head. So I did want to say that.

And one other thing on chronic care management, if you're performing that in your hospital, there are probably three pages of new rules that will apply for chronic care management provided in a hospital setting. You'll want to go to the proposed rule and look at that if you're providing those services just to make sure you're in uniformity, because I think it's going to be harder to pull off than to actually perform this service. So just wanted to make sure I remind you of that. Thanks.

MR. ASHMORE: Thank you, Karen.