BEST PRACTICES MINUTES
July 18, 2016 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE. Good morning, everyone. I'm Wesley Ashmore with the Hospital Association. I'd like to welcome you to our Summer 2016 RIC/RAC meeting. And with us this morning, we have Debbie Rubio with Medical Management Plus, who is filling in for Karen Northcutt this morning to do our Best Practices.

MS. RUBIO: I do want to start with a topic that Karen covered last time. Medicare has coverage policies both at the national level, which are your national coverage determinations, or NCDs, and at the local level, where the individual jurisdictional Medicare Administrative Contractors, or MACs, developed the local coverage determinations, or LCDs. And also, the MACs may sometimes publish articles that define the coverage of an NCD or an LCD or include coding and billing information.

So Medicare has an NCD on pacemakers. And they tried to publish some coding and billing guidance at a national level, but that was basically a disaster because their instructions were incomplete and even the MAC couldn't get their edits right. So when people tried to bill for those services, they got a lot of rejections and problems. So Medicare retracted those coding and billing instructions. Now, the NCD is still effective, but they took back their coding and billing instructions and said, well, the MACs will handle that at a local level.

So in March, Karen told you about a draft LCD that Cahaba had developed that was going to include pacemakers and other cardiac procedures and was very thorough and covered a lot of issues. Well, you will not see that LCD. It did not make it to final. But what they did instead was publish an article about coding and billing guidelines for pacemakers. And to me, what's really interesting about that article is that every MAC in the country published the same article. So at least we're consistent across the MACs.

And it does also include a lot of good information about coding and billing for the pacemaker insertions. So it's a lot more complete and a lot more understandable than Medicare's original instructions. It addresses the diagnosis codes that are supported for the pacemaker insertion based on that NCD.

Now, remember, you would have to report those with a KX modifier. But it goes beyond what was in the original NCD by even including some cases where the patient needs a pacemaker insertion but is asymptomatic. And one of those things that was included in that was the thing that we were questioning here for those patients that are having a catheter ablation of the AV junction. Of course, they're going to immediately need a pacemaker, and that wasn't in the original NCD. So that is in that coverage article. You add a KX modifier for those indications also.

The article also includes some indications that were not addressed in the NCD. And there's a new modifier, or one that I had never heard of before, an SC modifier, that says the services are medically necessary. They list just a few examples of those types of indications as things not addressed in the NCD. But that includes a BIV pacemaker where you would have a third lead, or it also includes some congenital heart conditions where you might need a pacemaker. So just be sure and find that article on Cahaba's website and read it to address all of the coverage and coding and billing instructions that they have put in that article.

I also wanted to go over this morning a couple of proposals that Medicare has put out that they have delayed. The first one is the mandatory requirement for the JW modifier. Now, the JW modifier has been around for several years. You use it when you are reporting drug wastage. But prior to this

instruction from Medicare, it was up to the individual MACs as to whether they required the reporting of the JW modifier with wasted drugs or not; but this transmittal, originally effective July 1st, said that Medicare would be requiring the JW modifier on all drug wastage. And this would require that you report one line with the drug in the amount that you actually used and then you would report a second line with the JW modifier and the amount of the drug that you wasted. You also have to include documentation in the medical record that the drug was wasted.

But they have delayed that until January 1st of 2017. So that gives some time to figure out how you're going to implement that, how you're going to make sure you have the documentation in your record.

On the open-door forum, where this was discussed a good bit, they did say that they would be publishing a list of frequently asked questions to address the issues that people had. So if you have questions, you can send those to the open-door forum email address that you can find on Medicare's website and, hopefully, they'll address any concerns in those FAQs.

Another thing that has been delayed is the change in billing of therapy-like services. I just love the way they call those therapy-like services. But as a little background to that, let's talk about packaging and comprehensive APCs.

If you remember, Medicare is packaging, on outpatient basis, more and more services. Starting last year they implemented comprehensive APCs, where there is a primary procedure and everything else on the claim, all the adjunctive services, the payment for those are bundled into the payment for that primary procedure. So if you perform one of those procedures that are designated with the status indicator of J1, then everything else on that claim is packaged and you receive one payment for the entire claim. And, of course, this year, they also added observation as a comprehensive APC and gave it a status indicator of J2. So therapy services - that is your physical therapy, occupational therapy, and speech therapy, is one of those adjunctive services that they have been bundling into the comprehensive APCs.

Now, they've been doing that since the beginning. But they came out in the July OPPS update and said, well, we want you to report those therapy-like services differently. Now, these are not the therapy services that are under a recurring plan of care. Like I said, this is therapy that you would be providing when a patient had a procedure in a hospital and was just there for a day or two and the doctor wants them to have a little therapy. They now want you to report those with a 940 revenue code instead of the therapy revenue codes.

When this was discussed in the open-door forum, their reason is, well, some hospitals were having problems with codes that required the functional limitation modifiers. And the audience listening to the open-door forum told them very quickly that that was a lot of overkill to solve that problem with something else that was going to create more problems.

But anyway, as of today, that's still what they're planning to do. But they have delayed that from July 1st to beginning October 1st. So we'll just wait and see if they change their minds again or if they go forward with that.

I did want to mention a few things from the proposed rule that came out this year on July 6th. There's not a lot of changes. Probably one of the most significant was what they published in the rule about implementing the change in payment for off-campus provider-based departments. If you will remember, the Balanced Budget Act of 2015 has a rule in it or a law in it that new off-campus provider-based departments will no longer be paid under the OPPS payment system. That payment is more than what services would be paid in a physician's office or an independent clinic. Now they define new off-campus provider-based departments as those that were not billing as of November 2nd of 2015 when the law was passed.

So in the proposed rule, Medicare comes out with their suggestions on how they're going to implement that payment January 1st of 2017, when it's supposed to begin. And basically, they said we do not have a way to pay hospitals other than under OPPS. So they are proposing that for a one-year temporary solution, they are going to pay just the physicians. They will pay the physicians for the services provided in a new off-campus provider-based department at the Medicare physician fee schedule rate for a non-facility.

You know, physicians report a place of service code that says I did this in a facility or I did this in a non-facility. They get more money for a non-facility because that's where the physician has to have all the cost of running their office setting. And so that is what Medicare is saying they will do beginning January 1st for the new off-campus provider-based departments.

Now, the rule does not apply to on-campus provider-based departments. It does not apply to the old grandfathered provider-based departments that are off-campus that were already billing as of November 2nd of 2015. It does not apply to emergency department services. And it does not apply to some services that are already not paid under the OPPS.

And the example they give in the proposed rule is laboratory services that qualify for separate payment. They are paid under the clinical fee schedule. And so they'll continue to be paid under that. And if they're eligible for separate payment, you could bill those. I would think that rehabilitative therapy services that are paid under the Medicare physician fee schedule would be the same, but they did not mention that, so we did submit a comment to see if they would clarify that.

They also talked a lot about the grandfathered off-campus provider-based departments and some rules that they are considering with that. One of the things they're considering is that if an off-campus provider-based department changes locations, it loses its grandfathered status. So you can't move an existing off-campus provider-based department. And they even said if it's in a building with a suite of offices, you can't even expand into other suites. That would be new, and then you would fall under the new rules.

They're proposing that you will not be able to offer different types of services in grandfathered off-campus provider-based departments than you are already offering or were already offering as of November. So that's another change. And then the last thing is that you cannot transfer an off-campus provider-based department from one hospital to the other.

So there's a lot about that. If you're interested in how off-campus provider-based departments are going to be paid in the future, at least those new ones, you need to read the proposed rule.

We've already mentioned comprehensive APCs and how you get one payment for the entire claim for a procedure that has a status indicator of J1 and for observation services. They are proposing this year to add 25 more comprehensive APCs. And I just wanted to give you an idea of the scope of this.

Of course, an APC can include a lot of different procedures and HCPCS codes. So I looked back through the last few years at the addendum B and when comprehensive APCs started in 2015 with just a few comprehensive APCs - I think it started with about 25 maybe, something like that. It's up to 62 now with this addition of the latest 25.

But anyway, in 2015, there were 219 HCPCS codes that had a status indicator of J1. So that means that you would get the comprehensive payment. As of today, July 2016, there are 875 HCPCS codes with a status indicator of J1; and in the proposed addendum B for 2017, there are 2,736 HCPCS codes with a status indicator of J1. And I think we'll continue to see more and more packaging into a primary procedure by Medicare for outpatient payment.

They are also proposing this year to do away with the L1 modifier for lab services. We've talked about packaging for comprehensive APCs. They also package a lot of other services. They give those a

status indicator that starts with a Q. They've been packaging all lab services since 2014 with the exception that if lab services are the only procedure provided, they will pay those separately or, if they are unrelated, you would receive separate payment if you reported those lab services with an L1 modifier.

And Medicare defines unrelated as lab services provided on the same day as another outpatient service that is ordered by a different physician for a different diagnosis. But they say this year that they think even those lab services ordered by a different physician for different diagnosis could be related to the others. And I don't think it will be a huge deal because I'm sure implementing that and getting an L1 modifier on there for unrelated lab services was a pain anyway. So that may be a blessing in disguise there. I mean, it probably wasn't that much. And of course, last year they went with a Q4 status indicator, which meant you didn't have to report a modifier to be paid for lab services that are the only service provided. They do that automatically for you. So that's good.

Last year they started packaging lab services per claim instead of per date of service. This year they're proposing to package Q1 and Q2 services on a per claim basis instead of per date of service. Those are things that are bundled with surgery or bundled with surgery and visits and other procedures.

Again, with all of the comprehensive APCs that we have, with observation being a comprehensive APC, I don't think that will be a huge impact either because I think most things are already packaged one way or the other. So it would be per claim instead of per date of service, so if you had a patient there over midnight. But like I said, I don't think there will be a lot of that.

Inpatient-only procedures. This year they are proposing to remove six procedures from the inpatient-only list. There are four spinal procedures that I believe are add-on codes and then there are two laryngoplasty codes. But probably the most significant thing about the inpatient-only list is that they are asking for comments from the public on removing the CPT code for total knee arthroplasty from the inpatient-only list. I just saw a case manager's mouth drop.

You know, they tried that in 2013. But the reasons are, is that the geometric mean length of stay for total knees has really gone down since it started in 2000. There are a lot of advances in technology and in means of doing knee surgery now, and there are a lot of knee surgeries being done on an outpatient basis for non-Medicare, for your commercial payors. So those are the reasons for putting that out there. And they want to approach it on a per-patient basis. You know, some patients would still require an inpatient stay.

And just because they remove it from the inpatient-only list does not mean that you could not do it on an inpatient, but what it means, if they should remove it from the inpatient-only list, then the documentation in your record will have to support Medicare's criteria for the two-midnight rule. There will have to be documentation to support that the physician expected a stay of two midnights. And also remember on your knees, Cahaba has a LCD, so you also want to make sure that your record has the documentation to support the indications in Cahaba's policy.

The last thing is just a little bit about the MOON. And not the MOON in the sky at night, but the MOON, the Medicare Outpatient Observation Notice; that it's the requirement of the Notice Act, which was passed last August and was supposed to be implemented within the year which would be August 6th of this year. But there hasn't been any final rules. There's a proposed form out there, but it has not been finalized, at least as of last week when we checked.

You would give this notice to patients who have had over 24 hours of observation but before they've got to 36, so somewhere between the 24th through the 36th hours. It tells the patients that they are in an outpatient status, that they will have a copay for each procedure they have instead of the inpatient copay that they would have had had they been inpatient. It explains about the skilled nursing

facility requirement for an inpatient stay to meet that criteria. And one other significant thing is that it talks about self-administered drugs. So, you know, you have never really had to tell patients about self-administered drugs because they're statutorily excluded. Well, when you give the patient the MOON, it's right there.

Now, remember also that the OIG came out and said that if you waive payment for self-administered drugs ,in other words, you don't bill the payment, that's fine; that's not an inducement as long as you don't make a big deal about it and advertise it and all that kind of thing. So the OIG is fine that you don't charge patients for self-administered drugs. But it is on the MOON notice. So if you don't, you might have to explain that. Hopefully that's not advertising it. But if you do, then there you are, and a new patient might question that. But I just wanted you to be aware of that.

And that's all the news from Medicare. Probably not all of it, but some of it, anyway.

AUDIENCE: When the MOON Act is in effect and you issue a Code 44 and you notify that patient let's say at hour 25, do you know if you have to follow-up with the MOON Act form as well? Or with the notification, if you give the patient something in writing for the Code 44, would that suffice?

MS. RUBIO: You're going to have to notify the patient when you use the Condition Code 44. I mean, Medicare does say that. I would not think that you would have to follow-up with the MOON. The MOON is for once you've had 24 hours of obs.

And remember, it's not outpatient. It's obs. And so to me that's crazy. But Medicare did not include just straight outpatient. So until you reach 24 hours of obs, I wouldn't think you would have to give the MOON in addition to another notice.

MR. ASHMORE: Okay. I guess we don't have any more questions. Thank you, Debbie.