BEST PRACTICES MINUTES
July 17, 2017 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: Good morning. We'll go ahead with Debbie Rubio and our Best Practices section.

MS. RUBIO: I guess the biggest news is that the OPPS proposed rule came out last week, on Thursday, July the 13th. I read through parts of the proposed rule and put together what I thought were some of the main issues that we needed to know about for 2018.

The first thing is drug administration services. CMS is proposing to package low cost drug administration services, except for add-on codes and preventive services. Now, this has been kind of proposed a couple of times before and comments have always caused CMS to back off. I have a feeling they will not back off this year. They say that this fits with their existing bundling policies and the geometric mean cost of the services they are proposing is below that $100 threshold that they have been using for conditional packaging. Also, this puts the hospital payments more in line with what a physician's office would receive for this service.

The main codes that will probably affect your hospital are the therapeutic SubQ IM injection code and the chemotherapy SubQ IM injection codes. If you are looking at the display copy of the proposed rule, you can find the list of codes on pages 119 and 120 of that display copy. Watch that list carefully because they list all the level one and the level two drug administration codes. Some of them are being made in the additional package Q1, and then when you get to the add-on codes, they are remaining an S-status indicator, which they will continue to be paid separately.

It also excludes the preventive services which is the administration of your flu, your pneumonia, and your Hepatitis B vaccines. CMS is continuing to see comment on ways to balance the prospective payment system with access of care, not just in drug administration services but in a lot of other areas. This is one of those areas that they ask specifically for comments.

Another issue that was fairly important is that they plan to remove total knees from the inpatient only list. They talked about this last year and asked for comments. They received a good many comments, and actually a lot of people supported going ahead and removing total knees from the inpatient only list. If you remember, things are put on the inpatient only list because Medicare thinks that they can only safely be provided in an inpatient setting. And then every year they evaluate to see if there are outpatient departments that are equipped and are able to provide these services, and even if there are outpatient departments that are already providing these services to non-Medicare patients, and then if they think they're safe to be provided in an ambulatory surgical center or if there are related codes that have already been removed from the inpatient only list, they might consider removing. This year they're removing two codes in addition to the total knee arthroplasty which is CPT code 27447. They are removing CPT code 55866, which is the laparoscopic prostatectomy code. Remember, when they remove codes from the inpatient only list, it does not mean that you can never do that procedure on an inpatient basis. It just means that now Medicare will pay for it on an outpatient basis as well as an inpatient basis. So there will be patients having total knees that still need to be inpatient.

CMS encourages providers to develop an evidence based patient selection criteria to determine whether patients should be outpatient or inpatient. So for inpatient, remember, if it's a surgery that's not on the inpatient only list, you need to meet that two-midnight criteria for the patient to be in there. But you will have patients that are one of the exceptions, and I'm not even going to go into those exception things, but you know about those.

The other thing that they published about the inpatient only list this year is they are now accepting comments on removing partial and total hip arthroplasty procedures from the inpatient only list. They have observed that there is a shortening length of stay for these types of procedures since they were first put on the list back in 2000, 2001. They have had comments submitted already that are supporting the removal of these. The commenters have said that with a shorter hospital stay there's fewer medical complications. And we all know that the longer you stay in the hospital, the more likely you are to get sick from something else. Also there's better patient satisfaction and improved results and cost savings for Medicare if you can get that patient in and out and they still do well.

Also, they say that some non-Medicare insurances are already having patients have partial or total hips performed on an outpatient basis. Now, again they say that this will require careful selection of the patients to determine which patients are eligible to have a partial hip or a total hip on an outpatient basis. My dad had one about a year ago, and he couldn't do outpatient, but he's 80. He has lots of complications. He did great, but it did require more than two midnights.

The other thing -- and this is pretty big -- the 340B program. It began back in 1992, and it allows certain providers to purchase certain outpatient drugs at a discounted price. If you read the proposed rule, it goes into exactly what it is. It's your DSH percentage and who owns you and the type of patients you serve and all those kinds of things as to whether you're eligible to be a 340B hospital. Then they also use formulas to calculate the discounted price. The Health Resources and Services Administration handles that. Medicare has been looking at this. The MedPAC, which is the Medicare Payment Advisory Commission, released a report a while back that estimated that the 340B hospitals receive a minimum discount of 22.5 percent of the ASP (not the AWP) for drugs that are paid under OPPS. The OIG has looked at this, the GAO has looked at it, and everyone says that at least that much of a discount or more. Medicare therefore feels that they are spending too much for outpatient drugs for these 340B hospitals because if you get that kind of discount and they're paying you at ASP plus 6 percent, they're overpaying for drugs. Then also the beneficiary pays 20 percent of that payment, and the beneficiary is also overpaying for drugs. So they are proposing to pay for separately payable outpatient drugs acquired under the 340B program at ASP minus 22.5 percent excluding pass-through Drugs and Vaccines. They are planning to create a new modifier that will have to be put on drugs that are not acquired under the 340B hospital program.

They did again request a lot of comments. There was even a mention of should they phase this in over two to three years or something like that, so this may not go. We'll just have to wait and see what happens to this, but, you know, maybe they can phase it in. They've been trying to do something with payment for drugs for a while, and so that's one way to knock that cost down.

The next thing is supervision of therapeutic services. And in general, therapeutic services provided in a hospital or a hospital provider based department required direct supervision, and that means the physician has to be immediately available and able to take over performance of the procedure. This became a huge issue back in 2009 when they clarified it. In 2010 they tried to reclarify it, but this is really hard for critical access hospitals and really small hospitals. They put into place a non-enforcement of those supervision rules, and they did that for a couple of years and since then Congress has extended that non-enforcement year after year after year until finally that non-enforcement expired on December 31st of 2016.

CMS is proposing to reinstate that non-enforcement of the direct supervision requirements for critical access hospitals and small rural hospitals having 100 or fewer beds for two years, calendar year 2018 and calendar year 2019. They are again saying that the reason they are putting this off is to give those hospitals more time to get ready. And remember, you can request a status change for specific services. You know, they have that status where it requires supervision at the initiation of the service

but then not throughout the whole service. So you can request a status change for a specific service, but we'll just see where that goes.

The last thing that I wanted to talk about from the outpatient proposed rule is a potential change to lab date of service policy. I am a lab tech formerly, before I got into compliance and what I do now, and I have to say that the lab date of service rule is hard to understand. So I'm going to try to just explain it a little bit because they are just talking about this. The way it read in the proposed rule, I think they'll end up doing something, but they want comments before they decide what they're going to do.

So first of all, if a lab test is performed on a hospital inpatient or a hospital outpatient, where either the hospital actually does the test or under arrangements they send the test out to someone else, the hospital has to bill Medicare. In general, the date of service for a lab test is the date of collection, but there are a couple of exceptions. One is specimens that are archived. If they stay archived for more than 30 days and then you pull them out and test them, the date of service is the date you pulled it out of the archive.

Now, there is another rule, and this is the one they're talking about changing called the 14-day rule. This is for those patients that come to your hospital either as an outpatient or an inpatient, and they have a surgical procedure done, and they have these tissue specimens that are stored. Then after that patient is discharged, the physician orders some more tests. It could be like those chemotherapy tests to see if they have certain markers or they need certain drugs or that kind of thing. If that test is ordered within 14 days of discharge, the rule now is that the hospital has to bill. And a lot of these tests go off to specialty labs. The hospital bills and then the hospital has to pay the specialty lab. The problem with that is that sometimes the Medicare payment doesn't cover what the specialty lab is billing. If the test is ordered after 14 days after discharge, then that specialty lab or whatever testing lab can bill.

So what they are looking at and what their main concerns were, for one thing, you have a hospital that's billing for a test that they didn't do, that doesn't even affect the hospital treatment. Then the other concerns were all kind of related to access of care. Are hospitals delaying ordering tests? Would you wait until that 14 days had passed? Are you delaying or are some people just not getting the tests that they need? Medicare tries to look out for that access thing. We already mentioned that with one issue. They are thinking of changing that 14-day policy for either just the ADLTs, which are the advanced diagnostic laboratory tests. Those are tests that are done by one specialty lab or for the ADLTs and molecular pathology tests. So as long as it was after discharge, the testing lab could bill. So that's what they talked about there.

They also talked about maybe doing it some other way, maybe looking at that under arrangement section. Like I said, we'll just have to wait and see what they come up with there, but I think that they probably will do something in the final rule. We'll wait and see what that is.

That's all from the proposed rule, but there are a couple of other things that I wanted to mention. One has to do with the inpatient only procedures and the three-day payment window rule. The reason I wanted to talk about this is we had someone recently ask us a question about this, and when I started to research this, it wasn't nearly as straightforward as I thought it was going to be. And that's because of the way Medicare does their manuals sometimes. And the question was can an inpatient only procedure performed on an outpatient basis be reported on a subsequent inpatient claim if it meets the three-day payment rule, which is it was performed the day of admission or within three days prior to admission.

Now, I knew in my brain that Medicare changed that rule. They originally said, No, you cannot do that. But they changed the rule. So I start looking for it. And we'll talk about my struggles in a little bit, but they did change the rule on April of 2015. They changed the rule so that now an inpatient only

procedure that's provided to a patient in the outpatient setting on the date of admission or during the three calendar days prior or one calendar day if it's a non-section D hospital, preceding the date of the admission, that would be deemed related to the admission, according to their policy for the payment window. They will treat that as inpatient services, and it will be covered by CMS and eligible to be bundled into the billing of the inpatient admission.

Here's the problem I had. When I have a question, even though I think I know the answer, I always go to the manuals to confirm my answer. So I go to the manuals, and there's nothing in the manuals that says that you can bundle that together. I was like, am I absolutely going crazy? Which as you get older, you forget so much. Anyway I go back through all the manuals, and what happened was that originally those sections of the manual said that you could not do that. When they updated the manual, what they did was they took that language out. They didn't put anything in. They just took that you can't do it out. Well, that you can't do it is still out, so you can bundle an inpatient only procedure into an inpatient admission under the three-day rule.

This is my personal opinion. Although we discussed it here, I don't know what kind of answer we got. I do not think that CMS intended this policy for you just to get a late order if you forgot to get one for an inpatient only procedure. I think the perfect example is when there's an emergency situation. This is what happened at this hospital. They had a patient come through the ER in an emergency. They had to rush him to surgery. They ended up doing an inpatient only procedure. So much going on with the patient they didn't get an order, an inpatient admission order, until the next morning. I think that's a perfect example of when you can use this rule.

Also sometimes you have a patient that comes in to have an outpatient procedure. They get into the surgery. That outpatient procedure becomes an inpatient only procedure. Again, I think if you failed to get that order until the next day or whenever, that's a perfect time that you can bundle that. I'll just leave you to decide what you can do. I don't think they meant that you can just hang around and get an order whenever you wanted.

Another thing I wanted to mention was the OIG work plan. They used to publish that on an annual basis, then the past couple of years they've started publishing a midyear plan. This June when it was time to publish their midyear plan, they said, we're just going to start publishing updates monthly. I understand that it's a very dynamic process for the OIG. I understand why they would want to do that on a monthly basis. Here's my problem, and it may just be a personal problem. Like I said, I'm old. I get confused. When they published that work plan, they would divide it into the sections, CMS and the other departments of HHS, and then in that CMS section, which was the only one I cared about, they put it into Medicare's Part A and B, Medicare's Part C and D.

Then in that Medicare Part A and B section, they said hospitals. I love that. I just went straight to that hospital section. I usually scanned through the rest of Parts A and B just so if there was anything like in sleep testing or something they would hide and say it applied to outpatient hospitals, but at least I knew right where to go. Now you've got a list on the OIG work plan webpage, and it has a list of recently added topics and then active work plan items. Now it does tell you which department so you know if it's a CMS issue.

But other than that, it doesn't tell you whether it's Medicare A and B, realistically you should be able to read the issue and know if it applies to you or not, but the first thing was a list of 18 issues, 12 of them I think were CMS issues, so you have to think a lot more. I liked it when I didn't have to think so much. That's the OIG work plan.

The last thing that I wanted to talk about is that new Medicare cards are coming. We all know that the Medicare cards that are out there today have someone's Social Security number on there, whether it's the patient or one of their relative's. So that's not very good for identity theft reasons. In

fact if you go to the Social Security page, they have a little pamphlet. They say don't carry your Social Security number around with you. If you're a Medicare patient, that's kind of hard not to do. You need that Medicare card with you. So starting next April of 2018, they're going to begin mailing out the new cards. They say they will all be mailed out by April of 2019. They are replacing the Social Security HIC number with a Medicare beneficiary identifier, an MBI.

They are also planning to develop some capabilities where healthcare providers can look up the new MBI through a secure tool at the point of service. And there is a 21-month transition period where you can bill either with the HIC number or the MBI number. But they said that provider systems need to be able to accept the new MBI format by April of 2018, even though you can continue to bill during that transition period with either the MBI or the HIC number. They have a lot of resources out on Medicare. I hope everyone that needs to be in this room is on Medicare's list serves so that they get this type of news and the provider newsletter that they put out or look around their website and find these kind of things.

So that's all that I had. I did not mention when I talked about the 340B drugs that people that are still going to be paid for their drugs. That's not at 340B so they won't be that ASP minus 22 percent. They will be paid ASP plus 6 percent again this year. The drug packaging threshold for separately payable drugs went up to $120 this year. It was 110 last year, I think, for a couple of years. Now it's gone up again to $120. That's a per-day cost of the drug that's below that. You don't get separately paid for drugs.

MR. ASHMORE: Thank you Debbie for this information.