BEST PRACTICES MINUTES
March 10, 2014 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: Karen Northcutt is going to get us started today with Best Practices.

MS. NORTHCUTT: I am talking about observation today only because Ingram and several others have been asked to re-clarify and re-address back to our original segment and because we have quite a lot of new people coming in that may or may not know what the standard rules are between Medicare, Medicaid. So in general, I'm going to go through just the major payers, and specifically going to go with Medicare today.

Because in the proposed rule in November, the last time that we were here that there were going to be some changes to the emergency department, and that was going to change composite rates for observation, and then we were going to have a lot of other things bundled.

Well, a lot of things did not happen in the final rule that came out the day before Thanksgiving. But in general, some of the proposed rule they backed down on.

And one of the things that actually did not change was observation services. And, number one, we have outpatients, we have inpatients, and we have outpatients with observation services. And observation services to Medicare was for active monitoring of the patient to see if the patient is going to get better and go home or they're going to get sicker and be an inpatient. So that's really the definition of what observation services are.

When they proposed that observation would be paid, we would be paid under a composite rate. That part did not change. What did change was the basic premise of when you can get paid for observation. Okay. And you can get paid for observation if you are a Level 4 or 5 patient or a critical care that comes through the emergency room, has observation services ordered, and stays eight hours or greater. And if all of that happens, then we'll actually get a composite rate of $1,198, unadjusted.

We've had people call and say, you know what, observation, the HCPCS code, which is GO378, has zero payment on it, why is that? The reason it has zero payment on that code when you're paid is because Medicare has lumped the payment into the emergency room visit payment. Okay.

So in general, unadjusted - and they did go up on the pricing for the ED, which I was very pleased to see - for a Level 4 visit, you would be looking at about $455 if the patient went home. If the patient is an outpatient with observation services, then it changed and the payment is $1,198. You won't get that. Nobody in the state is going to get that because it's unadjusted. So you're going to get less than that, somewhere dependent on where you live. And it's based on the wage index.

But in general, for, say, Birmingham, we are looking at about a .89 percent of 60 percent of that payment rate. So it comes into this great formula. But never think that you're going to get what they say in the Addendum B, if you look up the pricing, unless you're very lucky.

Now, I had one hospital the other day - and I had never really witnessed it before, but it's out there - where they have Apple and everything in California, they had a wage index of

1.68. So they got almost double, plus the double what we would get here. But then again, it costs a fortune to live out there.

So in general, just to say unadjusted, you're looking at about $792 that you're going to get for that observation stay. Okay. That's added to the ED payment rate.

Okay. So in general, let's say you got $1,198. And that's going to be whether you're in the bed at midnight or you stay four days. Okay. So I just wanted to be very clear on that. Payment is not on the HCPCS code. And, number two, that's the only payment that you're going to get.

What happened, which was a good thing, Medicare was going to bundle diagnostic tests. They left them unbundled this year, but what they did do is go down significantly on CAT scan payments and MRI payments.

What they have discovered is that anybody that comes in with any kind of altered mental status of any kind or any symptom, it seems that everybody gets a CT of the head. So what they did is they went down about 22 percent on the payment rate for your CTs. MRIs went down about 18 percent. So that was one thing. They're still going to pay us. They went down on the payment rate.

What really happened that is an issue is that most clinical laboratory CBC, CKMB troponins, BNPs all that cardiac workup that you do in the emergency room, all the lab work was bundled. The only lab work that they did not bundle, which I thought was really weird, was drug screens and then molecular pathology, which you're not going to do in the emergency department. So the drug screens are left safe right now, and the same thing goes for observation.

So anytime you have laboratory work done outside the ED and let's say we're monitoring them and observation, all of that lab work bundles into that 792 extra dollars that you're getting.

So I just wanted to make sure that everybody is very, very clear on that. And I will say one other word about that clinical lab in just a few minutes.

There are two other ways that you can get in the door and have observation, and it is a direct admission from a physician's office.

So if I'm in a physician office and I'm having chest pain and Dr. Jones says you're going to the observation bed right from my office. So they call up, schedule a bed, and you're in observation services. It's not that the patient went home. It's not that they went and packed a bag. It's not that the patient called the doctor and the doctor said, well, you need to go on and I'll admit you. This is physically seeing the physician and then being directly referred.

For those that have a lot of hospital based clinics as we know now, we have one level. So in the past, you used to, if you were admitted from a hospital—based clinic with a Level 4 or 5 and went to the hospital, you could be observation. But now we only have one visit level. And we actually did pretty good on the clinic visit, which is unadjusted about $91. So for those that had low—level clinic visits, actually your reimbursement ticked up.

But in general most of the observation patients are through the emergency room for Medicare in general. I do have to say that for physicians that want their patient to be in a bed, just because they want them to be in a bed does not mean that they're observation, that we have plenty of outpatients in a bed now. And that's not going to change. An outpatient in a bed

means that they're trying to find out where to send your dinner tray to. Outpatient in a bed means that they need to get your lab results to you.

So in general, if you are an unscheduled dialysis patient, if you're anemic and you need a blood transfusion, if you're in there basically to get any type of infusion, if you're post—operative because the doc wants you to spend the night, that does not mean that you're an observation patient.

But the second big payer, of course, for observation services is going to be Medicaid. And Medicaid is completely different on their billing function. Medicaid only covers observation if the patient comes through the emergency department.

For Medicaid, it's pretty simple. You come through the emergency department and you can have observation. And they still call it a status. But observation is still going to be billed with the G—code. And as Jerri said, they usually don't cover G—codes. And a G—code is basically a HCPCS code that's billed and shows that you are an observation.

Medicaid reimburses $12.83 an hour. And they allow 20 hours in general for payment. So this is the little tricky part as far as billing goes, because Medicaid considers you being in the emergency room and up to the first three hours of observation as part of the experience in the emergency room. So your observation does not start until the fourth hour. So they cover the fourth hour through the 23rd hour.

So at the end of the day, even if they're there tomorrow or the next day, Medicaid will cover 20 hours. So you can take 20 times 12.83 and see how far that goes with you. So I guess Medicare did win out on that with our $792 that we need to split between everything.

I do want to say that for Blue Cross in general, they will cover observation. And, basically, it's going to depend on what type of service and what contract that you have with them.

And I think just about everybody in the room in general has what is called an ASC/POF, which means that you're a preferred outpatient facility and that you have signed a contract that you will contractually receive a set fee for the surgeries that you do on an outpatient basis.

So in general, if you even were admitted to observation post—operatively, they're still going to pay you based on the CPT code for the surgery that you provided.

So for all practical purposes between Medicare, Medicaid, and Blue Cross, there's no such thing as post—op observation, to the point that there is no reimbursement for that. Medicare really thinks that you have a recovery period of four to six hours, and they consider that your recovery.

And then when you really look at the patient, it is really, truly not active monitoring. They're basically spending the night because the doctor doesn't want them to go home. So, you know, I think that gig is up, and I think they knew it. They just quit paying us for it.

So in general, that is where observation stands today. So if you hear composite rate and you're looking for your reimbursement, go look at your emergency room visit level. And it's going to be your high levels.

I do want to say back just as a side note for the laboratory services, the bundled laboratory services for any visit that you come to the hospital. I'm an ED visit and I have lab

work. It's going to bundle into the ED visit. I'm observation. It's going to bundle into the observation visit. I'm Dr. Smith and I send a patient over to have lab drawn for lab work, and that's all I have. We've had to change how we bill that. Okay?

So for those that have had the headache of having to do that since January, it's been a hard process. Medicare will pay for clinical lab if it's not associated with anything else with that visit on that date of service if it's ordered by the same physician.

So even though, for example, a doc orders a CT, go over to the hospital, have this CT done, and we're going to have a creatinine because I'm worried about your kidneys, well, that creatinine is going to bundle now.

So the only time that we get paid for our clinical lab in the hospital, if it's the only service provided that day and/or we're acting as a reference lab and that vial of blood comes over to the hospital.

Now, here's the problem. And I've had one hospital that has lost about $147,000 since January because the billing was not working for them. But in general, right now, the bill type has to be what's called a 141 bill type, which is a specimen—only bill type, until July 1. Okay? Right in the past, we billed lab work only if a patient came in with a 131 bill type, saying I'm an outpatient hospital. I'm here. You are drawing my blood. And you're going to take my blood here and, therefore, it's a 131. Well, if you bill it on a 131 and it's the only lab, Medicare is not going to pay you for it. So there we go.

So go back and look and see if you need to rebill it. Some are working through the processes.

But in the meantime, what happened with this is that the National Uniform Billing Committee, that does all of the bill form locators, sent an angry letter to CMS because it was not in CMS's purview to tell hospitals what to use the form locators for. So if anybody saw that, I thought it was a really good letter that the NUBC sent CMS. And so CMS had to respond graciously and say they were right and that we will have to change this.

So people are confused right now, what do we need to do. You're going to continue to get a 141 bill type when it's clinical lab only until July 1. And then the ones that have to deal with billing are going to have to modify each lab line item with a newly developed modifier that they have not developed yet. So that's going to be the answer. We're going to have a bill stop. And for every reference lab that we have, we will have to modify it.

And for those that have to deal in charge master world, that's not going to be able to be modified within the charge master. So this is the remedy for Medicare that they just published, last Thursday or Friday. So that is the answer. We'll put another modifier.

Now, what I hoped for was that they would put assign condition codes. We could just put one code on the bill and let it go out the door. No. It's going to be that we're going to modify.

The other issue and if anybody has actually looked at the transmittal that just came out. It's the Med Learn Matter. It's SE1412. And, basically, what they're going to say is the effective date of it is January 1, 2014. Okay. The implementation date is July. So they can't implement this till July. But if you bill anything after July 1 that has a date of service from January 1 to July 1, then you're going to have to have a modifier on that as well.

So just take a look at it because there was one startling thing in there. They give you clinical examples of when it's appropriate to bill. And that modifier is going to say I attest that everything on this bill is correct and that we are appropriately billing it.

In some of the examples, I'm alarmed. I want to make sure before I scare everyone, but they were saying if you're referred from a hospital—based doctor's office and, oh, by the way, you're also being monitored for your psychological medication, but the doctor is going to give you cataract surgery in two weeks, what their example was is we'll pay you separately for the psych monitoring lab work but that the pre—operative lab work is not separately payable.

So for all of those that are in this situation and I'm not saying they're going to have to clarify this, but it was frightening to me that you could have your pre—op a week before. And for those that bill that separately, the question is, is all the pre—operative lab work now connected with that doctor that ordered that if they are in a hospital—based clinic.

So just read the examples. I'm sure we'll have more out there. But I can't guarantee that they're not trying to lump all the pre—operative lab work if you do it on a separate date of service in which with the physician who does the surgery, if you will.

MR. HALEY: Thanks Karen.