BEST PRACTICES MINUTES
November 3, 2014 RIC/RAC Meeting

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: Thanks everyone for coming today. Before we bring our payers in, I'm going to turn it over to Karen Northcutt.

MS. NORTHCUTT: When the RIC committee started, we had 13 people, and we were bantering, basically, about what was called local medical review policy. Nobody had ever heard of it. And now, of course, they're called LCDs, and they're the rules that we live by for medical necessity for certain services. So that is how the RIC/RAC came about.

And the reason that I am here that is not representative of a hospital, was back in the day when we were in a small board room, I did the what/if questions at that point. So I was called the beard. So if anybody had a question that would implicate themselves or the hospital, then I would ask the global what/if question.

I've really been the beard for about 12 years now. So that's my role. It started with revenue integrity and then, of course, the RACs came. So we had a lot of information and a lot of different expertise that we needed within the group to answer the vast questions.

Last year the outpatient perspective payment system (OPPS) final rule came out the day before Thanksgiving, this year the proposed rule came the day before July 4th, and the final rule came out on Halloween. So I got to read the final rule all weekend for the OPPS and I have outlined just a few things to go over.

I know that some of this is going to be a little technical, and know that I don't have a whole lot of time to go over it, I know there's going to be a lot written about it. And if anybody wants to stay after Blue Cross, I'll be glad to talk more in-depth about it.

Medicare has a payment system, APCs, and basically it is an outpatient perspective payment system where they pay us on codes. And anybody that has to code knows how difficult it is. Now even though we bill all codes, they may or may not pay us for them.

So what CMS's aim has been since the year 2000 is to continue bundling services together. They proposed last year that they would bundle quite a bit of things. They backed off on it. This year it is final. We will have a lot of bundling going on.

And I'll just mention the big things.

- Any device-related procedure , they're calling them device-intensive procedures. All services associated with the procedure except for a few services will bundle into the payment for the procedure. So if I have a pacemaker, an ICD or a stent put in, for example basically, every service that I bill with that procedure will not be paid in addition to the procedure. So, number one, we get one single payment for that event or that episode.

  In general, if you put something in or if it's a device or a stent, then basically you're going to get one payment. We're still going to bill the other services. You're just not going to get paid for the other ancillary services.

- In 2014, if I have a visit to the emergency room or if I have a visit to a clinic in a hospital last year, if I had lab work performed during that visit, then they quit paying us for the lab work. Everything else was okay.
  This year, for an emergency room visit, all simple diagnostic radiology such as chest x-ray will be bundled. We're still going to bill it. You're just not going to get paid for it. MRI, CT and nuclear medicine will still be paid.

- All pathology, technical components with a surgery, those will be bundled as well.

- If we have respiratory treatments provided during a visit these will bundle into the visit and will not be paid separately.

I did look at the visit payment rates, because I thought, well, okay, they're going to give us a significant increase in the emergency room visit level. For a Level I, they gave us an increase of $4; for a Level II, there is an increase of $12; for a Level III, there is an increase of $40; and a Level IV is an increase of $37; and a Level V is around $34.

So that is your increase to cover the reimbursement loss that you're going to get when you have these ancillary services. Your EKG's are also bundled as well.

So for this next year, what I had covered so far is device-related procedures, going to get one payment. Emergency department, most ancillaries will be packaged.

Another interesting thing that they failed to bundle last year was drug screens. They caught it. So drug screens will be bundled as well into that ED visit.

And as a side note, for anybody in the room that has to deal with charge description master changes and charges, if you have your new CPT books, I would take a very strong look at drug screening because the whole thing on how you code it has changed. Your order sets will have to change. Your doctors are going to have to be informed as to what is considered in a tiered drug screen.

So I do want to say that just as a side note. If you haven't started on that, you really need to go ahead and do that.

We're going to have to look at is it more worthy of the intent of the visit was to have a pulmonary function test or a clinic. So now we've got some determinations to make to see what is going to be bundled.

Again, the only thing that's going to be left standing on a routine clinic is going to be infusion therapy and injections. And in most cases, the reason you're coming to the clinic is under these circumstances is to have the infusion. So you usually don't have a clinic visit with that anyway. But that is crucial to now really know what the intent of that visit really is.

Also for this year which is voluntary, it's called a PO modifier. And if you have an off-campus clinic department, then you will have to modify everything on the claim, all the codes on the claim to identify this is a different clinic; basically, outpatient hospital. They're going to make it up, and they haven't decided what to do.

CMS is also going to create two new place-of-service codes for physician billing to identify if the physician is practicing in an off-campus department of the hospital clinic or if it's on campus. So that's to come. This is voluntary this year, but it will be mandatory next year.

Also CMS updates their inpatient-only list. One lucky thing for those case managers or those that have to deal with the inpatient-only list, they took two things off that I think have been very bothersome to people when they're having back surgery. Basically, if you have one lumbar or one cervical disc, then you're safe as an outpatient. If it went to two, and the doctor didn't know they were going to do it until they got in the OR, we don't catch it, it's on the inpatient-only list, and then it denies.

So they have taken that off the inpatient-only list. So you can have an additional cervical or lumbar disc on those surgeries, and it will not be on the list. So, therefore, we don't have to monitor those like we used to.

Certification now will be required before the 20th day of an inpatient stay. So now the doctor has to certify long stays. So we've gone from certifying a two-day stay to now you don't have to do that because it's in your documentation. You've got to certify a 20-day stay.

So what they're saying is on or before the 20th day that the patient is in your hospital, the physician has to certify why they're there, how long they think they're going to remain, and what is the post-hospital plan. So that is finalized in this rule and so that will start January 1.

And that goes back to one other point I want to make, is if you're determining that you have a medically unnecessary stay and you're going to do a Part A to Part B rebill. When you have a Part A to Part B rebill from a self-audit, that patient is still considered an inpatient, and they still qualify if they stayed three full days for a SNF visit. The patient must be notified that the inpatient stay was not medically necessary. The status changed only from a billing standpoint. Their status remains an inpatient, and the patient notification is that their inpatient stay was not medically necessary. So when you notify them, don't say their status changed because it was an inpatient stay that was not medically necessary. So the verbiage kind of has to be right. We're supposed to notify them within two days of knowledge.

But in general, if you're starting your letters or how you're going to inform the patient, we have actually contacted CMS and have not heard back. But there is no education by CMS to the beneficiary in any of their publications to even let the beneficiary know that this process is acceptable and this is what the hospitals can do. Because, again, when we go Part A to Part B, anything that happened before that inpatient admission, the

emergency department, they were ob's and then they were admitted, that's going to be billed on an outpatient bill.

Anybody have any questions?

THE SPEAKER: Hi. This is LaShonda Smith from Baptist Health.

My question is regarding the two-day notification. Is that considered if we postmark a certified letter, would that be within the two days, if you sent it out within two days of actually knowing it?

MS. NORTHCUTT: I think so. I think it can be, if you're right in that area. I think we have a safety net, and this is just my opinion, because CMS has not informed the patient really of this and that this process is new to us as well. You know, it would be perfect if we could have it within two days, and I think that could be the goal.

MS. WHATLEY: Well, that was very informative, as always. Thank you, Karen.