KOHLER HEALTHCARE CONSULTING

PIECES FOR SUCCESS

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Welcome to our 109th edition of Kohler HealthCare Consulting's "Pieces for Success" newsletter. We hope you find our monthly publication to be informative and of assistance to you. If you know others who may find this information useful, please feel free to share our newsletter with them. We look forward to you being a part of what makes us great (great people) while we strive to provide excellent and functional content.

In this edition you will find the following articles:

Quick Thoughts

Really Look at The Proposed Medicare Physician Fee Schedule for 2021
The first thing is the major decrease in payment. The conversion factor moves from **$36.09** to **$32.26** for 2021, or a 10.6% decease. Although there is addition of approved telehealth services, the increased use of telehealth has reduced revenue already!

CMS proposed rule changes the definition of direct supervision to allow the supervising physician to be remote and use real-time, interactive audio-video technology. This is a significant change because the current definition of direct supervision requires the physician to be physically present in the office suite and immediately available to furnish assistance and direction throughout the occasion of service. (It does not require the physician to be physically present in the actual room when the service or procedure is performed.) If the rule is finalized, the change would be in effect through December 31, 2021 or the end of the Public Health Emergency (PHE), whichever is later.

Many refinements for E/M coding, in particular for prolonged visits, and revaluing 8 code sets, including maternity services, therapy evaluation and transitional care services. Much about performance standards for the Medicare Shared Savings Program. We have time: Public comments on the proposed rule are due by **October 5, 2020**.

Outpatient Prospective Payment System Proposed Rule For 2021

CMS released the proposed rule on **August 4, 2020**. Here are five takeaways from the 785-page proposed rule:

1. **Payment Update:** CMS proposed increasing OPPS rates by 2.6 percent in 2021 compared to 2020. The department estimates that total payments to OPPS providers would be $83.9 billion in 2021, up from $7.5 billion from 2020.
2. **340B Program:** CMS proposed cutting the payment rate for 340B drugs. Under the proposed rule, CMS would pay hospitals 28.7 percent less than the average sales price for certain drugs purchased through the 340B program. CMS proposed an alternative of continuing its policy of paying hospitals 22.5 percent less than the average sales price for 340B-acquired drugs. "We are disappointed but not surprised that the administration has chosen to continue its pursuit of this damaging payment policy," 340B Health, an association of more than 1,400 hospitals, said in a statement. "It should go without saying that during a global pandemic, it is foolhardy for the administration to stubbornly push and worsen a Medicare payment policy that hurts safety-net hospitals and their patients".
3. **Inpatient Only List:** CMS proposed eliminating the Inpatient Only list over the course of three years beginning with the removal of approximately 300 services.
4. **Prior Authorization:** Beginning July 1, 2021, CMS proposed implementing a Prior Authorization process for the following categories of hospital outpatient department services: cervical fusion with disc removal and implanted spinal neurostimulators.
5. **Comment Period:** Public comments on the proposed rule are due by Oct. 5, 2020.

Some Really Good News for Telehealth Services for Rural Hospitals

President Trump signed an executive order to expand access to Telehealth services in rural communities and makes certain services permanent once the COVID-19 public emergency ended on August 3, 2020. Since this White House release, the PHE has now been extended through October 2020.

It increases telehealth services and accessibility in rural hospitals and requires HHS to implement a new payment model tailored to the needs of rural communities. Additional components of the order include improved communications infrastructure and extend availability of certain telehealth services after the pandemic ends, including boosting reimbursement rates.

See: https://www.whitehouse.gov/presidential-actions/executive-order-improving-rural-health-telehealth-access/.

Ready for the New ABN? You Have More Time
Due to COVID-19 concerns, CMS is going to expand the deadline for use of the renewed ABN, Form CMS-R-131 (exp. 6/30/2023). Currently, the renewed ABN mandatory start date is 1/1/2021. The renewed form may be implemented prior to the mandatory deadline. KHC will be holding a **Quick Bits** YouTube on the new ABN this coming October.

The ABN form and instructions may be found at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

Medicare Promoting Interoperability Program
CMS requires that all eligible hospitals use 2015 Edition certified electronic health record technology (CEHRT) to meet the requirements of the Promoting Interoperability Programs. Eligible hospitals may be exempt from Medicare penalties if they can show that compliance with the requirement for being a meaningful EHR user would result in a significant hardship. The deadline for eligible hospitals to submit a Hardship Exception Application has been extended from July 1, 2020 to September 1, 2020 due to COVID-19. Submit Exception Applications here.

Appropriate Use Criteria Program-Delay: Deadline Has Been Extended Through 2021
Appropriate Use Criteria Program "NOTICE: The EDUCATIONAL AND OPERATIONS TESTING PERIOD for the AUC Program has been extended through CY 2021. There are no payment consequences associated with the AUC program during CY 2020 and CY 2021. We encourage stakeholders to use this period to learn, test and prepare for the AUC program."

An official MLN Matters will be issued. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program.

Maryland Medicaid Coverage for Facility Telehealth
The saga continues with Maryland Medicaid clarifying coverage for facility Telehealth with the latest transmittal. This information is very different from Medicare's "hospitals without walls" and can provide issues depending upon how provider telehealth programs are structured.

https://mmcp.health.maryland.gov/Medicaid%20COVID19/Hospital%20Telehealth%20Billing%20Update%20(Final%2007_30_2020).pdf.

Good News for Our Maryland Hospital Clients Trying to Recoup Undercharging in FY 2020 Related to The Quarantine
The expansion of rate corridors has been extended through 9/30/20:
https://hscrc.maryland.gov/Documents/COVID-19/Corridor%20Expansion%20Compliance%20Memo%20July2020.pdf

Looking for The Prior Authorization Cover Sheet for Medicare?
Please go to: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00234303

Thank You to CMS for Clarifying COVID-19 Laboratory Instructions in the Following Document
https://www.cms.gov/files/document/se20011.pdf

Wage and Staffing Updates
CMS has pushed the Wage Index Occupational Mix Survey deadline back to September 3, 2020 (revisions by September 10, 2020). The staffing data waiver for long-term care was terminated June 25, 2020. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

How Can Maryland Hospitals Apply for the Long-Term Care Partnership Grant Discussed in the July HSCRC meeting?
Please visit: https://hscrc.maryland.gov/Pages/Long-Term-Care-Partnership-Grants.aspx. Send questions to hscrc.rfp-implement@maryland.gov.

Is Counseling a Patient Regarding the Importance of Self-Isolation When Testing For COVID-19 Chargeable as an E/M?
Per CMS, yes, but ensure you are following the guidance [https://www.cms.gov/files/document/SE20011.pdf] and meeting requirements using their checklist [https://www.cms.gov/files/document/counseling-checklist.pdf].

How Will Payers, Including Medicare, Identify and Track the Therapies COVID-19 Patients Are Receiving for Treatment?
There are new ICD-10 procedure codes for therapeutics, such as Remdesivir and Convalescent Plasma, being implemented August 1, 2020. https://www.cms.gov/files/document/icd-10-ms-drgs-version-372-effective-august-01-2020.pdf.

COVID-19 September 1, 2020 Update
A positive test result **is required** for the increased DRG payment **effective September 1, 2020**. Read this new transmittal for additional information to ensure that your facility will be in compliance. https://www.cms.gov/files/document/SE20015.pdf.

Featured Articles

KHC Quick Bits: COVID-19 Turning Points
By: Lauren Rose

We are hoping many of you were able to view our first ever Kohler Health Care Quick Bits. [https://www.youtube.com/watch?v=hCymrg9zIXs&feature=youtu.be].

Although it is true that the pandemic has highlighted areas for improvement within healthcare and caused around the clock stress on both personal and professional levels, KHC has been impressed to see positive changes that happened almost immediately after the crisis began. We saw unintentional "walls" between departments within silos that have often existed in healthcare entities fall. There was a renewed sense of determination and teamwork. Instead of debating which department should handle certain tasks or responsibilities, there was a focus on individuals with varying backgrounds working together, even when it meant stretching far beyond comfort zones.

One of the most amazing processes to watch was the collaboration between the Center for Medicare and Medicaid Services (CMS) and providers across the nation through the ongoing Office

Hours calls. It is no secret that CMS often blazes the path among payers when it comes to the expansion of coverage for services, innovations of new payment models, and tackling industry challenges. In the beginning of the crisis, however, there was frustration. Not because providers felt like they were not being heard or that CMS was not moving faster than ever before, just that regulations were generally needed the same day the need was identified. As weeks passed and CMS continued to move more quickly than ever before, much of the frustration turned to appreciation.

Are we in a perfect state? Have all questions been answered? Unfortunately, no, far from it. But are we better than we were in March? Most definitely. Healthcare already looks very different than it did only six months ago, and the transformation is far from over.

As this atmosphere of open communication hopefully continues throughout the crisis and during future initiatives; healthcare patients and the overall health of our country can be placed first.

KHC is excited to partner with our clients during this exciting, albeit stressful, time in the evolution of healthcare. We enjoy sharing ideas with all of you. Have you noticed positive outcomes of the crisis as well? Do you have a new concept you would like to see discussed on an upcoming Quick Bits? If so, please do not hesitate to reach out to me at lrose@kohlerhc.com.

Home IV Therapy Is Separated from Home Care
By: Charlotte Kohler and Jessica Felder

There are multiple changes in Home Health reimbursement for 2021. It is the first full year for PDGM, the new case mix index that replaced the heavy reliance on physical therapy to determine the Home Health Agency (HHA) payments. It also removes Home Infusion Therapy (HIT) from HHA and into its own providers/suppliers of this service. A HIT can be a pharmacy, physician, or provider of services or supplier licensed by the state in which the supplies or services are furnished to patients. In addition, these HIT must also be able to furnish infusion therapy to patients with acute or chronic conditions requiring the administration of home infusion drugs. The HIT must be available on a seven day a week 24-hour day basis and be accredited by an organization that will be indicated by the Secretary of the Department of Health and Human Services.

Why is this different? The benefits include more than those provided under other Medicare coverage and includes nursing services, furnished in accordance with the plan of care, patient training and education not otherwise covered under other benefits, as well as remote monitoring. The patient must be under a plan of care from a physician or other qualified provider. It also eliminates the inconsistencies found in reimbursement for infusions provided under different settings and some limitations found that only covered certain types of IV therapy (pumps and meds) in DME. The infusions must be delivered at the patient's home and for at least 15 minutes. Insulin pumps and any self-administered delivery is not a covered service.

How will this be paid? There will be a single payment that will be calculated based on the type of infusion therapy and adjusted for the Geographic Wage Index and other costs that may vary by region, patient acuity and the complexity of the drug administration. There is an outlier component to this reimbursement methodology. It is also interesting to note that the calculations were made based on a five-hour limit per day for infusion.

This change was mandated under the 21st Century Cures Act and created a new Medicare benefit. A transitional program was established starting January 1, 2019. This change will make the reimbursement permanent and include the regulations to establish the CMS-approved home infusion therapy accreditation programs. See section V.B. of the Proposed Rule found in the federal Register, page 39430 (June 30, 2020). Bottom line: if the service is to be provided by your organization, you must be sure to apply and register as a qualified provider/supplier.

Healthcare and The Coming Digital Revolution
By: Anthony Borgetti

The healthcare industry however, lifesaving it may be, is also lagging in terms of technical innovation. Systems are old and legacy processes and data has created the need for integration across many layers of the applications we use in everyday settings. This isn't necessarily a bad thing, but when we step back and take a broader view, we find that hospitals are stuck in applications that are dated and not very efficient, with a lot of budget being run through those older systems. With COVID-19 the need for a digital transformation has never been more necessary.

As a result of COVID-19, the traditional model of healthcare and patient care has been shattered in favor of a more seamless journey with new challenges at the helm. With new federal funds being shifted into the world of hospitals along with the identification of new and different challenges, we are seeing this evolution of the healthcare system shift towards a review of these processes and the applications that support them. We are seeing that we require a more robust technical model that puts patient care at the forefront of modern healthcare delivery and hopefully leaves some of that old infrastructure in the archives. Here's how I think we are going to accomplish that.

Patient care and the upcoming revolution of medical smart devices will bring an infusion of digital healthcare technology with integration between telehealth, medical devices, HIPAA, and hopefully an expansion on the Healthcare Bill of Rights that includes these up and coming technical advances. On July 29, 2019, a proposal was issued by CMS stating that hospitals must make prices from payer negotiated contracts available to the public. This may be seen as a bold move to achieve price transparency, but will this be enough to benefit the patient? Price transparency is without a doubt moving us forward by bringing down the high costs associated with healthcare. This touches on our initial point that patient care will be at the forefront. Price transparency will give patients the ability to compare multiple facilities, physicians, and costs at the drop of a hat to ensure the most suitable financial outcomes.

Another upcoming innovation to keep your eye on is how we are moving forward with personalized medicine. Part of that challenge lies in the development of these new technologies, but another equally challenging aspect is meeting the demand in order to realize better overall healthcare. In certain cases, we've seen researchers fabricating organs from 3D printing with organic materials to be transplanted into humans. This is still very prototypical, however there are some TED talks available that reference the Institute for Regenerative Medicine at Wake Forest Baptist Medical, in North Carolina, which is printing and delivering kidney tissue on the same day. As time continues, doctors and researchers envision generating very complex systems of tissues and organs, even bones to assist with traumatic wound care settings. Note that there are some serious concerns over

this, and we do not expect this technology to be generally available for the next 50 or so years, as evidenced by the FDA causing several of these prototype projects to shut down.

As we take off into the world of regenerative medicine, we should ask the question, is there a reduced cost associated to providing the right drug to the right patient at the right time? In the next 10 years I anticipate we will see stem cell treatments take off along with cures for blindness, cancer, lung disease, and heart failure.

References:
https://medcitynews.com/2012/08/personalized-medicine-by-2020-this-and-other-predictions-on-the-future-of-healthcare-nfographic/#:~:text=Personalized%20medicine%20%282020%29%20As%20we%20continue%20to%20see,accuracy%2C%20affordability%20and%20policy%20will%20come%20into%20play.

https://www.3mhisinsideangle.com/blog-post/healthcare-price-transparency-in-2020-is-it-enough-to-control-prices/

Face Masks: Are All Masks Created Equally Effective?
By: Susan Santoro

The wearing of a mask as a protective measure against the spread of COVID-19 has been a matter of mixed messages from health authorities. The recurring message from many public health experts and doctors has been simple in that wearing a face mask can saves lives.

With the proliferation of face masks on the market, so begs the question about mask efficacy. Duke University researchers recently completed a study, "Low-Cost Measurement of Facemask Efficacy for Filtering Expelled Droplets During Speech" to provide some answers. [1]

Researchers tested 14 commonly available masks or masks alternatives, one patch of mask material, and a professionally fit-tested N95 mask.

Mandates for mask use in public during the recent COVID-19 pandemic, worsened by global shortage of commercial supplies, have led to widespread use of homemade masks and mask alternatives was prompted by mandated mask use in public during COVID-19 and worsened by global shortages of this item.

It is assumed that wearing such masks reduces the likelihood for an infected person to spread the disease, but many of these mask designs have not been tested in practice. Duke researchers demonstrated in an optical measurement method the efficacy of masks to reduce the transmission of respiratory droplets during regular speech. The researchers compared a number of commonly available mask types and observed that some mask types had the performance of surgical masks, while some mask alternatives, such as neck fleece or bandanas, offer very little protection.

"A fitted N95 mask, which is used most commonly by hospital workers, was the most effective, Warren said, noting that the mask allowed "no droplets at all" to come out. Meanwhile, a breathable neck gaiter, well-liked by runners for its lightweight fabric, ranked worse than the no-mask control

group. The gaiter tested by the researchers was described in the study as a "neck fleece" made from a polyester spandex material, Warren said. [2]

What we do know is that the CDC recently updated its guidelines on masks, noting that the agency does not recommend the use of coverings that have valves or vents. "This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others," the CDC wrote.[3]

Face masks, while it was a topic of much debate, it should be clear that wearing an appropriate face mask or covering can save lives.

1. "Low-Cost Measurement of Facemask Efficacy For Filtering Expelled Droplets During Speech" https://advances.sciencemag.org/content/early/2020/08/07/sciadv.abd3083.
2. Allison Chiu, "Wearing a neck gaiter may be worse than no mask at all, researchers find." Washington Post, August 11, 2020 https://www.washingtonpost.com/lifestyle/wellness/mask-test-duke-covid/2020/08/10/4f2bb888-db18-11ea-b205-ff838e15a9a6_story.html?outputType=amp
3. Centers for Disease Control, "Considerations for Wearing Masks How to Stop the Spread of COVID-19", August 7, 2020. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html.

Check Your Hand Sanitizers: Hand Sanitizer Products Contaminated with Methanol That Have Caused Blindness, Hospitalization, and Death in Both Children and Adults

The FDA has published and is continuing to update the list of harmful hand sanitizers. As of July 8, 2020, the list now includes over 55 hand sanitizers that may contain methanol, a substance that can be toxic because it is absorbed directly through the skin. These can cause death.

The FDA has tested these products and although many are recalled, one of these products may be on your shelf. Methanol is mostly used to make fuel and antifreeze and can be toxic when absorbed through skin or ingested. It can be life threatening if ingested, the FDA said, and just a small amount could be lethal in a young child.

Labels that indicate that the product contains ethanol can be contaminated with methanol. Methanol exposure can cause nausea; vomiting; headache; blurred vision; permanent blindness; seizures; coma; permanent damage to the nervous system or death.

https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-hand-sanitizers-methanol#products.

COVID-19 Pandemic: Telehealth and The Federally Qualified Health Center (FQHC)
By: Sara Rivenburgh

So far, 2020 has proven to be a year we will not-soon forget – filled with extraordinary events… one after another. For the healthcare industry, especially, the challenges we face are daunting, to say the least. One of the greatest challenges is providing quality patient care when the most effective weapon against the spread of the Coronavirus infection is social distancing. This is where Telemedicine has emerged as the most effective method for assessing virus-related symptoms as well as providing routine care to vulnerable patients who are better off at home, limiting their exposure to other patients and healthcare staff members.

Before its expansion necessitated by the COVID-19 Pandemic, Telemedicine was already a vital tool used to reach patients in rural and underserved areas, although it was very limited in regulatory scope. Patients couldn't receive care from the comfort of their homes; they had to go to an "originating site" where they could receive medical services from their practitioner, the "distant site provider", using telecommunication technology. The technology utilized was required to provide real-time, audio, *and* visual communication between the patient and the provider.

Among the providers who historically served as originating sites for Telehealth visits are Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). RHCs, as their title suggests, are clinics located in rural, medically underserved areas of the United States. FQHCs are Federally funded, community-based health centers that provide comprehensive medical services to all persons regardless of their ability to pay. For these facilities, regulatory entities such as the Centers for Medicare and Medicaid Services (CMS), have finally caught up to the unique needs of their patients.

Not only are FQHCs and RHCs serving as originating sites when necessary, CMS has expanded flexibilities authorized by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to include distant site telehealth services to Medicare beneficiaries. Effective March 1, 2020, CMS removed the audio/visual component requirement, allowing FQHCs to provide telehealth services via audio-only technology. This action is a monumental change for a sector of the population that generally does not possess the technology devices necessary for audio/visual communications.

Distant site telehealth services can be furnished by any healthcare practitioner working for the FQHC within their scope of practice. Practitioners can furnish these services from any location to new as well as established patients. There are four types of Virtual Communication Services offered to patients by FQHCs.

1. **Virtual Check-In:** this is a brief (5-10 minute) communication or remote evaluation to decide whether an office or other service is needed. Patients must initiate and consent to the service but can be educated by staff on the availability of said service prior to initiation. Claims for services on or after March 1 and for the duration of the Public Health Emergency (PHE) will be reimbursed at a new rate of $24.90, instead of the CY2020 rate of $13.54.

2. **Online Digital Evaluation and Management (E/M)**: A non-face-to-face, patient initiated, digital communications using a secure patient portal. Where reimbursement before and after the Public Health Emergency (PHE) was/will be $13.54, from March 1 until the end of the PHE, claims will be paid at the new rate of $24.90.
3. **Telehealth Visit***: To identify telehealth distant site services furnished by the FQHC between July 1, 2020 and the end of the PHE, claims must have the FQHC specific G2025 HCPCS code and will be reimbursed at the $92.03 rate. If the PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 Physician Fee Schedule (PFS) average payment rate for these services.
4. **Telephone Visit***: At least 5 minutes of telephone E/M provided by a practitioner who may report E/M services to an established patient, parent, or guardian. Reimbursement during the PHE is $92.03.

***** In July, CMS added revenue code 0900 to Telehealth and Telephone visits allowing for Behavioral Health Treatment/Services.

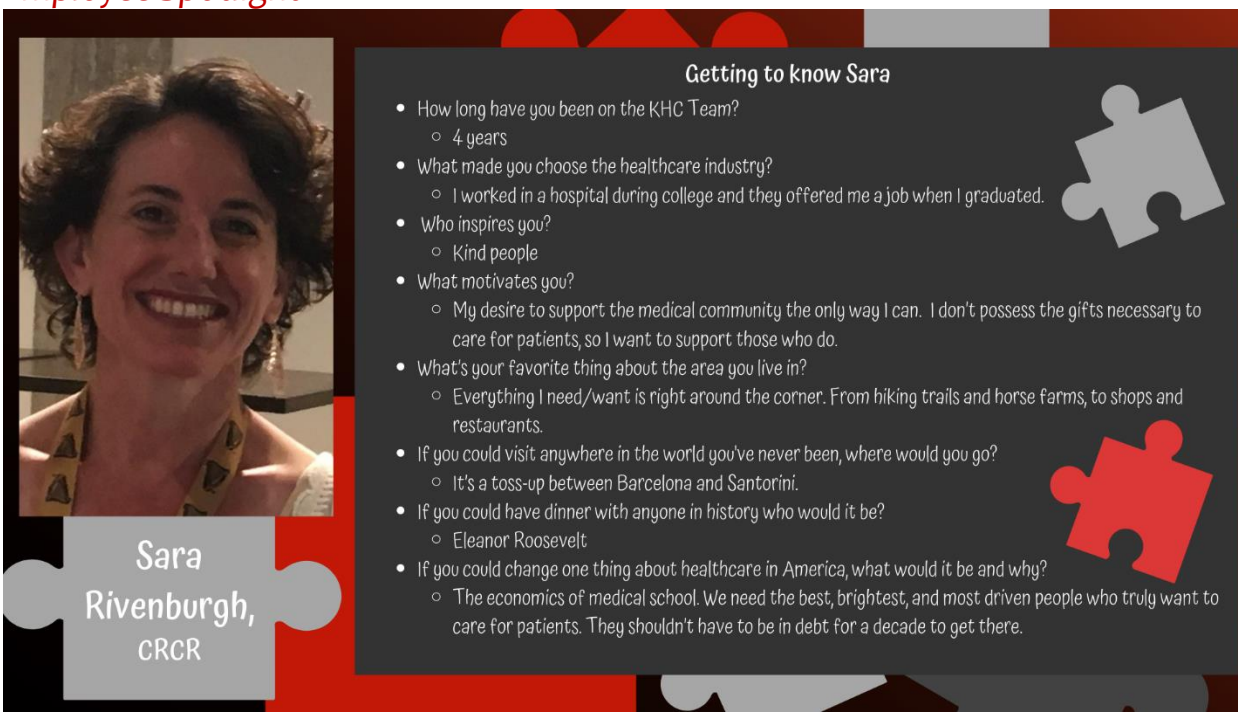
For claims submitted on or after July 1, 2020 (regardless of the date of service), the claim should ONLY list one G-code, code G2025. If any other G-code was on the claim, it needs to be removed before the claim is resubmitted to the Medicare Administrative Contractor (MAC).

If you have questions regarding FQHC billing for services or any type of practice/facility billing during the COVID-19 Pandemic and beyond, please contact Kohler HealthCare Consulting at 410.461.5116. We can customize an Assistance Contract to fit your needs.

Visit Type	Description	Billing	Reimbursement
Virtual Check-In	Brief communication or remote evaluation (G2012 or G2010)	UB-04/837I; RC-0521 HCPCS-**G0071** Modifier-CS*, no 95	$24.90 During COVID-19, 03/01/20 and after
E-Visit	Online digital E&M (99421-99423)	UB-04/837I; RC-0521 HCPCS-**G0071** Modifier-CS*, no 95	$24.90 During COVID-19, 03/01/20 and after
Telehealth Claim submission after July 1, 2020	Same as a face-to-face encounter at FQHC	UB-04/837I; RC-0521 HCPCS G2025 Modifier-CS*, 95 (optional)	$92.03
Telephone Visit Claim submission after July 1, 2020	At least 5 minutes of telephone E/M provided	UB-04/837I; RC-0521, 0900 HCPCS G2025 Modifier-CS*, 95 (optional)	$92.03

*Append Modifier-CS if applicable.

Employee Spotlight



Education

COVID-19 Self-Isolation Counseling Checklist
By: Dawn Homer

CMS has released a checklist to help providers counsel patients who are self-isolating **after** they are tested for COVID-19 and prior to the onset of symptoms, per CMS news alert.

A counseling checklist is available through CMS on their website, along with links to more information. View this at https://www.cms.gov/files/document/counseling-checklist.pdf.

This checklist was released as part of an announcement from CMS and the Centers for Disease Control and Prevention (CDC) stating that payment is available to providers under E/M codes to counsel patients at the time of COVID-19 testing. The ability to bill for teaching and education for home health would include this counseling and has always been billable, but this checklist provides a nice outline for education and information for patient education on COVID-19.

More information on COVID-19 is available from CMS at: https://www.cdc.gov/coronavirus/2019-nCoV/index.html.

Counseling Check List Example:

- Discuss the need for immediate isolation, even before results of the test are available.
- Advise patients to inform their immediate household/contacts that they may wish to be tested and quarantine as well. Review locations and individual that they have been in contact with in the past two weeks.
- Review the signs and symptoms of COVID-19.
- Inform patients, that if positive, they will likely be contacted by a public health worker and asked to provide a list of the people they've been with for contact tracing, encourage them to 'answer the call'.
- Discuss services that might help the patient successfully isolate and quarantine at home.

Changes to the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS)
By: Jessica Felder

On August 4, 2020, CMS issued a final rule that updated the Medicare payment and rates for Fiscal Year 2021. According to CMS-1729-F,[1] Inpatient Rehabilitation Facilities can expect changes in the following areas: facility coverage requirements; post-admission evaluation rules; flexibility with patient visits; and a change to payment rates.

1. **IRF Facility Coverage Requirements**

Prior to FY 2021, an IRF claim was not considered reasonable and necessary unless there was a reasonable expectation that the patient met all the IRF coverage requirements at the time of admission. In the FY 2021 IRF PPS final rule, CMS will be making changes to codify existing documentation instructions and guidance that will improve clarity and reduce administrative burden on both IRF providers and Medicare Administrative Contractors (MACs).[2]

2. **Post-Admission Physician Evaluation Rule Change**

In prior years, a post-admission physician evaluation was required by the IRF within the first 24 hours of admission. The purpose of this was to ensure that the patient had not experienced any significant changes and was still qualified for an IRF admission. CMS has now eliminated the post-admission physician evaluation requirement.

3. **Flexibility with Patient Visits for Physicians**

Currently, a physician must conduct 3 patient visits per week with their patients while they are in an IRF. In FY 2021, CMS will be lessening the burden for the physicians by allowing a NPP to perform one of the three required visits. While the physician still has the option to visit with the patient three or more times per week, they can now use an NPP, if needed.

4. **Payment Rate Changes**

"For FY 2021, CMS is updating the IRF PPS payment rates by 2.4 percent (reflecting a 2.4 percent IRF market basket reduced by a 0.0 percentage point multifactor productivity adjustment). An additional 0.4 percent increase to aggregate payments due to updating the outlier threshold to

maintain estimated outlier payments at 3.0 percent of total payments results in an overall update of 2.8 percent (or $260 million)".3 CMS will also be applying a 5 percent cap on wage index decreases.

For more information on these changes, you can locate the CMS final rule here: https://www.federalregister.gov/documents/2020/08/10/2020-17209/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

References:

1. https://www.cms.gov/medicaremedicare-fee-service-paymentinpatientrehabfacppsirf-rules-and-related-files/cms-1729-f
2. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-inpatient-rehabilitation-facility-irf-prospective-payment-system-pps-cms-1729-f
3. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2021-inpatient-rehabilitation-facility-irf-prospective-payment-system-pps-cms-1729-f

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Medigap Policies: Did You Know This Information?
By: Beth Franzak

"As of January 1, 2020, Medigap plans sold to new people with Medicare **aren't allowed to cover the Part B deductible.** Because of this, Plans C and F are not available to people new to Medicare starting January 1, 2020."[1]
If the Medicare Beneficiary had either of these plans or were covered by one of these plans (or the higher deductible version on Plan F) before January 1, 2020 the Medicare Beneficiary is able to keep their plan. If the Beneficiary was eligible for Medicare before January 1, 2020, but had not enrolled yet, the beneficiary may be able to buy one of these plans.

Medigap Benefits	**Medigap Plans**									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	**No**	**No**	**Yes**	**No**	**Yes**	**No**	**No**	**No**	**No**	**No**
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit in 2020**	N/A	N/A	N/A	N/A	N/A	N/A	$5,880	$2,940	N/A	N/A

* "Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,340 in 2020 before your policy pays anything. (Plans C and F aren't available to people who are newly eligible for Medicare on or after January 1, 2020.).

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission." [2]

If you live In Massachusetts, Minnesota, or Wisconsin: Medigap policies are standardized in a different way

1. https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies.
2. https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies.

Severe Malnutrition – Still an Incorrectly Assigned Diagnosis Code That Has Recently Cost Medicare $1 Billion
By: Robin Stover

The diagnosis of severe malnutrition has long been a key focus of the Health and Human Services (HHS) Office of Inspector General (OIG). In a recent OIG audit for fiscal years 2016 and 2017, it was found that hospitals overbilled Medicare approximately $1 billion due to the incorrect assignment of a severe malnutrition diagnosis on inpatient hospital claims. The audit randomly sampled two-hundred claims and found that only 27 of the claims appropriately assigned the severe malnutrition diagnosis code which resulted in incorrect billing for 173 claims.

This error in assignment of severe malnutrition diagnosis did not change the DRG/payment for nine of these 173 claims. For the remaining 164 claims, hospitals should have used codes for other forms of malnutrition or no malnutrition code. This resulted in overpayments of $914,128. The OIG estimated through extrapolation that hospitals received overpayments of $1 billion for Fiscal Years 2016 and 2017.

The OIG recommended that CMS collect the $914,128 for the overpayments identified in the audit. They also recommended that CMS notify appropriate providers so that they can review, identify, report, and return any overpayments associated with the OIG audit findings.

In order to meet the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for severe malnutrition in an acute care setting, a patient must present with the following symptoms:

- Energy intake: less than (<) 50% estimates energy requirement for greater than (>) 5 days
- Weight loss (% of body weight):
    - >2% in one week; or
    - >5% in one month; or
    - >7.5% in three months
- Muscle mass loss: moderate
- Body fat loss: moderate
- Edema masking weight loss: moderate to severe
- Reduced grip strength: measurable reduced

Coding professionals would use ICD-10-CM code E43 to report severe malnutrition, also known as Starvation Edema. They would use ICD-10-CM code E42 to report severe protein-calorie malnutrition with signs of both kwashiorkor and marasmus.

Identifying and treating malnutrition in hospitalized patients is essential to improving patient outcomes. Documentation of the malnutrition diagnosis is also important for appropriate reimbursement to hospitals for the actual work done by the health care team. Consistency of diagnosing malnutrition at each hospital can be obtained by a multidisciplinary group writing the policy for defining malnutrition based on evidence-based guidance. At this time, the ASPEN criteria are still being followed in the U.S. However, the standard clinical criteria for diagnosing severe malnutrition are actively evolving.

Facility-Specific Coding Guidelines
By: Diane Jordan

The demand for reliable data has never been more evident than it is today. Coding is a significant process and performs a crucial role in providing complete, accurate, and reliable healthcare data. Coding professionals focus is to code completely and accurately so that the data can be used for various purposes.

To have standardization of code assignment, coders are required to follow the ICD-10-CM/PCS Official Guidelines for Coding and Reporting. These guidelines equip both coders and healthcare providers with the information required to properly document, assign codes, and report diagnoses and procedures.

Most facilities also have facility-specific coding guidelines. Facility-specific coding guidelines are exactly as stated in that they are guidelines established to meet the needs of the individual facility. For example, the guideline could include whether the coder can code from the Problem List or if the pathology report must be in the medical record prior to coding. The problem is that these guidelines are hardly ever documented by the facility.

A new coder may learn of these guidelines through training, conversation with another coder, or unfortunately, when a there is a coding error. Everyone may not be aware of the guideline(s) or over the years, the guideline(s) may have changed. Word-of-mouth is the worst way to learn of any guidelines that must be adhered to, especially coding, which impacts the hospital and others directly.

Auditing is another area whereby the auditors should be made aware of the facility guidelines. Without that information, the auditors may identify errors that would not have been counted. If the facility guidelines are not documented, the auditor may not take your word but request a written document. These guidelines are frequently requested by auditors. Whether facility-specific coding guidelines are developed for the coding staff or auditors, these guidelines need to be in place, provided and/or communicated to the respective staff members.

Facility-specific coding guidelines should be a priority for every HIM coding department. If the guidelines are not documented, a good start is to identify the undocumented rules. Understanding the data needs of the organization is the first step in developing facility-specific guidelines that will be useful and provide guidance. This will require preparation and successful facility-specific guideline creation requires preparation. Vital decisions must be made, and several topics reviewed and finalized prior to writing the guidelines. A collaborative approach, including all relevant hospital departments, is recommended to cover all aspects of the guidelines.

According to Coding Clinic, "Facilities can work together with their medical staff to develop facility-specific coding guidelines which promote complete documentation needed for consistent code assignment. Additionally, these guidelines can guide the coding professionals as to when they should query physicians for clarification of their documentation. Any guidelines developed must be applied consistently to all records coded." [1]

Subsequent publications of Coding Clinic include articles that emphasize that facility-specific guidelines must not conflict with the Official Coding Guidelines and address the inappropriateness of inserting the interpretation of abnormal laboratory values and substituting clinical documentation to support diagnoses. [2,3] The facility-specific coding guidelines should not duplicate information found in the ICD-10-CM/PCS Official Guidelines for Coding and Reporting, Coding Clinic, or CPT Assistant.

Guidelines should be developed by patient type such as inpatient, outpatient, emergency room, behavioral health as the requirements may vary by type. Developing separate guidelines by patient type will simplify ongoing maintenance.

“Coding professionals should assign codes for principal or first-listed diagnosis codes and all secondary conditions that meet the definition of reportable conditions. Procedures assigned by the coding professional for inpatient and outpatient records should be clearly defined. For inpatient coding, the coding professional should assign procedure codes for all procedures that impact reimbursement and quality reporting, and ensure data is captured to meet the organization's needs as designated by the facility guidelines. For outpatient coding, the guidelines should outline which procedures are assigned procedure codes by the coding professional as many outpatient procedure codes are assigned via the charge de-scription master (CDM).” [4]

The facility-specific coding guidelines should also include coding compliance. Supporting documentation of services provided is likely a denial and compliance issue. The guideline should define the process to resolve documentation issues with the healthcare provider.

Coders are most often the last people to touch an account prior to the bill submission and are oftentimes required to verify and abstract specific data. One of these items is the Discharge status.

The Discharge status may be assigned by HIM or another department and then verified by HIM. Identify who is responsible for assigning/verifying the status and which documentation is utilized to establish this data element. Coders may also abstract other data, i.e., attending physician, surgeon, and consultant. Outline specifically the data that is abstracted by the coder.

Facility-specific guidelines support consistent coding and collection of accurate data at the organization and should be reviewed and updated at least annually and by version.

1. American Hospital Association. Coding Clinic for ICD-10-CM and ICD-10-PCS, First Quarter 2000, p. 4.
2. American Hospital Association. Coding Clinic for ICD-10- CM and ICD-10-PCS, Second Quarter 2004, p. 14.
3. American Hospital Association. Coding Clinic for ICD-10- CM and ICD-10-PCS, First Quarter 2014, p. 15-16.

Journal of AHIMA, Developing Facility-Specific Coding Guidelines. January 14, 2020. https://journal.ahima.org/developing-facility-specific-coding-guidelines/#:~:text=The%20facility%20guidelines%20should%20specify,to%20the%20facility's%20billing%20software.

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Event Calendar

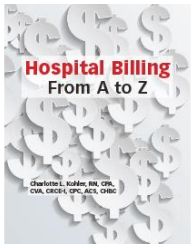
September 16 ,2020
Virginia AAHAM
Revenue Integrity vs. Revenue Cycle
Lauren Rose and Beth Franzak

November 13, 2020
Region IV HFMA
January 1 CPT Updates
KHC to Coordinate

November 18-20, 2020
AMA CPT/RBRVS 2021
Virtual Event

December 2, 2020
National AAHAM Event
January 1 CPT Updates
Lauren Rose

Publications



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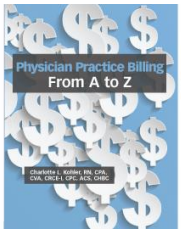

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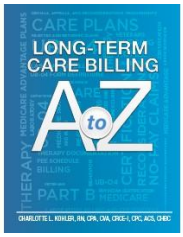

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