KOHLER
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Putting the pieces together

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Welcome to our newest edition of Kohler HealthCare Consulting's "*Pieces for Success*". *We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.*

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TIDBITS, ANNOUNCEMENTS AND EDUCATIONAL/SPEAKING ENGAGEMENTS

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us at 410-461-5116.

Kohler Connection Webinars, Speaking Engagements and News:

- **3/5/18 and 3/6/18 -** Spring MD HFMA Conference in Annapolis. Charlotte Kohler, President, Kohler HealthCare Consulting, Inc. and Kristen M. Bohl, Esquire, Principal, Baker Donelson are speaking on "***You Need to Worry About the Stupid Things***", concerning compliance and the law centered around hospitals on supervision requirements and provider based charges.

- *Scott Wilson,* MBA, CPA, CFE has joined KHC as a Director effective 2/12/18. He is a seasoned 20-year professional with significant experience in Medicare Regulations and Compliance, SEC Reporting, Sarbanes-Oxley, Consolidations, International Operations, G/L Operations, Budgeting, Audit & Systems Implementation. You can contact Scott on swilson@kohlerhc.com or 410-599-2971.

- *Jessica Felder* our new Office Manager is currently enrolled in a course to obtain her CPCS certification. The Certified Provider Credentialing Specialist certification is provided by the National Association of Medical Staff Services (NAMSS). Upon completion of the course, Jessica will sit for an exam to complete her certification. One portion of the course has been completed thus far and she hopes to complete the course over the summer.

- **New Tricare Website** – Take a look at the new website. It is easy to navigate and find information.

(https://tricare.mil/CoveredServices/BenefitUpdates/Archives/02_01_18_NewWebFeatures

Tricare has also eliminated the requirement to get a referral to go to urgent care centers. Also of note: On 1/1/2018, TRICARE Select will replace TRICARE Standard and TRICARE Extra. As a result, beneficiaries will notice improved coverage for preventive services with TRICARE Select.

- **New Tax Law Implications** – One of the interesting ones discussed in the Modern Healthcare 1/8/18 issue is that the ability to deduct False Claims Act settlements requiring the hospital attorneys to identify the specific portion of the FCA settlement of any total settlement. Another one? A 21% excise tax on the top five highest paid employees over $1 million. If there are multiple entities, it's per each entity. It does exclude compensation for direct provision of medical services.
- **Medical Director of Health Plan Admits He Does Not Look At Medical Records in Denying/Approving Care.** In case you missed it, https://www.beckershospitalreview.com/payer-issues/aetna-s-former-medical-director-says-he-never-reviewed-patient-records-before-denying-care.html. Jay Iinuma, MD, who served as medical director for Aetna, Southern California from March 2012 through February 2015, said in a 2016 deposition he followed Aetna's training by relying on recommendations from nurses when deciding whether to approve or deny care.
- Please follow KHC on Linked In: https://www.linkedin.com/company/kohler-healthcare-consulting-inc.

HCPro Books Authored by KHC Staff:

Long Term Care From A to Z, Written by KHC Staff— published in December 2016. The book is now available for sale thru: https://hcmarketplace.com/long-term-care-billing. See website for more details.

Hospital Billing From A to Z**,** written by KHC staff is a reference guide that covers Medicare requirements with ease of use for those involved in hospital billing. The book is available thru: http://hcmarketplace.com/hospital-billing-from-a-to-z?code=EB313813&utm_source=HCPro&utm_medium=email&utm_campaign=HBFAZ

Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPro: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

CMS, OIG AND MEDICARE UPDATES

UPDATE: CMS PHYSICIAN TEXTING CLARIFICATION – Diane Jordan

On December 28, 2017, the Centers for Medicare and Medicaid Services (CMS) issued a memorandum that provided clarification relating to texting by physicians and other healthcare providers. CMS hasn't changed anything, but felt it had to respond to worries raised by providers and telemedicine advocates. The CMS position aligns with that of the Joint Commission.

CMS has determined that the practice of texting orders from a provider to a member of the care team is **NOT** in compliance with the Conditions of Participation (CoPs) or Conditions for Coverage (CfCs). The sections §489.24(b) and 482.24(c) CoPs for Medical Records requirements apply, which include requirements for maintaining medical records, accurately completing medical records, accessing medical records and securing medical records.

CMS requires hospitals to maintain medical records for each inpatient and outpatient. These records must be accurately written, promptly completed, properly filed and retained, and accessible. A system of author identification and record maintenance also must be used to ensure the authentication's integrity and ensure the records' security.

Furthermore, medical records must be retained in their original or legally reproduced form for at least five years. Information from these records, or copies of them, may only be released to authorized individuals. Original medical records may only be released in accordance with federal or state laws, court orders, or subpoenas.

CMS has indicated that Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider. The memo states that a physician or Licensed Independent Practitioner (LIP) may enter orders into the medical record via handwritten orders or CPOE. Orders entered via CPOE, with an immediate download into the provider's electronic health records, would be permissible because they would be dated, timed, authenticated, and promptly placed in the medical record.

CMS made clear that texting patient information is allowed as long as a secure texting platform is used. Providers must

comply with HIPAA and meet the applicable conditions of participation to ensure that patient confidentiality is upheld and documentation requirements are met. CMS highlights the need to:

- use secure, encrypted platforms to limit the risk of exposing patient information
- develop and adhere to policies and procedures that ensure the security and integrity of the secure texting platform

Although texting physician orders are prohibited, CMS recognizes the essential and valuable use of other forms of texting as an important means of communication among providers. CMS also said it expects that health care providers and organizations will routinely assess the texting platforms for security and integrity.

At this time, providers should review their policies concerning the communication of health information through text messaging. Providers should be prepared to update text messaging practices to better reflect the new guidance from CMS on patient confidentiality and record retention. Keep in mind the December 2016 guidance from The Joint Commission when reviewing those policies. Be prepared to address these issues.

If a secure text messaging system is not already available, providers should analyze current practice, benefits, and the risks of adding a secure, encrypted text messaging service before incorporating text messaging into approved practice. Any new or existing text messaging or secure messaging service practices should be routinely analyzed and updated to avoid risk and ensure that the system is effectively guarding patient information. Health care providers should document their risk analysis of incorporating text messaging platforms as part of their health care organization and ensure that an appropriate risk management strategy is implemented and followed. Evaluations and maintenance of those safeguards should be revisited regularly.

CMS Texting Guidance Letter

Joint Commission Clarification

https://www.jointcommission.org/assets/1/6/Clarification_Use_of_Secure_Text_Messaging.pdf

CONGRESS END THERAPY CAP…KIND OF…- Julie Leonard

At the end of 2017 the Centers for Medicare and Medicaid (CMS) reverted back to a *hard* cap of $2,010.00 annual therapy cap for outpatient physical, occupational and speech therapy (combined). This meant that the practices could no longer use the exception process and bill for services about the cap utilizing the KX modifier (Requirements specified in the medical policy have been met).

As of February 9, 2018, the therapy cap is now a thing of the past, due to the new budget deal that was signed by President Trump. The cap has been replaced with a *therapy threshold* of $3,000.00 for combined physical, occupation and speech therapy. Once the threshold has been reached, the providers will submit charges with the KX modifier. The charges that are submitted with the KX modifier after the $3,000.00 threshold has been reached will now be subject to medical review.

“Claims that go above $3,000 will not automatically be subject to targeted medical review. Instead, only a percentage of providers who meet certain criteria will be targeted, such as those who have had a high claims denial percentage or have aberrant billing patterns compared with their peers”[1]

As was stated in Volume 27 Number 6 February 12, 2018 *Report on Medicare Compliance:*

“By affixing the KX modifier, the therapist is making an attestation that the therapy is medically necessary and there’s documentation in the medical record to support this. Therapists need to be careful—they are making an attestation”[2]

According to the same article providers should be aware of coming changes to provider billing and reimbursement in the form of modifiers and fee schedules.

“Congress also took a big step toward identifying Medicare services provided by physical therapy and occupational therapy assistants. The bill directs CMS to create a modifier for tracking use of therapy assistants in 2019, with an eye toward collecting enough data in 2020 to come up with a Medicare fee schedule rate that’s 85% of the fees paid to

[1] http://www.apta.org/PTinMotion/News/2018/02/09/TherapyCapRepeal/
[2] https://www.hcca-info.org/

physical, speech and occupational therapists by 2022, Beckley says. It's supposed to be subject to the rulemaking process, so it will take some time and allow the industry to comment"[3]

This would bring the fee schedule ratio in line with Physicians and Mid-Level providers.

PHYSICIANS AND PRACTICES

ADVANCED PRACTICE PROVIDERS - A WISE INVESTMENT – Sara Rivenburgh

A licensed physician's assistant is a sound investment of time, money and reputation. How can you make sure you're getting the most out of your investment? One of the most overlooked benefits is billing for PA services under their own National Provider Identification (NPI) number. Without an individual NPI number, you may be missing out on Medicare dollars and licensed PAs can see the same kinds of patients as the physicians in your group. They can diagnose, treat, prescribe, perform minor procedures, and first assist in surgery – all under their own NPI number. Medicare pays a PA's employer for medical and surgical services at 85% of the physician rate.

"Incident to" is a Medicare billing provision that allows reimbursement for services at **100%** of the physician fee schedule in a non-facility setting, such as a physician's office. With "incident to", the physician must have seen the patient on their initial visit to establish the treatment plan, and a physician must be onsite at the time services are rendered.

Dispelling some of the myths:

- Myth: Physicians must see every patient and/or be onsite. Truth: Medicare does not have a requirement that the physician see the PA's patients, and does not require that the physician be physically on site when services are provided.[4]
- Myth: The practice will make more money by hiring a physician. Truth: In fact, PAs are generally paid half a physician's salary and their profit/contribution margin is **higher**.[5]
- Myth: PAs can't prescribe controlled substances. Truth: The primary supervising physician (PSP) can delegate the authority to prescribe prescription drugs, controlled dangerous substances and/or medical devices. PAs must have valid Federal Drug Enforcement Agency (DEA) and state controlled substance registrations.

Hiring a licensed physician's assistant can be beneficial to the economic growth of your practice while improving patient satisfaction by providing greater access to care. The physician can spend more time with complicated cases without sacrificing profitable office time. These are just a few of the many advantages of hiring a licensed physician's assistant. Make sure to utilize your assets to their fullest extent.

CODING AND DOCUMENTATION CORNER

IMPORTANCE OF REPORTING CPT 99024 – Robin Stover

CPT 99024 (*Post-operative follow-up visit*) is a code included in the surgical package and utilized for reporting E/M services provided during a post-operative period for a reason related to the original procedure. CPT 99024 that is a Medicare bundled code with zero RVUs and no fee in the Medicare Physician Fee Schedule.

Effective July 2017, CMS began requiring offices with ten or more practitioners in nine states to report claims data on post-operative visits provided during the global period for specific procedures (See *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-04-25-Global-Surgery-Presentation.pdf* for the complete list of procedures

[3] https://www.hcca-info.org/

[4] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

[5] *Maximizing Utilization of PAs & NPs: Rules, Realities, and Reimbursement*, Educational Conference & Exhibition, Tricia Marriott, PA-C, MPAS, September 20, 2016; using MGMA data.

for 2017.) The list of included procedures will likely be updated annually.

Although there are no RVUs or payments specific to this code, payment for these post-operative services is bundled into the reimbursement for the surgical procedure. Sine CMS pays for these services in advance, they are now interested to see if those post-operative services are actually performed. These services do not need to be documented with the same detail used for other E/M services. However, they do need to contain support for medical necessity of visit, status of patient's recovery, counseling, testing, referrals, and nature of patient's problems.

If the surgeons in the nine targeted states do not report all post-operative visits using CPT 99024, CMS may consider reducing the global payments for certain procedures which would affect all physicians performing those procedures. The global package was developed to include a certain number of pre and post-op services and if these are not being provided, CMS will be forced to reduce reimbursement.

NEW CODES BENEFIT PROVIDERS OF INTERNATIONAL NORMALIZED RATIO (INR) INSTRUCTION – Julie Leonard

The Centers for Medicare and Medicaid (CMS) has created new CPT codes for services that providers have long been providing and confused about how to bill for.

As of 01/01/2018 new Anticoagulation Management CPT Codes - these codes are to report the initial (93792) training of a patient or caregiver for use of home monitoring international normalized ratio (INR) with proper use and care of the in-home monitoring system. CPT code 93793 is used to report training of patient or caregiver on a new home monitoring system.

"**93792** (Patient/caregiver training for initiation of home international normalized ratio monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results).

93793 (Anticoagulant management for a patient taking warfarin must include review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s) when performed).

Lay Description: Home and outpatient INR monitoring is anticoagulant management of warfarin therapy, including ordering, review, and interpretation of new INR test results; patient instructions; and dosage adjustments, as appropriate. In 93792, face-to-face, clinician-directed training is started for the patient and/or caregiver for in-home INR monitoring to include proper use and care of the INR monitoring device, instructions for obtaining blood samples, and reporting INR test results. A documented determination as to the patient's and/or caregiver's ability to adequately perform testing and reporting is also required.

Report 93793 for review and interpretation of a new home, office, or lab INR test result with instructions and dosage modifications, as necessary, as well as the scheduling of any additional tests, when performed."[6]

CMS GIVES A GIFT TO TEACHING PHYSICIANS – Julie Leonard

The Centers for Medicare and Medicaid (CMS) announced in a recent outreach that it will be updating the documentation requirements for students and teaching physicians. It has long been wondered why a student documented an entire evaluation and management (E/M) and the teaching physician was then required to also document the same E/M service.

"*The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to allow the teaching physician*

6

https://www.encoderprofp.com/epro4payers/cptHandler.do?_k=101*93793&_a=view&searchTerms=93793&codeTypes=%5BI%4019b119b1&_mrad=true&#selected

to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work."[7]

This move seems to take into account the sometimes burdensome documentation requirements placed on teaching physicians and facilities and we can only hope it is a sign of more changes to come.

THE PATTERN OF E/M CODING IS CHANGING - Charlotte Kohler

Based on CMS data, the bell curve for E/M coding has been moving upward so that the 99213 is no longer the most prevalent but rather there is equalization between 99213 and 99214. Insurance companies are seeing this as well and as a consequence, we are seeing more audits and requests for medical records relating to 99214. This is not a sudden change. It has been a trend the last couple of years with some specialties increasing 4% each year and other specialties such as orthopedics increasing 17% for 2014 through 2016. On an overall basis, there has been a 27% increase from 2010. Yet, the overall denial rate has been between 3% to 4%.

There are several reasons why the increase to level 4 has been happening. The first, of course, is that the increased use of electronic medical records, in which the software helps the provider determine the level of services, and also helps in identifying elements necessary to "improve" the level of service. It also may help remind the provider of the elements that need to be recorded. In many cases, from our auditing work, we find that the electronic medical record helps the physician remember to add the elements of the history component of E/M. The lack of past family social history or documenting the review of systems which reduced the level of service is now highlighted within the electronic medical record.

There is also some level of conscious documentation improvement that in turn increases the amount physicians are paid under the RVU methodologies when they are employed physicians. Plus, keep in mind that the methodology behind E/M coding is now "not new" -- 20 years of experience helps to improve the overall outcome.

It is also interesting to note that as 99214 increases, we are also seeing an increase in 99215s. However, this increase in 99215 is not as significant as 99214.

So what does this all mean? It means that the benchmarks that have been used to evaluate the overall E/M coding patterns will also be changing. It will not immediately relieve practices of the concern from third-party payers unhappy about the increases in the 99214s. It still means, however, that documenting of medical necessity will be required to support whatever codes are billed.

OTHER ARTICLES OF INTEREST

ENSURE YOUR INFECTION CONTROL STRATEGY INCLUDES NON-CLINICAL OFFICE AREAS – Dawn Homer

Routine office equipment and apparel are easily contaminated and need to be part of infection control procedures. Clerical items and everyday actions spread pathogens.

"Data from the World Health Organization show that hospital-acquired infections account for complications in 6% to 10% of admissions in developed countries and 200 deaths per day in the United States. The data also show that compliance with hand-hygiene guidelines which, if properly undertaken, can stem the spread of pathogens, is "frequently below 40%."

Many studies show that mobile devices, computer keyboards and office phones are bona fide breeding grounds for bacteria. Some helpful hints to combat this would be;

[7] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10412.pdf

- Purchase antimicrobial keyboard covers for non-clinical as well as clinical staff
- Switch cleaning products from week to week or month to month to deter resistance
- Encourage hand washing with signs, alcohol-based cleaning stations and other compliance efforts.
- Invest in anti-bacterial wipes and ensure all non-clinical devices are thoroughly wiped on a regular basis

Lastly, talk to your janitorial staff/company and ensure the training they are receiving on infection control and stay in contact with them regarding compliance.

2018 OUTPATIENT HOSPITAL LABORATORY TESTING REGULATORY UPDATE - Lauren Rose

The Center for Medicare and Medicaid Services made a significant policy change January 1st, 2018 regarding hospital outpatient laboratory services performed by reference laboratories.

There is now a new exception to the CMS date of service rule concerning Molecular Pathology tests and Advanced Diagnostic Laboratory Tests (ADLTs) provided to hospital outpatients when the tests are performed by reference laboratories. Molecular Pathology tests and ADLTs are performed after the hospital outpatient discharge date as these samples are collected, processed, and prepared to be shipped to a reference laboratory for performance of the test(s). These specimens often arrive to the reference laboratory late in the evening or the next day. Because the results do not guide the treatment of the patient on the date the sample was drawn (as the tests have not been performed and resulted during the outpatient encounter), CMS is now requiring that a) the date of service reported be the date that the test is performed and b) the performing laboratory vs. the hospital bill for these services.

The Health Services Cost Review Commission has confirmed this regulation is applicable to Maryland as hospitals in Maryland typically follow national rules with regard to outpatient laboratory billing and date of service reporting.

Some of the most common questions and concerns include:

Q: Which tests are included in this new regulation?

A: Per 82 FR 59396 (December 14, 2017), advanced diagnostic laboratory tests and molecular pathology tests that are currently excluded from OPPS packaging except for gene sequencing procedures [GSPs], proprietary lab analyses [PLAs], or protein-based molecular multianalyte assays. Reference laboratories are publishing the impacted codes for their hospital clients. Codes included in this update appear to include CPTs 81105-81383, 81400-81408, and 81479, however, the exact CPTs should be confirmed with the specific reference laboratory.

Q: What about other reference laboratory tests performed on outpatients where the results are not known on the date the specimen has been drawn?

A: So far, it is only the tests referenced above included in this regulatory update. Outside of Maryland, most laboratory services are already packaged vs. separately reimbursed and as such, their billing is not under review by CMS. CMS will continue to review GSPs, PLAs, and molecular multianalyte assays that were excluded this year.

Q: Are "non-patients" or "specimen only" accounts impacted by this regulation?

A: Per CMS, this regulation only relates to outpatients where the specimen was drawn at the hospital. They reference that the reference laboratories may already bill for the "non-patients" on page 59398 of the 82 Federal Register (December 14, 2017).

Q: Does this regulation apply to Medicare or all payers?

A: This regulation was published by the Center for Medicare and Medicaid Services and should be confirmed with other payers.

ADDITIONAL INFORMATION

Thank you for your interest in Kohler HealthCare Consulting, Inc. If you wish more information about KHC and the services we offer, ***please visit our website http://www.kohlerhealthcare.com or call 410.461.5116.*** *If you prefer not to receive future issues of our publication, please hit 'reply' and let us know and we will immediately remove you from our distribution. Thank you.*