KOHLER
HEALTHCARE CONSULTING INC
Putting the pieces together

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**MARCH 2018** ◊◊◊◊◊◊◊◊ ***Volume 8 - Issue #80***

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.*

## IN THIS ISSUE…….

## 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:


- *Deborah Carr,* CCS, has joined KHC as a Senior Consultant effective 3/19/18. She has over 19 years of experience in medical billing coding for many medical and surgical specialties, including anesthesia, pain management and ambulatory surgery centers. Ms. Carr is also a proficient and knowledgeable trainer of physicians and staff. You can contact Deborah on dcarr@kohlerhc.com.
- *Joshua Leventhal* will join KHC as a Director on 3/26/18 with experience focused in the healthcare and life sciences industries. Josh specializes in data mining and analytics, data conversion, database development and database programming related to litigation matters, regulatory compliance, and government contracting for healthcare providers, payers and pharmaceutical manufacturers. Josh also provides financial modeling to support risk exposure and damages analysis, pharmaceutical government price reporting calculations, and other analyses. His expertise in data mining and analytics across several healthcare industries allows him a unique perspective.


- *Lauren Rose, CPA, CPC, Managing Director at KHC was nominated and now has been elected as a Director for the Maryland Healthcare Financial Management Association this month.*


- **Coming To a PEPPER Report Near You**. The hospital Program for Evaluating Payment Patterns Electronic Report [PEPPER] began including Emergency Room CPTs March 6, 2018. PEPPER will be identifying if a hospital appears to be an outlier from an upcoding or downcoding perspective. [Report on Medicare Compliance, Volume 27, Number 8, February 26, 2018.]. See article below for more details.

- **2018 Maryland HFMA Spring Institute.** It was great to see many of you at this year's Maryland HealthCare Financial Management Association Spring Institute in Annapolis on March 5th and 6th. The theme for this year's event was "Healthcare Redesigned" and the conference included great diversity of both speakers and topics. Attendees were able to see healthcare through the perspectives of a neurosurgeon, health systems and hospitals, the Maryland Hospital Association and state legislators, independent physician groups, insurers, attorneys, and healthcare consultants. Hope to see you at the next HFMA event!

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- **Healthcare Provider Claims**. According to the Maryland Workers' Compensation Commission, prior to October 1, 2017 there was no timely filing limit for healthcare provider claims. However, as of October 1, 2017, healthcare provider claims are subject to a 12 month filing limit from the date of service or the date the claim was determined to be compensable. The complete regulation can be found at www.wcc.state.md.us.

- **Anthem Rolled Back the Payment Reduction to Evaluation and Management (E/M) Services With "Same-Day Service"**. In a letter to the American Medical Association dated February 23rd, Anthem's Executive Vice President and Chief Clinical Officer Craig Samitt, MD announced the policy reversal. Anthem had been poised to reduce E/M services that were billed with a 25 modifier by 50%.

- **Request from MedPAC to Eliminate MIPS.** The Medicare Payment Advisory Commission has released its semiannual report on Medicare payment policy to Congress, which includes a recommendation to eliminate the Merit-based Incentive Payment System. MedPAC recommends Congress adopt a new model, the Voluntary Value Program, which would utilize a unified set of population-based measures.

  MedPAC said it decided MIPS should be eliminated after a two-year deliberative process, since they believe it's "fundamentally incompatible with the goals of a beneficiary-focused approach to quality measurement."

  MedPAC agrees with the philosophy but not the route to get there: "MedPAC shares Congress' goal, expressed in MIPS, of having a value component for clinician services in traditional Medicare that promotes high-quality care. However, the Commission believes that MIPS will not fulfil this goal and, therefore, should be eliminated," the commission wrote in its report.

- 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

## EMERGENCY DEPARTMENT SERVICES ADDED TO THE PROGRAM FOR EVALUATING PAYMENT PATTERNS ELECTRONIC REPORT (PEPPER) – Janet Ellis

Hospitals should review charges for Medicare services for correct documentation and appropriate billing. At this time, there is no national standard for designating Evaluation and Management (E/M) codes in an emergency department setting. The Centers for Medicare and Medicaid Services (CMS) recommended each hospital establish facility guidelines for billing back in 2000. A hospital's coding represents the volume and intensity of services used in the care of a patient. The services utilized should be documented and show medical necessity. Recently added to the reports will be the E/M emergency department visits and in particular, hospital facility fees.

PEPPER is developed by TMF Health Quality Institute and is under contract with CMS. The reports are sent quarterly to acute care hospitals. PEPPER reports do not indicate payment errors. The reports are used to compare data regarding claims and identify areas of concern. The March PEPPER report will let hospitals know if they are outliers.

Specifically, CPT code 99285 is being addressed since it is the highest code and the potential to upcode is great. Each hospital's internal guidelines should be applied yet the medical record should have concise documentation that would support the code. A hospital would be identified as being in a risk category if it is in the 80$^{th}$ percentile or higher or as a low outlier if below or at the 20$^{th}$ percentile. It will be up to the hospital to determine if the data supplied is a compliance issue. PEPPER reports are used to compare data over time to identify billing practice changes and help to reduce improper payments.

References:

https://www.pepperresources.org/PEPPER

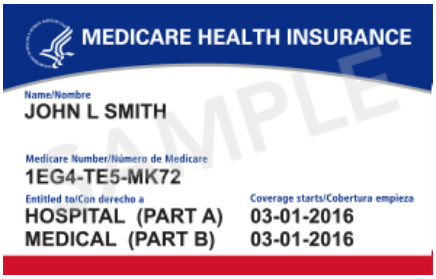
https://www.acep.org/Content.aspx?id=30428

## NEW MEDICARE INSURANCE CARDS – Khalida Burton

Did you know CMS is removing Social Security Numbers from Medicare cards in order to prevent fraud, fight identity theft and to keep taxpayer dollars safe? The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. In place of the social security based Health Insurance Claim Number (HICN), CMS will assign new unique, randomly-assigned numbers called the Medicare Beneficiary Identifier (MBI). The new cards will be mailed to Medicare beneficiaries beginning April 2018 with the expectation of having all Medicare cards replaced by April 2019.

CMS has identified a few steps for Providers to take in order to prepare for the New Medicare Cards:

1. Continue to bill Medicare using the HICN during the 21-month transition period. Work with your system vendors to ensure your systems are able to accept the new MBI number. Test the data exchange between your systems and Medicare.
2. As Medicare beneficiaries present to your hospital or office, complete 100% demographic and insurance verifications. For example – verify their address and ensure the address you have on file is the same address on file with Medicare.
3. Display helpful information signs and posters in your organizations to help the beneficiary adjust to the new Medicare card. The MBI will be 11-characters in length made up of numbers and uppercase letters with no special characters.




For more information – please visit https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

## IRF DENIALS: BUT WE ONLY MISSED IT BY MINUTES! – Daria Malan

Medicare pays for physical, occupational, and speech therapy delivered in inpatient rehabilitation facilities (IRFs), if beneficiaries participate at least a total of three hours a day. Minutes of therapy are calculated on a daily basis, with the goal of three hours per day. However, known patterns exist, resulting in Medicare denials up to 20% if patients miss the three-hour threshold by just minutes. Common and justifiable reasons occur during an IRF stay that include a medical hold for patients who experience serious problems during the therapy session, such as chest pain or shortness of breath, the need for stat diagnostic tests such as x-ray/EKG, or even a patient's request for a short 10 minute rest break from therapy due to temporary fatigue. Often patients make up these missed minutes the next day.

Medicare accounts for 60% of IRF discharges. Denial trends are noted since MACs will deny claims for the patient's entire stay in the IRF, rather than just the sessions or day that fell short of the three-hour daily threshold. Many of these claims have been eventually overturned upon appeal; however, the volume of appeals has caused an undue backlog.

New guidance from CMS could stop these rehab denials. To address this issue, there is a CMS policy change notice that states starting March 23, 2018, MACs can no longer deny claims solely based on the daily three-hour threshold falling short. Contractors are being asked to use clinical judgment when reviewing claims, to determine if the IRF services are covered based on the patient's overall needs and treatment outcomes, rather than simply the calculation of therapy minutes. This guidance should sufficiently clarify these types of issues; however, the MAC interpretation and application of this guidance is a "wait and see" for IRF reimbursement. Stay tuned.

# CODING, DOCUMENTATION AND COMPLIANCE CORNER

## CODING ERRORS THAT CAUSE CLAIM DENIALS – Simbo Famure

When claims are being processed, it is important to make sure that not only the patient demographics are accurate and referrals are provided for specialty visits, but also, the coding rules are being followed.

There should always be specific and appropriate diagnosis codes to match all procedure codes. The diagnosis should be up-to-date and placed in order of priority and highest level of specificity. Medical necessity is also very important and this should be exhibited in the documentation always, especially if there may be a need to review the patient's chart.

Modifiers also play an important role in coding. Many codes get denied because the appropriate modifier that should go with a CPT code is not included; for example, if the location for a upper or lower limb is being treated or examined, modifiers LT, RT or 50 will be used.

A very important part of coding procedures is to be careful not to code procedures that cannot be coded together because one of the codes is already included in the primary code. This is referred to as unbundling and good sources for checking for these types of errors are the CPT book or NCCI (National Correct Coding Initiative) edits on

the CMS website.

## CONDUCTING A COMPLETE CODING COMPLIANCE PROGRAM – Deanna Turner

Does your organization conduct an internal review of its coding and billing practices at least annually? By incorporating an audit process to ensure the documentation supports the coded and billed services, you can minimize risk and regulatory exposure, receive appropriate reimbursement and ensure compliance with specific federal, state, and internal rules and policies by performing periodic coding and documentation audits.

There are many components to a complete coding quality compliance program, including chart selection methodologies, retrospective versus concurrent audits, frequency of audits, and scope of audits. When planning your audits key factors include:

1. Determine the frequency of audits: daily pre-bill, monthly, quarterly, semi-annual, or annual.
2. Consider the scope:
    a. *Inpatient:* total data quality (validation of all codes) or DRG validation only? MS-DRG and/or APR-DRG?
    b. *Outpatient*: Which outpatient service types are to be included? Emergency department, same day surgery, endoscopy, observation, wound care, ancillary/diagnostics, recurring such as physical therapy, occupational therapy, chemotherapy, blood transfusions, interventional radiology, clinics, etc.
    c. *Professional Fee*: Which specialties are to be included? Which providers are to be included?
    d. *Medical Necessity:* Should a review for medical necessity for short stay admissions (one- to three-day stays) be included?
3. Determine the volumes for review: Specific volume per DRG, per coder, per coder per service type coded (for cross-trained coders).
4. Choose a chart selection method: Random, random from top MS-DRGs or APR-DRGs, targeted by MS-DRG or APR-DRG or specific code, targeting of specific records.
5. Determine if the review will be concurrent or retrospective.
6. Decide which payers are to be included: All payers versus specific payer types such as Medicare only.
7. Decide which dates of service are to be included.
8. Plan time for the review: Set aside adequate time for reviewing the recommendations and responding to the auditor(s).

When considering the various components of a complete coding quality compliance plan, the best plan should involve frequent reviews, allow for a variety of chart selection methods and include a process that supports coder education and consistent, complete and compliant reporting of coded data.

# OTHER ARTICLES OF INTEREST

## THE FINAL MARYLAND HEALTH SERVICES COST REVIEW COMMISSION POLICY UPDATE ON READMISSIONS – Lauren Rose

The staff of the Maryland Health Services Cost Review Commission has worked diligently all year updating each of the necessary policies (i.e. Readmissions, Hospital Acquired Conditions, Quality, Update Factor, etc.) for the new rate year. At the March 14th meeting, the final policy – Readmissions - was approved by the Commission.

The Readmissions policy has seen hospitals in Maryland not only meet but also surpass goals set based upon the

state's 2013 results as well as national trends. When Maryland began this project, Maryland looked very poor compared to the nation. The HSCRC commended hospitals on achieving these goals.

**Payers -** The latest policy updates are not changing to only include Medicare vs. all payers. The rationale for including all payers is to ensure this policy is tied with the all-payer philosophy in Maryland. Opponents of the all-payer component argue that outside of Maryland, the metrics focus on Medicare only.

**Targets -** The policy will also continue to utilize the better of attainment and improvement metrics for each hospital; however, the HSCRC will be looking into only having attainment goals for next year. Attainment targets compare hospitals to each other whereas improvement targets compare the hospital to itself. By using the "better of" the two, a hospital can be rewarded for performing well overall or improving its performance.

**Observation -** The HSCRC is considering the inclusion of observation cases in addition to inpatient cases for the readmissions policy when it is next updated. This would definitely have a significant impact on the numbers given the increasing utilization of observation status within hospitals.

Watch for potentially significant policy updates for Readmissions and the other policies during the next "go round" of updates, especially with regard to Hospital Acquired Conditions where a task force has already started meeting to begin the analytics necessary to overhaul the existing policy. It is never too early to determine if/how the potential impacts might impact your hospital.

## 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.*