KOHLER
HEALTHCARE CONSULTING INC
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.*

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.

- **Removing the Cost Barrier to Primary Care - At Walmart.** All Walmart workers can have a telehealth visit with a doctor for only $4, rather than the previous $40 charge. At this price level, it could really have an impact in nudging employees toward a high-tech way to get diagnosed and treated remotely. But will it work? Patients have been slow to embrace virtual care. Eighty percent of mid-size and large U.S. companies offered telemedicine services to their workers last year, up from 18 percent in 2014, according to a report from Mercer which also stated that only 8 percent of eligible employees used telemedicine at least once in 2017 (most recent figures show). Those who may be the most reluctant to use telehealth: Sick child and the elderly.

- **Help to Tricare Members – Good "Explanation" for the Explanation of Benefits.** Most people see the reports from the payers and just have problems understanding what it's trying to tell us regarding what the payers paid. Now Tricare has published this guide to help.

  See it at:
  https://tricare.mil/CoveredServices/BenefitUpdates/Archives/2_19_19_Understanding_Your_TRICARE_Explanation_of_Benefits

- **Looking for Guidance from CMS on CAR T-Therapy?** CMS issued a proposed national coverage determination for Chimeric Antigen Receptor (CAR) T-cell therapy on 2/15/2019. It can be found at https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=291.

  If you want to see more about this, read this "proposed Decision Memo for Chimeric Antigen Receptor (CAR) T-cell Therapy for Cancers (CAG-00451N)". This publication explains all the requirements that must be met.

- **Maryland Activity.** The MHA Medicaid Task Force was kicked off in March. Look on the MHA website for the new way to report any issues or concerns. As an update on the Emergency Department HSCRC Task Force: This is moving along quickly with the deadline last Friday (March 15) to have the conversion worksheets in from each hospital. The upcoming meeting of March 27 will be an important one to attend either in person or on the conference line.

- **Want to Know More About Federally Qualified Health Centers?** FQHCs are safety net providers, such as community health centers and outpatient programs designated by CMS to enhance primary care to the underserved in urban and rural communities. HRSA is responsible for oversight and is the principal resource to assist in the pathway to creation, eligibility and compliance for FQHCs, operating under non-profit status or as a public agency. HRSA's website has great resources, such as program funding, compliance, quality, opportunities, FAQs and data: https://bphc.hrsa.gov/programrequirements/index.html. Another resource to check out is **FQHC MLN ICN 006397 Jan 2018**, which offers information on CMS certification, services and payment.

- ***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

ACA, CDC, CMS, OIG, MEDICARE and MEDICAID UPDATES

SNFs MOVE TO PATIENT-DRIVEN PAYMENT MODEL- LAUNCH DATE OCTOBER 1ST – Daria Malan

As of October 1, 2019, SNF prospective payment system (PPS), based on the current resident classification system, will undergo a comprehensive change. Under Part A, the new Patient-Driven Payment Model (PDPM) will reimburse Medicare SNFs based on a patient's needs, which will be determined using ICD-10 diagnoses codes, patient characteristics, and other clinically relevant factors.

RUG-IV is going away: The Resource Utilization Groups, in place since 1998, has functioned as a case-mix-adjusted PPS, to predict the cost to treat LTC patients based on their diagnosis, services utilized, and/or other indications of resource use. This model relies on three primary predictors of cost for SNF residents: clinical characteristics, activities of daily living (a measure of functional assistance required by a resident), and skilled services received (rehab, extensive services, IV medication). RUG-IV levels are ultimately captured via the required the Minimum Data Set (MDS) 3.0 assessment tool that assigns residents to one of 66 RUGs, also known as case-mix groups. The largest segment of residents receive therapy, and their RUG level is determined primarily by the number of therapy minutes they receive.

Under PDPM, CMS worked toward refinements to improve payment accuracy since the current payment model does not fully consider the wide range of clinical characteristics that influence the relative resources necessary for the diverse range of residents in SNFs. Research provided two key recommendations[1]:

1) Remove therapy minutes as a determinant of payment and create a new therapy payment model in which payment is linked to differences in clinical characteristics.
2) Create a separate payment component for Non-Therapy Ancillary (NTA) services, using resident characteristics to predict utilization of these services.

Therefore, the PDPM considers the broader range of care requirements: PT, OT, SLP, Nursing and NTA.

Unlike RUG-IV, which incentivizes ultra-high volumes of therapy to capture the maximize payment, PDPM will require SNFs to carefully manage how they deliver services in order to provide just the right level of care for each resident. SNFs who over-deliver therapy won't get paid for services provided beyond the reimbursement level for each resident classification. But under-delivering therapy will lead to poor patient outcomes and potential Medicare audits and take-backs.

With a reduction in total therapy minutes provided, SNFs can anticipate less demand for rehab care, which has been a concern of the OIG, since payments have exceeded costs of therapists over recent years.

PDPM is designed to be "budget neutral." Within SNFs, this is expected to be true. With some therapy dollars reallocated to nursing, SNFs will be able to offset the loss in therapy reimbursement with higher reimbursement for the nursing care that's already being provided, but not captured. (Example-It is predicted that PDPM would adjust

[1] https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/pdpm_technical_report_508.pdf

the nursing component by adding another 18% to the nursing per-diem payment for residents who have HIV/AIDS, due to their care needs).

For more detailed information, go to American Health Care Association Patient-Driven Payment Model (PDPM) Resource Center: https://www.ahcancal.org/facility_operations/medicare/Pages/PDPM-Resource-Center.aspx
AHCA also offers PDPM FAQs at:
https://www.ahcancal.org/facility_operations/medicare/Documents/AHCA%20PDPM%20FAQs%201-22-19.pdf

APPROPRIATE USE CRITERIA PROGRAM (AUC) NOT JUST AFFECTING RADIOLOGY – Julie Leonard

The Appropriate Use Criteria (AUC) changes will affect all providers that order diagnostic imaging services, not just the radiologist. "This program impacts all physicians and practitioners (as defined in 1861(r) or described in 1842(b)(18)(C)), that order advanced diagnostic imaging services and physicians, practitioners and facilities that furnish advanced diagnostic imaging services in a physician's office, hospital outpatient department (including the emergency department), an ambulatory surgical center or an independent diagnostic testing facility (IDTF) and whose claims are paid under the physician fee schedule, hospital outpatient prospective payment system or ambulatory surgical center payment system."[2]

The ordering practitioner or clinical staff working under the physician's direction will need to access the Clinical Decision Support Mechanism (CDSM) when ordering advanced imaging services for Medicare beneficiaries. CMS has named computed tomography (CT), positron emission tomography (PET), nuclear medicine and magnetic resonance imaging (MRI) as advanced imaging. A list of the CPT codes effected can be found in the Medicare MLN matters MM10481 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf). The CDSM is an interactive portal or electronic tools used by the ordering clinician to determine the appropriateness of the desired imagining based on the "patient's specific clinical condition". A list of approved CDSM can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html .

These requirements are not slated to take effect until 01/01/2021. However, prior to the implantation CMS will operate an Education and Operation Testing period starting 01/01/2020; claims will not be denied during this time for lack of the AUC consolation information. As of 01/01/2018 a voluntary participation period began and advanced imaging studies that have been ordered and cleared through a CDSM can be submitted to CMS with modifier QQ.

Exceptions to the AUC include:

- The ordering professional having a significant hardship;
- Situations in which the patient has an emergency medical condition; or,
- An applicable imaging service ordered for an inpatient, and for which payment is made under Part A.[3]

The AUC came about as part of the Protecting Access to Medicare Act (PAMA) of 2014. Questions regarding the AUC program can be submitted to ImagingAUC@cms.hhs.gov . CMS has stated, "Ultimately, practitioners whose ordering patterns are considered outliers will be subject to prior authorization. Information on outlier methodology and prior authorization is not yet available." It is apparent they will be gathering data on all ordering practitioners based on the claims submitted.

KHC will continue to monitor the changes or updates to the AUC as we progress toward the 01/01/2021 implementation date.

E/M MODIFIER 25 AND RACs – Julie Leonard

Currently on the approved Recovery Audit Contractors (RAC) list for all regions are Evaluation and Management (E/M) services with a surgical procedure that have 10 day global and 90 global period surgical code, and what is most concerning, with surgical codes that have 000 global days. See their notice:

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[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html

[3] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf

"This Query identifies E/M Services that are incorrectly billed within the codes that have a Global Days designation of "0" days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-operative and post-operative Evaluation and Management services. These E/M services are referred to as 'Global Days'. Procedures with MPFS global days of "000" include only E/M services rendered on the day of surgery. Physicians can indicate that E/M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E/M service."[4] This is an automated review type and effects all CPT and HCPCS codes with 000 global as designated by the Medicare Physician Fess Schedule (MPFS).

When billing for an E/M on the same day as 000 global day (minor) procedure, the key is that the E/M documentation must support a "separate service". This does not include the decision to perform the minor procedure. Generally, the decision to perform the minor procedure would be inherent in the "pre-operative" portion of the RVU, unless it is a new patient requiring an assessment because the decision for the procedure can only be made after the assessment as described below:

The Medicare Claims Processing Manual Chapter 12 section 30.6.6 clearly states the conditions that would allow for separate payment for the E/M service separate from the surgical procedure - "Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for Evaluation and Management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. A/B MACs (B) pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim."[5]

Each MAC has specific information related to the use of Modifier 25. It is important to know the guidelines put forth by your specific MAC. Some MACS, for example, specifically state not to append a Modifier 25 on a New Patient service - "Do not append to E/M codes that are explicitly for new patient only (CPTs 92002, 92004, 99201-99205, 99321-99323 and 99341-99345). These codes are listed as new patient codes and are automatically excluded from the global surgery package edit. They are reimbursed separately from the surgical procedure and no modifier is required if visit meets significant and separately identifiable guidelines"[6]. Palmetto GBA also identifies the New Patient E/M codes as modifier 25 exempt. They do make an exception "new patient CPT codes require CPT modifier 25 when a separately identifiable E/M service is performed the same day as chemotherapy or nonchemotherapy infusions or injections as these are not considered surgery."[7]

Further, NCCI Chapter 1, General Coding Policies, instructs that the fact that a patient is a new patient does not in and of itself support a separately identifiable E/M "If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles."

Lots to remember and rules to follow. Modifier 25 use is on the radar for RAC contractors for all the MACS and should be used only when supported in both medical necessity and documentation. If there is any doubt as to the appropriate use of modifier 25 refer to both the NCCI Procedure-to-Procedure edits and your local MAC.

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[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics-Items/0032-EandM-Codes-billed-within-a-Procedure-Code-with-a-0-Day-Global-Period-Endoscopies-or-some-minor-surgical-procedures.html?DLPage=3&DLEntries=10&DLSort=0&DLSortDir=ascending

[5] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

[6] https://med.noridianmedicare.com/web/jfb/topics/modifiers/25

[7] https://www.palmettogba.com/palmetto/webTool.nsf/vTool/mod25

CODING CORNER

NEW 2019 PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING CODES – Simbo Famure

There are some new CPT code changes that are made for psychiatrists and psychologists that perform testing services. The psychological testing codes 96101 – 96103 have been retired in addition to the neuropsychological testing codes 96118-96120.

They are replaced by the following:

- 96130 and 96131 – Psychological and neuropsychological testing evaluation services by physicians or other qualified healthcare professionals.
- 96136 and 96137 – Psychological and neuropsychological test administration and scoring by physicians or other qualified healthcare professionals.
- 96138 and 96139 – Psychological and neuropsychological test administration and scoring by technicians.
- 96146 – Psychological and neuropsychological test administration with single automated, standardized instrument via electronic platform with automated results.

These codes came in effect January 1st, 2019. They allow for more accurate coding of the time taken when technical and professional services are applied. Question? Give us a call.

OTHER ARTICLES OF INTEREST

INTERVIEW QUESTIONS? GO TWO WAYS – Daria Malan

What approach do you take when interviewing a potential employee? In talking with many healthcare facilities, I hear over and over this typical method: "So, tell me about yourself." "Oh really? Then what? You gain some information, but the conversation can gradually drift away from what you are trying to achieve: getting the most intel within a short amount of time. Therefore, a structured approach is an intentional approach and will better assist the employer's decision-making to hire or to pass.

Think of it this way: Successful interview techniques stem from two basic platforms.

1. ***Behavioral***. An interview technique that focuses on a candidate's past experiences, behaviors, knowledge, skills and abilities by asking the candidate to provide specific examples of when he or she has demonstrated certain behaviors or skills as a means of predicting future behavior and performance.

   

   Describe to me a time when you served as project manager and how you used financial data to support the success of the project. What key metrics did you use and what decisions did you have to make along the way?

2. ***Situational***. An interview technique that gives the interviewee a hypothetical scenario and focuses on a candidate's past experiences, behaviors, knowledge, skills and abilities by asking the candidate to provide specific examples of how the candidate would respond given the situation described.

   

   You have created a proposed departmental budget that considered current trends, pending changes and future growth needs. But your manager has flatly rejected it, saying it exceeds that of other similar departments. How would you handle this?

Crafting questions with these platforms in mind keeps the employer in the driver's seat and allows the candidate to respond specifically, not randomly. It also allows the employer to be consistent, and to use internal real-time scenarios posed as hypotheticals, when interviewing multiple candidates for the same position. Assessing the candidate's ability to reason gives you a peek into the way they think and begs the question: Will they fit into your organization…or maybe not?

EVERY SINGLE DAY IS AN ABILITY TO LEARN MORE ABOUT HEALTHCARE – Lauren Rose

As many of our clients are aware, I am home with my husband and we are utilizing hospice for the last leg of our family's cancer journey that started last summer.

Fortunately, because like you, I have a career in healthcare which has meant that every single day, whether I am researching an issue for a client, collaborating with our team and client on a tough project, speaking with doctors, nurses, and other care providers regarding my husband's plan of care, or directly caring for my husband's needs, I am learning more about this truly amazing field of healthcare. While it is easy to become cynical with the tough - and often political issues - that will always exist within healthcare, it is also easy to be in awe of the wonderful care that is being provided every single day.

My advice to all of you that are reading this newsletter, wherever you are in your career or in life:

Never be afraid to be vulnerable and ask questions. The other day, I prefaced a question to my husband's hospice nurse with "this is probably a dumb question, but…" and before I continued, she assured me there was no such thing and then helped me with my concern. I felt fully respected and better prepared to help my husband. This was just one of the many assurances during this journey that our family and our healthcare providers are a team working together towards the same goal – the absolute best possible care for my husband.

Similarly, KHC is very thankful for our clients that are willing to partner with us on all types of questions and issues. There is never a "dumb question". Healthcare questions and issues are complex, and we appreciate the opportunity to assist.

[*Lauren Rose is a Managing Director with KHC for over three years and has over 25 years of experience in reimbursement including charge capture, chargemaster, and charge compliance initiatives*.]

GUN VIOLENCE – SHOULD MENTAL HEALTH BEAR ALL THE BLAME? – Jessica Felder

On a depressingly more frequent basis, Americans are seeing more mass casualty shootings than ever before. According to ScienceDaily, an estimated 75,000 to 100,000 Americans are injured by firearms and 30,000 to 40,000 die from firearms each year[8]. The blame for this increase in gun violence has been primarily placed on the mental health of the shooter. However, a recently published study has indicated that mental illness is not to blame when it comes to these situations. Researchers at the University of Texas Medical Branch at Galveston conducted a study from 2015-2018 involving 663 participants. The participants were all young adults and had various mental illnesses which included: anxiety, depression, stress, PTSD, hostility, impulsivity and borderline personality disorder[9].

Throughout the study, surveys were completed that examined firearm possession and use as well as the mental health conditions referenced above. The researchers in this study found no link between mental illness and gun violence. Quite to the contrary, the research found that young adults with access to firearms are 18 times more likely to have threatened someone with gun violence regardless of the severity of their mental illness. So, perhaps it is time to examine more areas that could be influencing these unfortunate events and not put all the blame on mental health.

TIME MANAGEMENT TIPS – Khalida Burton

Have you ever found yourself running out of time while at work? Your manager has provided you with an assignment or you developed your own to-do list and it seems you are never able to meet the deadlines. Time is one of those

[8] https://www.sciencedaily.com/releases/2019/02/190207102607.htm
[9] https://www.healio.com/psychiatry/practice-management/news/online/%7Bd55bb344-876d-45aa-b623-e670b1af8cd4%7D/some-mental-illnesses-unrelated-to-gun-violence

things that no one can control. Time is also one of things you never get back. Some would like to believe that you can make up time by setting new deadlines, but the reality is that particular date and time has passed and will never come back again.

What are some things you can do to manage your time better?

1. *In order to get the most of your time, you must know how you are spending your time*. Figure out where your time goes by keeping track of your daily routine. At the beginning of the new week, review your daily logs and categorize each task. Categories can include the following: Emails, Meetings, Report Writing, Payroll/Timekeeping, just to name a few. The categories will vary based on your unique role in the workplace.
2. *Prioritize your tasks by deciding what is important*. Ask yourself, "Is this task something that needs to get accomplished or something that I want to get accomplished?". For example – I want to organize my office, but I need to write/finalize this monthly report.
3. *Plan ahead by creating a to-do list 30-minutes prior to leaving work for the day*. Create a to-do list according to priority and estimate the time for each activity. Use your email calendars to schedule the time needed to accomplish each activity. Using the calendar will help you estimate time, but you will need to ensure you keep up with your schedule. Follow through is important. If you can't commit to it, do not schedule it. Unaccomplished tasks will often make you feel unaccomplished and defeated. Make sure the to-do list is reasonable.

**Be careful not to over schedule yourself. Leave time between tasks and meetings. I know we are accustomed to 1-hour meetings, but will 50 minutes be sufficient. Downtime is needed.

4. *Learn to delegate*. Team work is important, and you cannot do everything on your own. Count on your team to help you accomplish the goals.
5. *Block out distractions*. Ask yourself this question, "Do I need to answer an email upon arrival?" Emails however minor will take time out of your time as every response is not simply yes or no. Some responses require research. If you must respond to emails upon arrival but you are in the middle of meeting a deadline, respond to the sender by stating, I received your email and will respond by close of business. Another distraction is your cell phone. Don't be tempted to check your cell phone constantly. Cell phones will eat away at your time without you really knowing it.
6. *It's okay to say "No".* Rome was not built in a day! Set expectations with your team especially when your plate is full. You can only handle so much.
7. *Slow down and make every action count*. Create value for yourself.

The above tips are not an exhaustive list as there are other ways to manage your time. Effective time management skills will make you more successful at work life in general. Taking the time to develop these skills can be a great asset and make you a better employee. I hope these tips will prove to be helpful to you.

WORKPLACE LONELINESS – Noel Asen

A recent study shows that 40 percent of adults in America report feeling lonely.

Workplace loneliness doesn't start overnight, it has been rising slowly over the years due three key factors. Starting with technology, it may be easy to connect with anyone, anytime, anywhere - social media has changed the game of social interactions and networking. People often forget that in real life they are not meeting any of their friends and socialization becomes messages, emails, chats and hours of browsing. Human touch is missing, and the loneliness slowly starts. Job changes and flexible work options have changed considerably over the years. Gone are the days when people worked for one employer until retirement. Building relationships with co-workers was much easier than with a much more transient work force.

Ways to Combat Workplace Loneliness: Promoting collaborative work often provides better work product and reduces workplace loneliness. The occasional team lunch/outing or even travelling together for business trips can make a big difference. Also, extra efforts should be made to connect with employees working remotely; make sure to have non-work-related conversation with team members.

We are underestimating the power of human emotions when the social contact part is neglected. The *CNN* article "Why Workplace Loneliness is Bad for Business" summarizes that lonely employees:

- have lower job performance
- are less committed to the company
- seem less approachable by co-workers

We need human connection more than we think and it holds true irrespective of gender, religion, culture, ethnicity and designation (yes, CEOs feel lonely, too). Building meaningful human relationships helps to nurture emotional intelligence (EQ) which in turn influences your relationship with others.

https://assets.aarp.org/rgcenter/general/loneliness_2010.pdf

https://www.cnn.com/2018/12/05/success/workplace-loneliness/index.html

ADDITIONAL INFORMATION

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