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.*

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.

- **What Does Legalizing Marijuana Do to Employer's Drug Testing?** This may go under the category of "I never thought about that". In states that have legalized recreational marijuana, what do companies do when there are required drug testing for jobs. Personnel may need to consider revamping requirements and classify jobs regarding safety to continue to test for drugs including marijuana, but this is just the start of new thoughts and maybe, new rules.

- **Rice-Size Microchip Has It All.** In Sweden, a tiny implanted chip between your thumb and forefinger has all the identify and information needed: your address, your blood type, emergency contact information, and perhaps the key to your home or your car. In the future, it may have the credit card information so paying for something will be a swipe of your hand across a reader. Nevertheless, it is still hackable – someone with a NFC (Near Field Communication) reader on a cell phone device could pull all the encrypted information if it were placed on the "seed".

- **CMS is Sharing Its Analytics – Be Sure to Review the Comparative Billing Reports (CBR)**. Hopefully you are comparing your volumes by CPT code – by provider and specialty if you have several professional providers in your practices. CMS has been increasing its analysis to pull out those that appear to be outliers. It also is providing comparisons outside your individual practices. Of course, their biggest gains are finding large dollar services that are improperly billed. One of the ones highlighted in the latest 2019 CBR is the 77301, IMRT, which CMS believes contributes to the 10.3% improper radiation oncology error rate. But it doesn't have to be high individual dollars that you should be monitoring. Even a high frequency of lower dollar billings can get CMS' attention and you need to monitor all code distributions to be first to find potential issues.

- **More Flexibility in Total Knee Arthroplasty (TKA) Can Spell More Confusion**. Many surgeons who owned ASCs were very happy to be able to do Medicare TKAs in an outpatient setting. From that flexibility comes several unanticipated problems. Although the thought that the removal of TKA from CMS' Inpatient Only List, would create an environment of more choice, the choice to do TKA outpatient took away the patient's ability to meet the three-day inpatient stay required for SNF or Rehab hospital coverage. It also means that TKA is subject to the two-midnight rule if the procedure is done as an inpatient. Further, many commercial payers, including Medicare Advantage Plans demanded almost a complete move to outpatient. Anesthesiologists faced more of an issue until the anesthesia code (01402) was finally removed from the Inpatient Only List. At this point, CMS has instructed RACs etc. to hold off reviews for TKA site of service, but they could still review for medical necessity. *MLN Matters* SE1236, even though published in 2015 is an excellent guide that covers the documentation requirements for medical necessity.

- ***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 and 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

CMS OFFICIALLY RETIRES THE PQRS WEBSITE – Sara Rivenburgh

Improving the quality of health care is a core function of the Centers for Medicare and Medicaid Services (CMS). The Physician Quality Reporting System (PQRS) was initiated in 2006 as a quality reporting program that encouraged the reporting on the quality of care to Medicare. PQRS gave participating eligible professionals (EPs) and group practices the opportunity to assess the quality of care they provided to their patients, helping to ensure that patients got the right care at the right time. It also provided financial rewards for reporting and penalties for not reporting. Although 2016 was the last year for PQRS, the program officially ended on December 31, 2018 when it transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).

With the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS did away with the Sustainable Growth Rate (SGR) which capped spending increases according to the growth in the Medicare population and a modest allowance for inflation. Through the QPP, Medicare can reward clinicians who provide better care through payment increases. Medicare can also reduce payments to clinicians who aren't meeting performance standards. CMS seeks to improve Medicare by helping clinicians focus on caring for their patients rather than filling out paperwork. They will continue to listen and take steps towards reducing burdens for clinicians and improving health outcomes for Medicare patients.

To this end, on March 29, 2019, CMS retired the PQRS website. If you have PQRS-related questions, you may contact the QualityNet Help Desk at 866-288-8912 or qnetsupport@hcqis.org.

CODING CORNER

BMI (BODY MASS INDEX) – TO REPORT OR NOT – Robin Stover

Over 70% of Americans are overweight, obese, or morbidly obese as defined by the American Heart Association BMI standards. Variances in reporting these overweight diagnoses along with BMI can affect quality scores under the Merit-based Incentive Payment system (MIPS). Incorrect risk adjustment scores may result in over- or under-payments.

While Overweight and Obese diagnoses do not affect quality scores under MIPS, morbid obesity affects both scores and payments. BMI may be reported as a quality measure in MIPS using HCPCS Level II codes (G8417-G8422, G8938, G9716). This measure identifies the percentage of patients with abnormal BMI, as well as a documented follow-up plan of care.

Obesity and Morbid Obesity are significant and should always be coded when documented. BMI (if documented) should always be reported with a diagnosis of obesity or morbid obesity. A diagnosis of Overweight should not be reported without additional discussion of the overweight condition and/or a documented plan of care.

To report a BMI code, there also needs to be a weight-related diagnosis. A coder should never convert a BMI code to a weight diagnosis. If the weight diagnosis is missing, the provider should be queried. The provider diagnosis that is documented should be coded even if the BMI falls in to the range for a different weight-related code.

BMI should not be routinely reported without a weight-related diagnosis. Co-morbidities do not change a diagnosis of obesity to morbid-obesity. Any co-morbidities should be considered by the provider when a weight diagnosis is determined.

BMI should never be reported during pregnancy. For inpatient claims, the attending provider's weight diagnosis supersedes all other documented weight diagnoses.

CHANGES TO E/M CODING AND DOCUMENTATION GUIDELINES – Julie Leonard

The Centers for Medicare and Medicaid Services' (CMS) Final Rule went into effect on January 1, 2019. It included updates to payment policies, payment rates and quality provision for services provided under the Medicare Physician Fee Schedule (PFS). Because of these updates and with the input of qualified healthcare professionals, the American Medical Association's (AMA) CPT Editorial Panel approved significant guideline changes to Evaluation and Management (E/M) reporting in February 2019.[1] Approved changes will be finalized just prior to the CPT code set's publication, expected to coincide with the CMS E/M updates slated for 2021, but could implement smaller updates as early as 2020 . CPT plans to publish the new guidelines under their own section header in the E/M section.

- Deletion of the level 1 office new patient E/M code 99201. In 2017, Medicare claims for code 99201 represented only 0.15% of E/M claims and had a 37% denial rate.
- New guidelines for codes 99202-99215: History and exam will no longer be key components for the selection of an E/M service level. Practitioners will be required to document that these elements were performed in order to report an office visit code.
- Practitioners would select E/M codes based on either the level of medical decision making (MDM) or the total time spent performing the service on the day of the encounter. This includes a major overhaul of the MDM documentation guidelines to emphasize complexity rather than the number of diagnoses reported.
- Per the AAPC News March 12,2019[2]:
    - "Number of Diagnoses or Management Options" is changed to "Number and Complexity of Problems Addressed"
    - "Amount and/or Complexity of Data to be Reviewed" is changed to "Amount and/or Complexity of Data to be Reviewed and Analyzed"
    - "Risk of Complications and/or Morbidity or Mortality" is changed to "Risk of Complications and/or Morbidity or Mortality of Patient Management"

- Total time would include "total time spent on the day of the encounter," instead of total face-to-face time.
- A plan to revise the E/M guidelines into three sections:
    - Guidelines common to all E/M services;
    - Guidelines specific to office and other outpatient visits; and,
    - Guidelines specific to E/M services in the facility setting, including observation, hospital inpatient, consultations, emergency department, nursing facility, domiciliary, rest home or custodial care and the home setting.

All changes from CMS and the AMA will be carefully followed by KHC staff and we will keep you up to date in this time of change.

NEW LESION REMOVAL, PROCEDURE BUNDLES IN CORRECT CODING INITIATIVE UPDATE – Dawn Homer

Correct Coding Initiative (CCI) version 25.1 has several hundred pending code bundles that encompass various lesion removal services as well as wholesale updates to a single irrigation of device code.

The latest quarterly edits took effect April 1. Nearly all the code bundles involving lesion removal services mentioned below take a "1" modifier which means Medicare is tightening its grasp on same day services. To get two of the codes through for the same patient during a single encounter you will be required to append a CCI related modifier to one of the codes.

In general, the integumentary section updates surround mainly four codes.

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[1] https://www.ama-assn.org/system/files/2019-03/february-2019-summary-panel-actions_0.pdf

[2] https://www.aapc.com/blog/46133-cpt-panel-approves-e-m-documentation-changes/

Two of the four codes target premalignant lesions:

- **17000** – Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesion [e.g., actinic keratoses]; first lesion)
- **17004** - (Destruction….premalignant lesions, 15 or more lesions)

While two cover benign lesions;

- **17110** – (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], of benign lesion other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions)
- **17111** – (Destruction…of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions)

In the update, four codes are newly bundled with dozens of other lesion-trim and lesion-removal services. For example, CPT #17110 is bundled with a 1 modifier with numerous lesion-shaving codes (11300-11313), lesion-removal codes (11450-11451) and lesion-destruction codes (17261-17276). Code 17110 also takes new bundles with lesion-shaving codes 11301-11313 and lesion-destruction codes (17261-17276).

Note that there are overlaps among the bundles, but not all removal services are paired with every one of the four codes. When performing work on separate lesions, you should be able to submit both sets of codes but be sure your documentation is clear and concise.

TECHNOLOGY BLOG

WHAT TO DO WITH ALL THAT DATA? – Anthony Borgetti

Anyone who's been around healthcare knows there's plenty of data floating around. Wouldn't it be great if we could just throw a lasso around all that data and wrangle it in? Today, we're getting overwhelming amounts of information related to our patients, our services, and our operations. Most of it is updating in real-time or near real-time. We have never been able to paint a more complete picture of our patients, processes, and staff but what do we do with all that data?

Working in healthcare we have data from both EMR and EHR systems. Working through this can be a daunting task, but it doesn't have to be. Between the two systems we have warehouses of information on social history, family information, and medical. So, how do we know where to look for the right information when we need it? Better, how do we search for what we want in a way that is meaningful and helps us work smarter. Can we continue to use the tried and true methods of data warehouses and quarterly reporting to get what we need…or do we need something else?

Well, I believe we've created the answer. Whatever we do, our first objective is to get that data to the decision maker. As I've followed the big names like Microsoft, Amazon, and Google across their journey through technological advancement and ultimately machine learning, I've come across numerous examples where these major companies are using machine learning technology and making a difference today. Machine learning which is a branch of Artificial Intelligence, has enabled us to streamline data and deliver meaningful data stories to our decision makers with agility and speed.

We have a small hurdle facing us as this is the first-generation adopting AI, but soon these methods will become adopted by companies across all industries large and small. Developers and Data Scientists are working through the first and second pass at this technology now. As we advance, more users of machine learning, and data science are coming into the workforce and our models get smarter and more valuable.

Once this trend takes hold it will impact healthcare and society in a major way. We need to be thinking about how we adopt these tools and where they can make a difference. Users of machine learning tools can take full advantage of available information to make an impact on business in real-time by generating detailed models that can help with decision making.

The tools that are available for people to create these algorithms and machine learning models are fascinatingly simple. You can think of these tools as drag and drop interfaces with steps to process the data and you apply the model of your choice. I believe as these tools become more user friendly it will enable minds alike across all industries and will likely demand some form of regulation as it can be quite powerful.

So, what do we do with all that data? We should start thinking of more innovative ways to improve our business processes by getting that data to the decision maker as quickly as possible. The next step is utilizing our data in machine learning models that can improve and even recommend the right decision to the folks who drive our business.

As you may have seen, Kohler HC has deployed a modernized cloud platform (KAP), capable of intaking data from any data source. We are primed and ready to innovate and modernize your operational data to better understand how your business is impacted and help us make better decisions. If this interests you, and you want to hear more about where we are going with technology, drop us a note or reach out to me directly at aborgetti@kohlerhc.com or 219-427-7465.

OTHER ARTICLES OF INTEREST

THE EPIPEN SHORTAGE: THE ANTIDOTE FOR AN ALLERGIC REACTION THAT CAN BE A MATTER OF LIFE AND DEATH DESPITE INTERNATIONAL PRODUCT SHORTAGES - Susan Santoro

Anaphylaxis is a severe, potentially life-threatening allergic reaction. It can occur within seconds or minutes of the exposure to something an individual is allergic to and requires an injection of epinephrine as well as a follow-up visit to an emergency room.

Anaphylaxis causes your immune system to release a flood of chemicals that can cause you to go into shock. Then there is a sudden drop in blood pressure, and a narrowing of the airways that results in blocked breathing. Signs and symptoms include a skin rash; rapid or weak pulse; nausea and vomiting. Some medications, certain foods, insect venom and latex are common triggers. If anaphylaxis is not treated right away, it can be fatal. [3]

Since November of 2017, EpiPen[4], the leading brand of epinephrine autoinjectors used to treat anaphylaxis, have been in short supply. Product shortages and product stock outs have been reported in the United States, Australia, Canada and the United Kingdom.[5]

The primary product manufacturer Meridian Medical Technologies, Inc., a Pfizer company, was cited for the reason for the shortage. In September of 2017, the U.S. Food & Drug Administration (FDA) had issued a warning letter to the company after inspecting their manufacturing plant and found significant violations of current good manufacturing practice (CGMP) for this type of product. [6]

In May of 2018, the Food Allergy Research & Education (FARE) organization called on the FDA to deem the current lack of availability of epinephrine auto-injectors as a national shortage, not just a spot shortage.

Two major events occurred in August of 2018 to address product shortage. First, the FDA approved the first official generic epinephrine autoinjector, produced by Teva Pharmaceuticals. Second, for EpiPen product types and lot numbers, the FDA extended the product expiration date to deal with this crisis.

Currently, there are four suppliers of the Epinephrine Injection, Auto-Injector product that include: Impax Laboratories, Inc., Kaleo, Mylan Specialty and Teva Pharmaceuticals as posted on the FDA website.[7] It should be noted that while the product is available from Impax Laboratories, Inc. and Mylan Specialty, both companies are experiencing manufacturing delays.

The question must be asked: Why is it two years later and this drug shortage crisis still exists?

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[3] Anaphylaxis, Mayo Clinic, Patient Care and Health Information, Diseases and Conditions, [Internet] https://www.mayoclinic.org/diseases-conditions/anaphylaxis/symptoms-causes/syc-20351468

[4] Mylan is the U.S. company, which in 2007 purchased the EpiPen brand.

[5] The EpiPen Shortage: How Has It Come To This? The Lancet Child and Adolescent Health, Editorial, Volume 2, issue 12, P839, December 01, 2018 [Internet], https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(18)30344-4/fulltext.

[6] U.S. Food & Drug Administration Warning Letter to Meridian Medical Technologies , a Pfizer Company, September 5, 2017, [Internet] https://www.fda.gov/iceci/enforcementactions/warningletters/2017/ucm574981.htm

[7] https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Epinephrine%20Injection,%20Auto-Injector&st=c&tab=tabs-1.

Obviously, the complete answer is this question is still not clear. The root causes of the problem must be thoroughly understood, and more immediate, forward-thinking action steps must be taken to resolve this crisis.

OPPORTUNITIES FOR EXCELLENCE WITH ELECTRONIC HEALTH RECORDS – Lauren Rose

KHC has had many engagements over the years helping our clients prepare for electronic health record system implementations (or unfortunately sometimes recover from them). We are now seeing our clients focus on comprehensive systems and process documentation to compliment these systems.

Some questions being considered:

#1-Are procedures well documented and well known? (If a key individual had to suddenly leave the office on an unexpected medical leave, is there enough documentation and cross training to keep the ship moving seamlessly?)

#2-Do team members not only understand the procedures (i.e. "what I do", "when I do it", and "how I do it") but just as important, the purpose (i.e. "why I do it" and "what happens if I do not do it correctly")?

#3-Are there any resources being used by staff that might be out of date and not being routinely updated and if so, can this situation be addressed by a policy/procedure? (For example, an "old cheat sheet" that has been "passed down" through a department and is no longer accurate.)

#4-Are departments breaking down walls that might have been unintentionally built because of the stress of the system implementation? (Are departments remembering they are actually all members of one very large team?)

If you can answer "yes" or "working on this" to these four questions, you are well on your way to capitalizing on opportunities for excellence.

IS FAXING NEARING ITS END? – Diane Jordan

When the fax machine was first successfully implemented in 1964, it was ground-breaking. You no longer had to wait for days to receive documents through the mail. A document could be faxed and delivered in minutes. The use of the fax machine is extensive in health care even with the widespread implementation of EHRs and other clinical and administrative systems. Faxing has become deep-rooted in the day-to-day information workflow across the healthcare system (hospitals, physician practices, ancillary providers, health plans, etc.), and to those people in health care who don't have access to technology.

Although faxing has been eliminated by most industries, it remains a standard form of communication in healthcare and is currently estimated to represent 75 percent of medical communication. Fax has traditionally been viewed as a secure method for data exchange, but it presents security risks when faxes are lost, misdirected or delivered to unauthorized recipients. Manual processes involved with faxing are time consuming and cost prohibitive.

Despite its dated technology and the many complaints, fax machines can be HIPAA-compliant as long as appropriate security safeguards are followed. HIPAA regulations do not prevent covered entities from faxing PHI.

On August 6, 2018, CMS Administrator Seema Verma spoke at the Office of the National Coordinator for Health Information Technology (ONC) Interoperability Forum and stated, "If I could challenge developers on a mission, it's to help make doctors' offices a fax free zone by 2020." [8]

Advancements in healthcare technology hold the promise of improving efficiency, security, and quality of care while reducing costs, but adoption has been slow across many organizations due to legacy communication systems. The number of hospitals using electronic records grew from 9% in 2008 to 83% in 2015,[9] yet hospitals and doctor offices still can't transfer electronic information to other hospitals and doctor offices. The government only incentivized healthcare to transition to EMRs, not interoperability which continues to be a hot topic.

Fax communication is still commonplace in hospitals because it allows physicians to quickly transfer patient-specific information to one another at the point of care. However, there are opportunities healthcare leaders should consider to better manage faxing and reduce risks, such as breaches in protected health information (PHI).

[8] https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-onc-interoperability-forum-washington-dc

[9] https://dashboard.healthit.gov/evaluations/data-briefs/non-federal-acute-care-hospital-ehr-adoption-2008-2015.php

Faxing Alternatives

- HIPAA X12 275 [10]– this transaction standard enables secure document sharing. The proposed rule was issued in 2005 but never finalized by Health and Human Services. The Patient Protection and Affordable Care Act, in Section 1104, called for CMS to issue this standard by 2014; again, it was not finalized.
- Direct Messaging – a point-to-point network, a secure e-mail approach that requires the receiver to have the key to unencrypt the data; reroutes an outgoing fax as an electronic message delivered through the recipient's health information service provider (HISP). Inbound messages are converted from faxes into searchable PFFs. The direct messaging program scans the PDF and cross-references it with the recipient's EMRs.
- Internet Fax - uses Internet Protocol rather than phone networks and replaces paper with digital transmissions, and has emerged as a popular alternative to the traditional fax. Internet fax is typically provided as a hosted service, whereby health providers can subscribe to a third-party entity that converts emails and other content to faxes. The Internet fax service provider has to follow security measures and other factors pursuant to HIPAA regulations. Electronic PHI data needs to be encrypted during transport as well as when it is being stored. The Internet fax service provider also needs to sign a business associate agreement, which authorizes them to become a business associate and create, receive, maintain or transmit electronic PHI on the covered entity's behalf. Most agreements also hold fax service providers accountable to safeguard PHI, sharing the responsibility with the health provider.
- Cloud Based - Cloud-based storage, retrieval and other forms of secure file transfer. Users can send documents, medical images and other files either through a secure link with an email notification or through a fax number. The user receives notification after the file transmits successfully, with a log of all transmission activity automatically updated for tracking purposes. With digital fax, all activity can be tracked which adds the benefit of accountability. You must be certain that the vendor is HIPAA compliant and that the data will be encrypted both when it is being stored, as well as when it is being transferred from provider to patient and from provider to provider.

The challenges associated with fax, paper, and interoperability in healthcare can be significant, but they are not impossible. Healthcare leaders and IT specialists who take the time to understand what an organization's clinical workflows around fax are and why they exist, will be better able to determine areas where technology can enhance value and better propose and implement a solution that works seamlessly with current workflows.

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***](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.*

[10] https://www.cms.gov/regulations-and-guidance/administrative-simplification/hipaa-aca/index.html