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.

Robert A. Marshall has joined KHC as our new VP of Business Development. He has extensive experience in building sales and management platforms to market professional service solutions. We look forward to utilizing Bob's expertise to accelerate KHC's growth and efficiency. Please join us in welcoming Bob. He can be reached at 443-610-0075.

- **Medicare SE19006: Part B Clinical Laboratory Fee Schedule.** You might be thinking that this 25-page February 27, 2019 transmittal does not apply to your hospital or physician office that performs laboratory services. After all, last time Medicare sent something similar out, it didn't... We are finding just the opposite as we talk with our clients and walk through this document unless you happen to have less than $12,500 in Medicare fee schedule laboratory reimbursement per NPI in a six-month timeframe. Medicare has provided significant information within SE19006 and is giving providers time to gather, review, and consolidate the necessary information before submitting the data. The required data is very specific and depending upon systems, time-consuming to analyze. Please let us know if we can be of any assistance as you move forward with this initiative.

- **Study Shows This One Simple Approach Wins Patient Approval.** Patients perceive that providers who sit down during interactions spend significantly more time with them, even when not true. Citations: Young RA, Burge SK, Kumar KA, et a. A time-motion study of primary care physicians' work in the electronic health record era. Fam Med. 2019; 50(2):91-99. Johnson RL, Sadosty AT, Weaver AL, Goyal DG. To sit or not to sit? Ann Emerg Med. 2008;51(2):188-193.

- **Emergency Department.** Visits continue to rise even as more Americans gained health insurance after the Affordable Care Act came into play, according to a study in JAMA. ED visits increased by 2.3 million a year from 2006 to 2016, with the proportion of uninsured ED visits relatively unchanged from 2006 to 2013, making up between 14% and 16% of visits. But uninsured ED visits dropped after the ACA's 2014 implementation, which included allowing states to expand Medicaid and requiring individuals to have health insurance. Uninsured ED visits made up 8% of all ED visits by 2016. Hospital discharges also declined. Uninsured patients made up 6% of discharges every year from 2006 to 2016 except for 5% in 2014 and 4% in 2016. [*from Modern Healthcare 4/22/19*]

- **CMS Has Been Extending Services Allowed by Medicare Advantage (MA) Plan.** Last year, CMS gave the authority to cover such items as shower grips, wheel chair ramps; the options had to be medically related and could include something like the cleaning of carpeting when someone has asthma. For 2020, the CMS extended the range of supplemental services to those that have a treasonable expectation of improving or maintaining the health. This means meal delivery, transportation needs, and house cleaning may be covered. See https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-rate-announcement-and-final-call-letter-fact-sheet

- ***Please follow KHC on Linked In*: https://www.linkedin.com/company/kohler-healthcare-consulting-inc**
- ***Kohler HC is now officially on Twitter*:** @KohlerHealthCa1.

- **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

OUTPATIENT OBSERVATION IS NOT A CATCH ALL STATUS FOR OUTPATIENTS LINGERING IN A HOSPITAL – Lauren Rose

Outpatient observation is a status where most hospitals understand the concepts but can have trouble with the details. While most, if not all, hospitals have very clear guidelines and criteria for inpatients, the guidelines can get a little more confusing for outpatients. With confusion comes the temptation to use a status of observation as a "catch all" when an outpatient appears to be lingering in a "holding bed". Like the "catch all" modifier '59 that is fraught with abuse and scrutiny, a status of observation should not be used inappropriately.

It is important to remember the high-level concepts when sorting through the details of a specific patient account. The purpose of observation is to provide a physician an opportunity to determine the best disposition for the patient. This status requires an order just as an inpatient admission should have an order. Patients are to be notified (https://www.cms.gov/newsroom/fact-sheets/medicare-outpatient-observation-notice-moon) when they are placed in Observation status for Medicare (and other payers may require this as well). Should the patient be admitted, or can the patient go home? As such, it should be a time period that is packed with monitoring and diagnostic tests to gather data to enable the physician to make this decision. It should not be a time period when the patient is waiting without any monitoring or testing or when a patient is being actively treated because the doctor has already determined the outcome. Many outpatients may require an extended emergency room visit, extended recovery from a procedure, or a transfer. Those "heads in a bed" patients should not be confused with Observation.

We hope these reminders can spur discussions at your hospital surrounding correct Observation status to ensure proper classifications of patients and all the necessary supporting documentation. If you have some challenging situations where your physicians and case managers are divided on how to handle a case and would like an outside opinion, please feel free to reach out to us at assistance@kohlerhc.com. Please do not send any PHI through this email address but try to send us much detail as you can surrounding your question.

CMS FY2020 PROPOSED RULE HIGHLIGHTS - Sara Rivenburgh

Every year, the Centers for Medicare and Medicaid Services (CMS) releases proposed changes to the way Medicare pays hospitals in the next fiscal year. For FY2020 the changes have two main themes: "Rethinking Rural Health" and "Unleashing Innovation". Medicare will accept comments on the proposed rule through June 24th.

Rural Health: One fifth of our nation's citizens live in rural areas. These individuals face many challenges when it comes to accessing quality health care. Medicare is proposing to raise the wage index of low wage index hospitals. The wage index is used to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area or statewide rural area to the national average. CMS is considering several ways to implement the change:

- Increase the wage index for hospitals with a value below the 25th percentile by half the difference between their value and the 25th percentile across all hospitals.
- Decrease the wage index for hospitals above the 75th percentile to avoid increases in Medicare spending.
- A 5% cap on any decrease in a hospital's wage index from that of FY2019.
- CMS will consider a transition for hospitals that experience significant decreases in their wage index values as a result of the changes.
- Remove urban to rural reclassifications from the calculation of the "rural floor" wage index. This term refers to the law stating that an urban hospital's wage index cannot be less than that of a rural hospital in that state. Some states have been using the reclassifications to inappropriately influence the rural floor wage index value.
- A 3.2% increase in Medicare rates for hospitals that use EHRs and report quality data. Distribution of almost $8.5 billion in Disproportionate Share Hospital payments; an increase of 2.6% over FY2019. These payments cover the costs of providing care to uninsured patients.

Innovation: CMS Administrator Seema Verma recognizes that, "We must continually update our policies in response to the rapid pace of advancement in medical science." Medicare's payment systems cannot keep up with the advancements in medical science - certain barriers must be removed for Medicare beneficiaries to have access to new medical technology. CMS is proposing several payment policy changes to ensure broad access to transformative technologies:

- Increase the new technology add-on payment which is additional payments to hospitals for cases with high costs involving new technologies. For example, hospitals offering CAR-T, a gene therapy used to treat certain types of cancer, would see an add-on payment increase of 30%.
- Wave the two-year requirement for evidence on treatments that meet the FDA's Breakthrough devices designation. With this payment policy change, Medicare beneficiaries wouldn't have to wait for access to the latest technologies like CAR-T.

Overall, CMS estimates a total increase in IPPS payments of approximately 3.7 percent as a result of these proposed changes.

Remember, the deadline for submitting comments on the proposed rule is June 24, 2019 – use this link http://www.regulations.gov .

DOES YOUR SERVICE FACILITY ADDRESS MATCH ON YOUR CLAIM AND IN PECOS? - Khalida S. Burton

CMS issued the *MLN Matters (SE18023)* on October 12, 2018 and *MLN Matters (SE19007)* on March 29, 2019 to address the validation edits that will be put in place for hospitals that have multiple off-campus provider-based departments. CMS conducted testing of claims against PECOS data and determined that the service facility location address on the claim did not match what was entered into PECOS. Many variations occurred in the spelling of the address. For example, **Road versus Rd**., although such minor variations will disrupt cash flow in the future.

PECOS Database	**Claim Form**
12345 Provider **Road**	12345 Provider **Rd.**
Service Town PA 12345	Service Town PA 12345

CMS is urging providers to update PECOS by submitting corrected 855A enrollment forms. Claims can be resubmitted 60 days after the correct information is updated in PECOS. In addition to updating PECOS, providers should update any billing, clearinghouse system and medical record systems. This task might seem daunting but will ensure that your cash flow is not disrupted due to minor technicalities.

Reimbursement Impact

Initially when provider-based status was established, hospitals were able to submit both the institutional (UB04) and professional (HCFA 1500) claims and be reimbursed based on the Outpatient Prospective Payment System (OPPS) and the Medicare Physician Fee Schedule (MPFS), respectively. The total reimbursement for the services provided

to the patients in provider-based locations was generally 50% more than for the same service performed in non-provider-based locations because of the combination of OPPS and MPFS payments[1].

CMS recognized that the provider-based status led to increased payments thus increasing Medicare spending. As a result of this, the Bipartisan Budget Act of 2015 (Act) was signed into law on November 2, 2015 and made effective January 1, 2017 as means to control federal dollars spent on healthcare services. Under this Act, and according to the 2017 OPPS Final Rule only 'excepted' provider-based departments' services will receive OPPS reimbursement. Nonexcepted (meaning not grandfathered) provider-based departments will be reimbursed 40% of the OPPS rate for nonexcepted services when billed with modifier PN. Modifier PN is used to identify services provided by provider-based locations that were not grandfathered into OPPS.

Remember this validation edit will look for exact matching of the service facility address on the claim form against what is in PECOS. Hospitals are required to identify on the claim exactly where the service was provided in the **service facility address** field on the claim. **Do not use the hospital's address as a default**. Providers are also cautioned that this change is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and commercial payers will likely require this change too.

CMS anticipates the validation edits will be in full production once testing is completed and the results are reviewed. CMS will direct MACs to permanently turn on edits after July 2019. Claims edits will be returned-to-provider (RTP) which will allow providers to make direct data entry (DDE) corrections into FISS.

Does your Service Facility Address Match on Your Claim and in PECOS?

To verify the service facility address you have on file with CMS visit https://pecos.cms.hhs.gov. You must have a username and password to access your facility's information. Only authorized or delegated officials have the ability to access and change PECOS information. Your next step is to verify the service facility address in your billing and clearinghouse systems. Make the needed corrections in PECOS or your billing and clearinghouse systems and submit your claims accordingly. Also, the access information for authorized officials should be maintained in a secure place in case the authorized user is not available.

If you would like help minimizing your reimbursement impact through a process to manage these changes, tracking claims that have to be resubmitted, etc. reach out to kburton@kohlerhc.com

For more information

CMS Medicare Provider – Supplier Enrollment https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

CMS National Provider Identifier 'How to Apply' https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply.html

CMS National Provider Identifier (NPI) Registry https://npiregistry.cms.hhs.gov/

CMS Medicare Revalidation Tool https://data.cms.gov/revalidation

CMS MLN Matters – Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18023.pdf

CODING CORNER

MEDICAL CODING IN THE OPIOID CRISIS – Simbo Famure

Now in 2019, most of us are all aware of the opioid crisis in our communities. We may not all know of a specific individual that misuses prescription drugs or has died of an overdose, but the news and social media frequently informs us of the alarming numbers of people that are suffering or have died because of drugs. In 2017, 70,237 people died as a result of drug overdose in the United States.[2]

[1] CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain. Department of Health and Human Services, Office of Inspector General. Page 1. https://oig.hhs.gov/oei/reports/oei-04-12-00380.pdf

[2] https://www.cdc.gov/nchs/products/databriefs/db329.htm

As healthcare professionals, we now encounter more records that contain this type information for us to review, analyze and code. It is very important that when it comes to coding, we assign appropriate diagnosis codes for each patient encounter based on their **use** (prescribed therapeutic long-term current use of opioid analgesics OR unprescribed/illegally), **abuse** and **dependence** of opioids.

Opioid Use Disorder (OUD) is the diagnostic term often used in medical documentation and the ICD-10-CM codes vary from F11.1 - (Opioid abuse), F11.2- (Opioid dependence) to F11.9 - (Opioid use unprescribed/illegally).

In situations where a patient is using therapeutic long-term opioids and is being properly managed, the appropriate code to use is Z79.891.

The ICD-10-CM Official Guidelines for Coding and Reporting for fiscal year 2019[3] clearly states the hierarchy/pattern of use when it comes to the order or choice of codes regarding; use, abuse and dependence;

"When the provider documentation refers to use, abuse, and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- if both use and abuse are documented, assign only the code for abuse;
- if both abuse and dependence are documented, assign only the code for dependence;
- if use, abuse, and dependence are all documented, assign only the code for dependence; and
- if both use and dependence are documented, assign only the code for dependence."

HSCRC

KEEPING UP WITH THE HEALTH SERVICES COST REVIEW COMMISSION – Lauren Rose

Despite the full agenda for the May 8th HSCRC meeting, it was effectively and efficiently run by Chairman Nelson Sabatini and Executive Director Katie Wunderlich.

As expected, the Nurse Support Program II funding was approved. NSP II is the nurse support program where funds are built into rates to award grants directly to educational programs across the state supporting nursing faculty needs. FY 2020 awards amounted to $6.2 million. In addition, the Maryland Patient Safety Center funding of $369k was also approved. This amount is reduced each year as the center moves towards sustainability through other sources of income. Significant achievements and upcoming goals for the center were highlighted during the meeting.

At next month's meeting, there will be a vote on the following draft recommendations:

- Market Shift Consolidation – Under global budgets, the market shift calculation is used to account for the movement of patient volumes between providers. Although this calculation will always be complex, this proposed consolidation is meant to reduce the number of service lines as well as establish a work group to further review demographic adjustments.

- Update Factor for Rate Year 2020 – Always a "hot topic", this year's proposed factor was based on gross inflation of 2.96%. After adjustments, the net increase for hospitals is expected to be 3.69%. With the newly adjusted payer differentials, this would mean that private payers would see a growth of 4.76% and public payers, 3.06%.

- CRISP Support – CRISP (Chesapeake Regional Information System for our Patients) is Maryland's health information exchange and serves both Maryland and DC. It has been proposed that CRISP receive $5.4 million in rates for their funding for FY 2020.

- Emergency Department Relative Value Units – If approved, all language surrounding the use of CCT (clinical care time) will no longer apply effective July 1st, 2019. Hospitals are required to establish their own internal criteria for the five ED levels based on resources consumed. Hospitals can choose to continue with CCT. Although not discussed during the meeting, there has been some confusion regarding the new RVU chart. Comments are to be sent to Bill Hoff by May 31st, 2019.

[3] https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf

Katie wrapped up the May meeting by sharing upcoming goals and projects for the staff. Many of these initiatives are the direct result of new Maryland legislation. These goals and projects include:

- Certificate of Need work with the Maryland HealthCare Commission
- Planning for use of excess regulated space
- Improved facility fee notifications and consumer awareness
- Maryland Primary Care Program (MDPCP) reporting
- Coordination with Emergency Medical Services providers and evaluation of Emergency Department overcrowding
- Update of financial disclosures
- Rural healthcare delivery and financing
- Medicaid Total Cost of Care
- Maryland Maternal and Children's Health initiatives

Based on this list, it appears that it will be another busy year!

DATA AND TECHNOLOGY

WHERE TO START WITH ALL THAT DATA? – Josh Leventhal

Just about every day I sit down to a new set of data, whether it is new data from a client, internal data, or a subset of data I was previously analyzing. The ultimate goal is serving the right data to the right people to take action, but before I can deliver I have to merge and aggregate disparate data. I ask myself, where do I start?

We are all aware that bad data into a perfect system will still result in bad information that drives decisions. Therefore, the initial data wrangling process (extracting, loading, transforming, unifying and harmonizing) is crucial to any data and analytics project's success.

The majority of time in a data analytics project will be spent on data wrangling, as supported by the explosion of tools to help streamline this process in recent years. Some of these tools are for those of us that enjoy writing out lines of code, and some have user interfaces that allow those with less coding experience to create a meaningful data set.

Data wrangling is both an art and a science as it requires you to identify and aggregate all the data that is needed for the defined analysis, while also have some level of foresight into the future needs that will materialize as the project evolves.

Regardless of the tool I use, there are some key tenants that I follow to help maintain integrity within the data, as well as provide flexibility to meet undefined needs. These tenants focus on maintaining the integrity of the data, as each time you change the data, you lose fidelity from the source.

***Ensure Completeness of Data*.** A critical step before analyzing disparate data sets is independently evaluating each data set for completeness. While smaller data sets can be reviewed easily, large data sets may require something more robust. At Kohler HC we use tools that come with some of the database tool we use, as well as some custom tools we developed to ensure that we understand what value each set of data has when compared in context to the other data in our project.

***Implement Traceability and Auditability*.** At Kohler HC we call this Mission Control. We leverage a process that assigns a unique value for each source of data at the file level, as well as a unique ID for each row within each source. This allows us to always trace back to the original source value. Mission Control is an invaluable part of our automated tasks, as well as when building data transformation processes as it allows us to easily validate transformations and data typing.

***Use Smart Field Labeling*.** We name our fields according to context. If you Google field naming conventions, you will find arguments for just about every nomenclature you can image. Naming fields according to context allows every consumer of the data, not just the wrangler to easily understand the content. We also will preface fields with "KHC" if we are mixing both source fields and calculated fields so that we can easily distinguish the two when performing analysis. This can be cleaned up further in the visualization layer of the project so that consumers at this level have a more streamlined experience.

Implement Data Typing. At Kohler HC we data type as far along in the process as possible. We start all analyses off with the data type specified by the source. If none is specified, we load everything as a text to ensure no loss of data and rely on downstream conversions as needed.

Remember that data wrangling has direct and indirect impact on the data used for analysis. The best way to approach this process is spending the time upfront to locate, document and understand the sources of your data.

Kohler HC has deployed a modernized cloud platform (KAP), capable of ingesting disparate data sets of any size from any source. We use KAP to innovate and provide creative data solutions to deliver insights your team needs to take action and solve problems now.

Have a data problem? Not sure where to start? Need some insights on the secret sauce behind Mission Control? Drop me a note at jleventhal@kohlerhc.com or call me at 312.933.2752; I always enjoy virtual cup of coffee over a data problem.

OTHER ARTICLES OF INTEREST

CMS FINDS INADEQUATE RN STAFFING IN SNFs -THE RESULT? MORE WEEKEND STATE SURVEYS – Daria Malan

CMS believes that nurse staffing is directly related to the quality of care that residents experience and is very concerned about resident health and safety risks related to inadequate RN staffing. CMS has identified through its payroll-based journal system matched against nursing home census reporting systems, that the requirement to have an RN onsite eight consecutive hours a day, seven days a week was not being met in at least 6% of SNFs. Those SNFs had 7 or more days with no RN on duty and 80% of those days fell on weekends.

To address its concerns, CMS is providing a list to State survey agencies and regional CMS offices with names of facilities with potential staffing issues: (1) facilities with significantly low nurse staffing levels on weekends; and (2) facilities with several days in a quarter without an RN onsite (see CMS memo QSO 19-02-NH[4]).

Consequently, states will now be required to conduct at least 50% (formerly 10%) of the required off-hour surveys on weekends for facilities on CMS' list. Surveys include either required annual surveys or complaint- based surveys. If a surveyor confirms that the RN staffing requirement has not been met, CMS directs that the facility shall be cited for noncompliance under staffing deficiency F-Tag 727.

Additionally, CMS urges surveying agencies to pay attention to any overall staffing-related care and complaint issues and act accordingly with deficiencies on care, resident rights, etc.

CMS also announced that nursing homes reporting seven or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain, which will drop their overall Nursing Home Compare star rating by one star for that quarter.

Required facility assessments may be used by surveyors to assess staffing levels, competencies and resources during an adverse event, but CMS suspects forthcoming facility assessment guidance is in order.

It's a great time for SNFs to address internal staffing issues and correct deficient scheduling practices, pursue fill of frozen RN positions, expand RN per diem pool, and review facility assessment procedures.

MEASLES - RECORD BREAKING NUMBERS - Jessica Felder

The number of measles cases in the United States has reached the highest level in over 25 years. Back in 2014, the Centers for Disease Control had seen a large spike in the number of reported measles cases. In 2014 there were 644 reported cases.[5] As of the end of April 2019, the United States has already surpassed this number as we reached a total of 704 reported cases.[6] If you do the math, that is already 60 cases over the TOTAL number of cases for the entire year of 2014.

[4] Ref: QSO 19-02-NH November 30, 2018: Payroll Based Journal (PBJ) Policy Manual Updates, Notification to States and New Minimum Data Set (MDS) Census Reports

[5] https://www.historyofvaccines.org/content/blog/final-measles-number-2014

[6] https://www.washingtonpost.com/health/2019/04/29/us-officials-say-measles-cases-hit-year-record/?noredirect=on&utm_term=.b7571ccf992c

What is the cause? The answer is the lack of vaccinations. There has been an increase in the number of parents opting to not vaccinate their children. Of the 704 cases reported this year, 500 of the cases were unvaccinated patients. Reasoning behind the decision to not vaccinate varies from simply not thinking the vaccines are necessary to concerns of side effects from these vaccinations.

According to the CDC, the MMR vaccine in not only effective but safe for recipients. The MMR vaccine, which also protects the recipient from mumps and rubella, is effective in preventing measles. The CDC provided the following information on its website: "Two doses of MMR vaccine are about 97% effective at preventing measles; one dose is about 93% effective"[7].

The easiest and most obvious solution to decrease the number of measles cases is to make vaccinations mandatory. This has been highly debated over the years. However, having a 97% chance of not having contracting measles is much better than the potentially deadly outcome of not being protected from measles at all.

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.*

[7] https://www.cdc.gov/measles/vaccination.html