KOHLER HEALTHCARE CONSULTING

PIECES FOR SUCCESS

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Welcome to our 110th edition of Kohler HealthCare Consulting's "Pieces for Success" newsletter. We hope you find our monthly publication to be informative and of assistance to you. If you know others who may find this information useful, please feel free to share our newsletter with them. We look forward to you being a part of what makes us great (great people) while we strive to provide excellent and functional content.

IN THIS EDITION YOU WILL FIND THE FOLLOWING ARTICLES:

QUICK THOUGHTS

COVID FUNDING AND THE COST REPORT

Curious if or how COVID funding affects cost reporting? CMS has posted a new FAQs document in Section V addressing Cost Report questions.

"COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing" https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

OCTOBER 1ST IS RIGHT AROUND THE CORNER

CMS Has Published the Following Updates:

1. October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3 https://www.cms.gov/files/document/mm11944.pdf.

2. October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule https://www.cms.gov/files/document/mm11956.pdf.

3. October 2020 Update of the Hospital Outpatient Prospective Payment System https://www.cms.gov/files/document/mm11960.pdf.

4. Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment https://www.cms.gov/files/document/mm11937.pdf.

5. October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files https://www.cms.gov/files/document/MM11854.pdf.

MEDICARE COVERAGE DATABASE SEARCH ON CMS

CMS has established a new Search page on the Medicare Coverage Database (MCD) website. Users can now search for Medicare coverage documents with keywords by ICD-10 and CPT/HCPCS codes or by document ID by utilizing a single search term box. This is great news for anyone who has ever tried to complete a search on the MCD website! The new Search Results page even allows for in-place filtering. For those who are accustomed to the previous MCD Advanced Search page, it will remain on the website for a time so users may switch back and forth between the Search options.

NEW REDUCING SEPSIS MORTALITY TARGETED SOLUTIONS TOOL FROM THE JOINT COMMISSION

On September 9, 2020, The Joint Commission's Center for Transforming Healthcare introduced a new web-based application to help providers reduce sepsis mortality and increase compliance with sepsis protocols. "The Center's release of the Reducing Sepsis Mortality Targeted Solutions Tool® (TST®) follows a comprehensive quality improvement project that decreased mortality among the cohort by nearly 25% and a subsequent multihospital pilot that reduced mortality from nearly 20% to over 50%." [1]

1. Joint Commission Center for Transforming Healthcare, "Center for Transforming Healthcare Launches New Reducing Sepsis Mortality Targeted Solutions Tool." September 11, 2020, https://www.centerfortransforminghealthcare.org/press-room/news/2020/09/center-for-transforming-healthcare-launches-new-reducing-sepsis-mortality-targeted-solutions-tool/.

FEATURED ARTICLES

NURSING PRACTICE: A LINCHPIN IN THE TELEHEALTH ENVIRONMENT

BY: DARIA MALAN

In ambulatory care, the RN has had a long-standing role that has grown in importance, especially considering the current environment of the delivery of remote healthcare. The growth in telehealth nursing practice is now an integral component of ambulatory care nursing.

Telehealth practice originally began when RNs were available to patients by telephone to ensure they had access to health care. The RNs triaged patients to appropriate levels of care. Telehealth RNs now hold a key role in patient care by providing nursing care in virtual environments; utilizing a variety of technologies during encounters to perform triage and nursing assessments; providing consultation, interventions, follow-up and surveillance of patients' condition(s); teaching patient; and providing resources on how to manage their health. Telehealth RNs can also support terminally ill patients and their families in the home during hospice/end-of-life care.

Telehealth nursing is both an art and a science that combines professional knowledge with interpersonal and technical skills. The science of telehealth nursing is based on a six-step nursing process: nursing assessment; diagnosis; goal/outcome identification; planning; implementation; and evaluation.[1]

Ambulatory care RNs continually collect both objective and subjective data. These professionals typically work within an interdisciplinary team where they can first prioritize patient needs and make decisions. The RN will then reach out to the provider and other disciplines to collaboratively develop a plan of care that includes important modalities, such as physical therapy for gait mobility in the home; occupational therapy for optimizing activities of daily living; or a social work consult for mental health support. These RNs use evidence-based practice in the form of clinical algorithms, protocols, or guidelines in order to systematically assess patient needs and symptoms and then design next steps.

Nursing productivity via telehealth is not closely measured at this time. The workload varies based on the patient population type to be assessed and monitored and the efficiency of

the technology that brings the patient and the RN or provider face-to-face (or voice-to-voice) plays a role in patient throughput.

Whichever types of technologies or electronic systems are utilized, the RNs recognize that their experience and trained judgment supersede the sole use of decision support tools, and in this way, they can synthesize both the data and the situation to make the best clinical decisions and recommendations for the patient, the family and the interdisciplinary team.

1. American Academy of Ambulatory Care Nursing. Scope and Standards of Practice for Professional Telehealth Nursing - 6th Edition 2018- V. The Science and Art of Telehealth Nursing Practice.

CMS TO REQUIRE COVID-19 TEST RESULTS FOR 20% MEDICARE ADD-ON PAYMENT AS OF 09/01/2020

BY: JULIE LEONARD

The Centers for Medicare and Medicaid (CMS) have clarified the requirements needed to receive the 20% increase in the weighted DGR. In MLN Matters SE20015 CMS States:

> *"To address potential Medicare program integrity risks, effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission.*
>
> *For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government run testing center can be added to the patient's medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement"* [1]

CMS will continue to apply the 20% increase when the discharge indicates ICD-10-CM code U07.1 (COVID-19) after 04/01/20. CMS may conduct post-payment reviews to ensure a positive test result is documented within the patient record.

The coding of U07.1 should be reported only when a positive test result is documented to avoid future paybacks to CMS. CMS has indicated in MLN SE200015 they will provide additional operational guidance "in the near future". It is wise to heed the CMS guidance, as this is an indication of upcoming post payment reviews. CMS has provided additional monies to cover the cost to COVID-19 treatment and it is in the best interest of CMS to ensure the monies were spent appropriately and to mitigate fraud, waste, and abuse. Make sure your coding/HIM staff is aware of these guidelines and an audit to ensure compliance would be a good decision.

1. Center for Medicare and Medicaid Services, Medicare Learning Network Matters Number SE20015, "New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act.", September 11, 2020. https://www.cms.gov/files/document/se20015.pdf.

HSCRC: CONTROLLING THE COST OF CARE DURING A CRISIS

BY: LAUREN ROSE

The Health Services Cost Review Commission (HSCRC) held their virtual public meeting on Wednesday, September 9, 2020.

The Medicare Performance Adjustment (MPA) was discussed at the meeting. The MPA is a calculation that attributes beneficiaries across the State of Maryland to individual hospitals under the premise that if the change in the total cost of care can be measured and monitored at the local hospital level, there is a better opportunity to control it at the state level. The attribution methodology has historically been very complex and somewhat unpredictable for hospitals. The HSCRC is working to simplify the methodology. For non-Academic Medical Centers (AMC), the geographic location of the beneficiary seems to work best. A solution for AMCs is still in process. This adjustment does directly impact hospital revenues and will be watched closely. The measurement of financial results for Care Transformation Initiatives (CTIs) may be integrated into the MPA as CTIs are also focused on reducing the cost of care.

On the other side of the coin, the HSCRC is closely monitoring hospital volume and financial trends considering the challenges of COVID-19. Fortunately, excluding the Emergency Department (which was excluded because of the recent Relative Value Unit conversion), June and July volumes were much closer to historic levels than prior months. In addition, because of the rate corridor expansion (i.e. temporary permission for hospitals to charge above their normal rates), revenues are more in line. As expected, certain rate centers such as Intensive Care and Laboratory are higher than historic rates while other rate centers such as Clinic and Same Day Surgery (i.e. outpatient surgery) are far below. Hospitals are to stop

charging above the rate corridor once their undercharge from fiscal year 2020 has been recovered.

Because no hospitals exceeded their Global Budget Revenue (GBR) volumes during the COVID-19 pandemic (volume troughs balanced out any surge activity), the "surge policy" which would have permitted hospitals to exceed their GBR budget was terminated on June 30, 2020. This policy can be revisited in the future if a second surge in rate year 2021 warrants the need.

The HSCRC is continuing to reconcile federal and hospital-provided information regarding the amount of federal funding that has been received by Maryland hospitals. Current estimates are $809 million for hospital regulated-only and $851 million for hospital regulated and non-regulated. This excludes the $1.5 billion in loans. When the HSCRC nets the FY 2020 performance under the global budget (i.e. over and under charges) and the regulated federal funding, there is a wide range of results across all hospitals/systems (between $80 million over funded and $80 million underfunded). In addition to monitoring the charge information, the HSCRC will also be reviewing the Annual Filing for significant expense fluctuations relating to the crisis.

If your head is spinning after reading all of this, please note that the HSCRC will be issuing a memorandum to all hospitals regarding their findings.

What happened with the $10 million available for hospitals through the newly approved Long-Term Care Partnership Grant? This program moved forward as planned and the awards will be posted in the post-meeting materials on the HSCRC website (link is below).

The HSCRC continues to juggle ensuring hospitals in Maryland are properly funded via both federal and local sources while not losing their focus on total cost of care, and supporting hospitals assisting long term care facilities with infection control.

Be sure to tune in for the October 14th HSCRC meeting. For more information regarding the above topics, please visit: https://hscrc.maryland.gov/Pages/commission-meetings.aspx.

IOT AND HEALTHCARE INNOVATION

BY: JOSH LEVENTHAL

Last month, my colleague, Tony Borgetti, wrote an article in our newsletter on the topic of innovations in healthcare. The article also addressed the recent changes by the largest internet of things (IoT) data companies to help track Coronavirus and inspired some

thinking in regards to personal medicine, social determinants of health and how our mobile phones are continuing to become the nucleus of our lives.

A commonly recognized definition of a nucleus is a central and highly important part of an object, movement, or group, that forms the basis for its activity and growth.

Our phones are the central connection point for many IoT devices that measure and quantify our health. They track our steps; our calories; our eating habits; sleep cycles; our movement/location; just to name of few of areas of functionality. The phone also serve as the hub of our daily communications that includes voice; video; text message; email; social media; chatting in addition to tracking our purchasing habits (i.e., Google Pay and Apple Pay).

In a sense, our mobile devices collect enough personal data that they may provide the best overall picture of our health. The first modern smartphone, the iPhone, was released over 13 years ago on June 29, 2007. Although the apps that we all utilize today were not released or built overnight, there is still good potential for historical data.

Multiple disparate data sources exist that could be pulled together to help us manage our health better. The data could also help our healthcare providers understand the larger context of an acute medical issue to ensure that the diagnosis is being made with more than "today's complaint" and develop care and treatment plans that are more likely to work for you as an individual.

Phones can also be utilized to detect and diagnose diseases that face our society. For example, the University of California has developed the technology to diagnose Type 2 Diabetes with an 80% accuracy rate by utilizing a smartphone camera. Although not perfect for the accuracy rate, the devil is likely in the details and this supports that the smartphone is becoming more integrated into healthcare beyond consumer apps.

The CMS announced the Medicare Coverage of Innovative Technology (MCIT) (CMS-3372-P) proposed rule on August 31, 2020 designed to spur innovation for Medicare beneficiaries.[1] The comment period for the proposed rule ends November 2, 2020.

The MCIT creates a "new, accelerated Medicare coverage process for innovative products that the FDA deems "breakthrough," which FDA approves on an expedited basis and could include devices harnessing new technologies like implants or gene-based tests to diagnose or treat life-threatening or irreversibly debilitating diseases or conditions like cancer and heart disease."[2]

Under current Medicare guidelines, innovative solutions must pass FDA approval and then go through an additional approval process for Medicare coverage. The MCIT provides national coverage at the same time of the FDA approval, for a period of four years. After these initial four years, CMS will reevaluate coverage based on evidence of improved health outcomes among Medicare beneficiaries. The four-year period provides manufacturers the opportunity to test and collect evidence of the efficacy of their products thereby encouraging innovation.

The discussion of this topic would not be complete without mentioning data privacy. As integration of consumer-based technology continues to accelerate in healthcare, the consumer and healthcare industry will need to work towards a middle ground on privacy. Consumer smartphone app privacy policies are not understandable and HIPAA provides robust requirements. As non-clinical data collected by consumer apps are integrated into healthcare, we will need to find a new definition for protected health information that functions to support breakthrough technologies.

Regardless of the data privacy risks, I am excited to see how CMS policy changes influences how care is delivered in the United States.

Footnotes. All websites accessed on 9/15/20.

1. Rich Hardy, "Smartphone Camera Can Now Detect Diabetes With 80 Percent Accuracy." News Atlas, August 17, 2020. https://newatlas.com/medical/smartphone-cameras-detect-diabetes-ppg-ucsf.
2. Federal Register, Vol. 85, No. 170 / Tuesday, September 1, 2020 / Proposed Rules, US Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR, Part 405, "Medicare Program; Medicare Coverage of Innovative Technology (MCIT) and Definition of "Reasonable and Necessary", Page 54327. https://www.govinfo.gov/content/pkg/FR-2020-09-01/pdf/2020-19289.pdf.
3. The Center for Medicare and Medicaid Services, "CMS Acts to Spur Innovation for America's Seniors." August 21, 2020, Press Release. https://www.cms.gov/newsroom/press-releases/cms-acts-spur-innovationamericas-seniors.

Analytics? Regulations? Data privacy? Humanity? Looking for a new friend? You can reach me at jleventhal@kohlerhc.com or 312.933.2752.

Josh Leventhal is a Managing Director with Kohler Healthcare. He has over 15 years' hands on experience in healthcare data and analytics solving problems for providers, payers, and life science organizations. Josh started his career in management consulting analyzing data for the largest joint defense litigations in the country before using his skills and expertise at local startups to assist the Medicaid managed care organization and medical research industries. His experiences as a consultant, product manager and developer allow him to work effectively with both business and technology stakeholders.

EDUCATION

APPROPIATE USE CRITERIA (AUC): MARYLAND HOSPITALS-ONLY

BY: BETH FRANZAK

CMS states that Maryland Hospitals are exempt from the Medicare AUC program.

"While hospital outpatient departments are included as an applicable setting for the purposes of the Medicare AUC program, the statute further requires that claims be paid under an applicable payment system. Since Maryland hospitals that are subject to the Maryland Health Services Cost Review Commission (HSCRC) are not paid under the hospital outpatient prospective payment system, CMS believes that advanced diagnostic imaging furnished at one of these hospitals' outpatient departments would not be subject to consultation with a qualified CDSM and would not be required to append consultation information on claims. CMS is currently trying to determine how to identify the related professional claims as they too would not be required to append consultation information to claims." [1]

This is for Maryland hospitals-only and not non-regulated freestanding sites.

1. Email: From: Leslie Long, Novitas-Solutions, To: from Brett McCone, Maryland Hospital Association dated, June 9, 2020.

UNITEDHEALTHCARE LABORATORY TEST REGISTRATION FOR FREE STANDING AND OUTPATIENT HOSPITAL LABORATORY PROVIDERS: NEW EFFECTIVE DATE

BY: BETH FRANZAK

In June of 2020, UnitedHealthcare (UHC) announced that effective October 1, 2020, all in-network, freestanding, and outpatient hospital laboratories are required to register their laboratory tests with UHC. UHC would then require all claims to be billed with CPT/HCPCs codes and a corresponding unique laboratory test code or the claim will be denied.

However, UHC has announced a date change:

> "**Effective January 1, 2021**, claims for most laboratory test services must contain your laboratory's unique test code for each service. Additionally, each test code submitted on a claim must match a corresponding **laboratory test registration** provided in advance to us, or we will deny the claim. To ensure compliance with these requirements, free standing and outpatient hospital lab providers should register their laboratory tests prior to **December 1, 2020**.
>
> These requirements apply to most UnitedHealthcare Commercial, Medicare Advantage and UnitedHealthcare Community Plan networks." [1]

The American Hospital Association (AHA) has written a letter to UHC on behalf of hospitals, health systems and other healthcare organizations requesting for a reconsideration of this policy.

1. UnitedHealthcare, "Laboratory Test Registry Protocol", https://www.uhcprovider.com/en/policies-protocols/lab-test-registry.html.

ELIMINATING KICKBACKS IN RECOVERY ACT

BY: KHALIDA S. BURTON

The Eliminating Kickbacks in Recovery Act of 2018 (EKRA) was written to prohibit individuals from referring substance abuse patients to recovery homes, clinical treatment facilities, and laboratories in exchange for kickbacks. The EKRA prohibits knowingly and willfully:

1. Soliciting or receiving any remuneration directly or indirectly for referring a patient to a recovery home, clinical treatment facility or laboratory; or
2. Paying or offering any remuneration directly or indirectly.

In addition, the EKRA prohibits providing inducements for a referral of a patient to a recovery home, clinical treatment facility, or laboratory or in exchange for the patient using the services at those facilities.

The EKRA is similar to the Anti-Kickback Statute (AKS), which also prohibits referrals for healthcare services in exchange for receiving kickbacks. The significant difference between the AKS and the EKRA is the safe harbor exceptions regarding the treatment of

compensation made to employees and independent contractors. The EKRA exception applies to employees and independent contractors and only protects an employer's payments to an employee or independent contractor.

For more information, please visit https://www.congress.gov/bill/115th-congress/senate-bill/3254.

2021 ICD-10-CM UPDATES

BY: SIMBO FAMURE

There are hundreds of changes that have been made for the FY 2021 ICD-10-CM Official Guidelines. Specifically, there are 490 new codes, 58 deleted codes and 47 revised codes. There are also several superficial updates that are associated with the wording in the official coding guidelines that help clarify the assignment of codes and the elimination of redundancy of expression.

These changes will take effect on October 1, 2020. Many of these changes and additions affect Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T88) and Chapter 20: External causes of morbidity (V0-Y99). There were no new changes to Chapter 8: Diseases of the ear and mastoid process (H60-H95).

Below is a brief overview of some of the changes by chapter: [1]

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1
A new section is included with detailed advice on how to code COVID-19. Section II gives specific guidelines on how to select the principal diagnosis. Other diseases including Human Immunodeficiency Virus (HIV), Tick-Borne Viral Encephalitis, Buschke's Disease and Babesiosis have additional or changed codes.

Chapter 2: Neoplasms (C00-D89)
There are no new code additions, however, there are more specific sub-term assignments in the alphabetic index under Thymoma, Leukemia and Meningioma.

Chapter 3: Diseases of the Blood and Blood-Forming Organs (D50-D89)
There are 43 new codes. They further define complications and assign codes relative to crisis in Sickle-Cell Disorders and other Autoimmune Hemolytic Anemias, Immunodeficiencies and other diseases.

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)
There are new coding instructions for diabetes patients that are being treated with insulin, injectable non-insulin drugs and oral hypoglycemics. A clear definition regarding the use of "Emaciation (due to malnutrition) – E41" is given.

Chapter 5: Mental and Neurodevelopmental Disorders (F01-F99)
There are new codes created for substance withdrawal. These substances include alcohol, cocaine, and opioids.

Chapter 6: Diseases of the Nervous System (G00-G99)
There are 24 new codes that are mostly split codes to further define codes for Congenital Myopathies, Cerebrospinal Leaks and Disorders of the Meninges. There are also new codes for Intracranial Hypotension following surgical procedures.

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)
The 7 codes for Hereditary Corneal Dystrophies H18.5-, have now been converted to 28 codes to specify laterality (right, left, bilateral and unspecified).

Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)
No changes were made.

Chapter 9: Diseases of the Circulatory System (I00-I99)
There are no new codes, however, there is a clear definition of codes relative to Atherosclerosis I70.- in hierarchy in the alphabetic index.

Chapter 10: Diseases of the Respiratory System (J00-J99)
There is a new code U07.0 – Vaping-related disorder in the Original Coding Guidelines Section I.C.10. There are other new codes for Pulmonary Eosinophilia and Other Interstitial Pulmonary Diseases.

Chapter 11: Diseases of the Digestive System (K00-K95)
There are several codes pertaining to Esophagitis and Gastro-esophageal Reflux Disease that have been split to specify encounters with bleeding.

Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-K99)
There are no new codes. The sub-term, "desquamative" under the main term "Dermatitis" offers further detail terminology for "other specified dermatitis – L30.8".

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
There are 57 new codes which include more specific codes for Pathological Fractures, Rheumatoid Arthritis, Osteoarthritis, and other joint derangements. The codes for Juvenile osteochondrosis of tibia and fibula were originally 3 codes but now they have expanded to 16 codes.

Chapter 14: Disease of Genitourinary System (N00-N99)
There are new codes that specify nephritic syndrome with C3 glomerulonephritis. Chronic Kidney Disease, Stage 3 – N18.3 has also been split into 3 new codes and there are also new codes for Granulomatous Mastitis.

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
There are new codes for maternal care of scars relative to cesareans. The is also instruction in Section 15 that explains the proper way to code COVID-19 in pregnancy and childbirth.

Chapter 16: Certain Conditions Originating in the Perinatal period (P00-P96)
There are 4 new codes for neonatal cerebral infraction.

Chapter 17: Congenital Malformations (Q00-Q99)
There are no new codes. The codes for the Doubling of the Uterus have been reduced 4 codes to 3 codes.

Chapter 18: Symptoms, Signs, and Abnormal clinical and Laboratory Findings, not Elsewhere Classified (R00-R99)
Code R51 for Headache is split into 2 codes to specify a Headache with an Orthostatic Component.

Chapter 19: Injury, Poisoning and Certain other Consequences of External Causes (S00-T88)
The are 54 new codes for poisoning/adverse effect of Fentanyl, Tramadol, and other synthetic narcotics. 36 new codes for complications of corneal transplant codes relative to laterality. Other code additions and changes include superficial Injury to the thorax.

Chapter 20: External Causes of Morbidity (V00-Y99)
There are several new codes relative to Pedestrian/Pedestrian Conveyance Accidents – V00-V06. These pertain to new devices; electric scooters, Segways and Hoverboards.

Chapter 21: Factors Influencing Health Status and Contact with Health Services
There are 3 new codes related to Encounter for Observation for suspected ingestion/aspiration/insertion of foreign bodies.

1. American Academy of Professional Coders, 2021 ICD-10-CM Expert the Official CMS Code Set.

ELIMINATING THE INPATIENT-ONLY LIST

BY: KHALIDA S. BURTON

As part of the Hospital Outpatient Prospective Payment System (OPPS) annual update, the Center for Medicare and Medicaid Services (CMS) has proposed to phase-in the elimination of the Inpatient-Only (IPO) list over three consecutive years, beginning on January 1, 2021.

The services on the IPO list will be assigned the applicable clinical ambulatory payment classification (APC) to be reimbursed under the OPPS. There are approximately 1,740 services on the IPO. The first set of services proposed to move from the IPO would be approximately 300 musculoskeletal-related services. A major driver behind the proposed rule is to allow physicians to use their clinical knowledge and judgment to determine if the procedure can be provided in an outpatient setting.

There are five criteria utilized to determine whether a service should be removed from the IPO list. The criteria are as follows:

1. Does the outpatient department have the equipment to provide the service?
2. Can the simplest procedure be provided in most outpatient departments?
3. Is the procedure related to services previously removed from the IPO list?
4. Is the procedure being furnished in numerous outpatient hospital settings?
5. Is it appropriate and safe to provide the procedure in an Ambulatory Surgery Center (ASC), and is the procedure on the list of approved or proposed ASC services?

The impact of the proposed rule will decrease inpatient admissions and reduce inpatient reimbursement. However, ASCs will see an increase in revenue, especially if the commercial payers follow the guidance from CMS and approve more services provided in ASC settings.

For more information: https://www.govinfo.gov/content/pkg/FR-2020-08-12/pdf/2020-17086.pdf.

CHANGES IN RVU BY CMS: COULD BE A SIGNIFICANT IMPACT TO PHYSICIAN COMPENSATION

BY: CHARLOTTE KOHLER

There has been considerable discussion regarding the changes that physicians will be required to make to document and select Evaluation and Management (E/M) codes in 2021, however, what has not really been addressed is the significant impact this may have on physician compensation.

If physician compensation is tied to the number of billed RVUs, then the CMS arbitrary increases in RVUs for the E/M codes means that "doing nothing different" could result in what may appear to be an increase in productivity, and thus, a corresponding increase in physician compensation.

The jerry rigging of reducing the Medicare Conversion Factor downward, and the increase in E/M RVUs as an offset makes this compensation impact inevitable for physicians. The

impact is driven based on the significance of E/M codes for a particular physician/specialty. Beyond the RVU changes, the 11% proposed reduction in the Conversion Factor means that any payment methodology based on payments (not RVUs) has a different impact: less money paid by Medicare for non-E/M services.

The impact of this change will be seen after the first year of the implementation, which is currently 2021; and may be a surprise to hospitals. If these changes go through for 2021, developing a proforma of the impact is needed to head off disputes with your employed physicians. Of course, one way to handle this is to amend physician contracts and utilize the pre-2021 RVUs as the basis of compensation rather than simply adopting the new 2021 RVUs.

COMPANY NEWS AND EVENTS

NEWS

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CHECK OUT LAST WEEK'S TOP 5 CHALLENGES HEALTHCARE PROVIDERS ARE FACING

VIDEO: PROVIDER BASED BILLING

KHC YOUTUBE: PROVIDER BASED BILLING

EVENTS

SEPTEMBER 16 ,2020 | VIRGINIA AAHAM REVENUE INTEGRITY VS. REVENUE CYCLE | LAUREN ROSE AND BETH FRANZAK

SEPTEMBER 18 ,2020 MARYLAND HFMA PHYSICIANS PRACTICE PANEL – COORDINATING BY KHALIDA BURTON

NOVEMBER 13, 2020 REGION IV HFMA JANUARY 1 CPT UPDATES KHC TO COORDINATE

NOVEMBER 17-20, 2020 ANNUAL AMA SYMPOSIUM – KHC IN ATTENDANCE

DECEMBER 2 ,2020 JANUARY 1 CPT UPDATES - LAUREN ROSE

DECEMBER 4 ,2020 MARYLAND HFMA IMPACT OF JAN 1 UPDATES ON MD HOSPITALS KHALIDA AND KHC TO COORDINATE AND SPONSER CEU

DO YOU HAVE QUESTIONS? EMAIL US

EMPLOYEE SPOTLIGHT

Jessica Felder, MHA, CPCS has been with the KohlerHC Team for 2.5 years. Jessica has always wanted to make a difference in the lives of others and while in high school, she volunteered at a SNF for her service-learning requirement and she loved it.

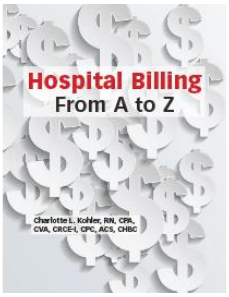
At that point, Jessica knew that healthcare would be her professional home. However, after a brief experience as a Nursing Assistant, Jessica determined that she was not suited for a career on the medical side of the healthcare industry. Therefore, healthcare finance became her career focus.

If she could change one aspect about healthcare in America, it would be healthcare inequality. There are so many people who do not have access to quality healthcare. She states that: "The quality of our healthcare services should not be based on where we live or economic status." She believes that as Americans we should all have the right to quality healthcare.

Jessica is inspired by her family and everything she does is for them. She is motivated by making a difference in the lives of others from a simple hug to buying a cup of coffee for a stranger. Not everyone realizes the impact that one small gesture can have on another person.

One day, Jessica would love to visit Tokyo, Japan. If she could have dinner with anyone, it would be with Mildred Loving. To wrap up, Jessica's favorite book is "Small Great Things" By Jodi Picoult.

PUBLICATIONS



HC PRO: HOSPITAL BILLING FROM A TO Z
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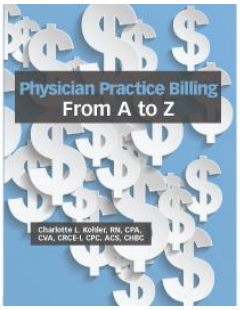
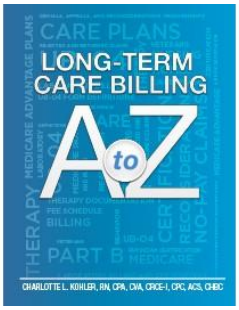
Who should read this book? Finance Staff, Billers and Coders, HIM staff, Clinical department staff, Revenue Managers, Compliance Officers Healthcare attorneys, consultants, and CPAs



HC PRO: PHYSICIAN PRACTICE BILLING FROM A TO Z
AVAILABLE FROM HCPRO

Who should read this book? Practice Manager, Office Manager, Practice Administrators, Physicians, Business Managers, Coding Supervisors, Billing Supervisors, Compliance Officer, Biller



HC PRO: LONG-TERM CARE BILLING FROM A TO Z
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