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.

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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.

COMING IN 2017 – Kohler Connection Webinars and Speaking Engagements:

- Kohler Connection – 8/30/17, noon. - “Recoupments Caused by CMS Transmittal 721” – Presented by Deanna Turner. In 2014 Medicare sent out Transmittal 541 indicating that when a hospital was denied payment for a service for lack of medical necessity, the physician would face recoupment for the related services. Then, almost nothing happened. With Transmittal 721, Medicare added teeth to the recoupment by MACs, under CERT, by RACs, SMRC, and ZPIC/UPIC. CMS also changed the names of the review types performed by these auditors. Although from CMS’ perspective it “levels the playing field”, many physicians and surgeons will be surprised by the recoupments.

In this 30-minutes Kohler Connection Seminar, you will learn about who and how these recoupments are determined. You will also learn how the types of reviews are changing. In addition, you will learn how to make sure the reviewers are meeting their requirements.

- Kohler Connection – 9/13/17, noon. - “In-Patient Rehabilitation Facility (IRF) Denials: Are You Meeting Basic Medicare Coverage Criteria?” – Presented by Daria Malan. The Presentation will include the Importance of Understanding IRF Admission Guidelines, Coverage Guidelines for IRF Admissions, and Preventing Errors and Avoiding Denials

- Kohler Connection - 9/27/17 - Provider-Based (Regulated) space, regulations, and billing - Presented by Charlotte Kohler covering the many changes that are now in place and upcoming changes.

Charlotte Kohler will be leading a workshop entitled, “How to Incorporate a Strategic Business Model to Ensure a Viable Urgent Care Center” scheduled for October 2nd from 5:30-7:30 p.m. at the 2017 Urgent Care Centers Congress (October 2 - 3, 2017) at the Loews Royal Pacific Resort in Orlando, FL.

Save the Date – 12/9/2017 - Maryland Hospital Clients --- The 3rd Annual HFMA CDM Forum will be Friday, 12/9/17 from noon to 4 p.m. KHC will be sponsoring this event and we hope to see all of you there. This event is an informal and interactive walk through of the January 2018 updates impacting hospital charge masters.
Watch for Quarterly CPT Updates – In 2017, it’s not only the Level II HCPCS that have been changing quarterly. Each quarter, the AMA adds new proprietary lab codes and for July 1, they made a few updates relating to vaccines. CPT 90587 has been added for the Dengue vaccine, quadrivalent, live, 3 dose schedule for subcutaneous use. CPTs 90620 and 90621 were revised and re-sequenced for Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB4C), 2 dose, intramuscular and Meningococcal recombinant lipoprotein vaccine, serogroup B (MedB-FHbp), 2 or 3 dose, intramuscular, respectively. Lastly, CPT 90651 HPV types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavolent (9vHPV), 2 or 3 dose, intramuscular was revised.

Acronym Assistance. If you or someone on your team needs assistance with the acronyms that Medicare utilizes, you may want to check out this tool from Medicare: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Acronyms-PDF-Print-Version-ICN-908999.pdf

CMS Looking to “Simplify” Evaluation and Management Coding. If this happens, it could take some costs out of healthcare - Less audits, fewer arguments, and perhaps less internal costs in training and monitoring. https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-14639.pdf starting on page 374, CMS acknowledges that the current requirements for the History and Exam portions are often burdensome and do not really provide enough of a difference in level. Rather, they commented that Medical Decision Making and time should be the more significant factors in explaining the intensity of service and the level. They indicate that the History and Exam should support the level selected, but documentation guidelines will be eliminated. This is also a result of the increased “issue” regarding the templated medical records for the history and exam. CMS is currently seeking comments. They believe this will be a multi-year process to make any changes to the current E/M methodology.

Your Therapist Resides in the Computer. Studies have found that patients with multiple chronic conditions (about 50% of the population) have underlying mental or behavioral health conditions. These account for 86% of the healthcare costs. At the Froedtert & The Medical College of Wisconsin, it was found that they could not obtain the behavioral health services to meet these needs. We know it’s not a unique condition limited to Wisconsin since we see the lack of behavioral and psychiatric services across the country. Looking at another option, Froedtert instituted computer based “cognitive behavioral therapy” (CBT) for patients with mild-to-moderate mental health issues. Although new to the US, it’s been used in Australia and the UK. There is a component of monitoring these patients to ensure the care is effective and to move to additional resources as needed. It is another option in seeking value-based care with limited resources.

Physicians Less Likely to Own Their Medical Practice. From the AMA: the percentage in 2016 was 47.1% compared to 53.2% in 2012. However, the number of physicians in hospital-owned Practices has stayed the same from 2014 to 2016: 32.8%; but in 2012 it was 29%. What we have been seeing is the amalgamation of single specialty Practices into mega-groups.

Hiring the Right Person. (from Oleg Vishnepolsky, Global CTO at DailyMail Online and Metro.Co.Uk) If you are hiring, take the candidate to lunch. Not only to convince them to take the job, but to watch how they treat staff and cleaning staff. If a person is nice, they are nice to everyone.

New Trend? Letters are coming from the Department of Labor appearing to be investigating hospitals that do not have in-network hospital-based physicians, or in other words “network adequacy.” One letter stated: “The Department’s [DOL] concern is regarding network adequacy. Regardless of how patients are billed, each patient that seeks medical services from an in-network hospital has a reasonable expectation that the doctors that attend to them are also in-network doctors. The Department is seeking answers as to why there were no in-network emergency room doctors on duty on November 10, 2016, and as to why the hospital, as an in-network provider to
[name of patient] insurance provider, allowed Dr. _____ to bill the patient, outside of the terms of the agreement that the hospital has with [name of patient] insurance provider.” If you receive such a letter, please contact your health care attorney.

Know About the NHCAA. The National Health Care Anti-Fraud Association was founded in 1985 by several private health insurers and Federal and State government officials. Its focus is exclusively on the fight against health care fraud. As a private-public partnership, members must be employed in private health insurers and those public-sector law enforcement and regulatory agencies with jurisdiction over health care fraud (both against private payers and public programs). The related HNCAA Institute for Health Care Fraud Prevention was founded in 2000 and is a separately incorporated, tax-exempt educational foundation providing education and training to private and public sector health care anti-fraud personnel.

Why is this important to the provider community? If you have wondered about how many insurance companies and government entities tend to have similar investigations, much of the industry uses this Association to understand issues and how they should investigate.


HCPRO Books Authored by KHC Staff:


Hospital Billing From A to Z, written by KHC Staff is a reference guide that covers Medicare requirements with ease of use for those involved in hospital billing. The book is available thru: http://hcmarketplace.com/hospital-billing-from-a-to-z?code=EB313813&utm_source=HCPRO&utm_medium=email&utm_campaign=HBFAZ

Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPRO: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

CMS, OIG AND MEDICARE UPDATES

CMS TO CONSIDER ALLOWING TOTAL KNEE REPLACEMENTS TO BE DONE IN ASC FACILITIES -- Julie Leonard

This past July, the Centers for Medicare and Medicaid (CMS) released a proposed change to the Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payments System that would remove Total Knee Replacement (TKR) from the inpatient only (IP) list. This would allow for the TKR to be performed in the outpatient (OP) setting as well as an ASC. CMS is also seeking comments on Total and Partial Hip replacements being removed from the IP only list.

“The Medicare inpatient-only (IPO) list includes procedures that are only paid under the Hospital Inpatient Prospective Payment System. Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. For CY 2018, CMS is proposing to remove total knee arthroplasty from the IPO list. The CY 2018 OPPS/ASC proposed rule also seeks comments regarding whether partial and total hip arthroplasty should also be removed from the IPO list.”

“Nearly half of the total joint population to date spends one to two days in the hospital, according to Sg2, a healthcare analytics company; these patients are "ripe for the shift to the outpatient setting." Hospitals are concerned they will see decreased revenues due to outpatient procedures or cases moving into ASCs.\(^2\)

Allowing total knee and hip replacements in the ASC could present a revenue opportunity for the ASC and Outpatient facilities and save the insurance companies, including CMS, money. ASC options also provide benefits to the patients with regard to access, convenience, scheduling, and wait times.

"Outpatient total joint replacement is expected to increase 457 percent for knee replacements and 633 percent for hip replacements nationally in the next decade, according to Sg2." \(^3\)

Total joint replacement is guaranteed to continue in growth, especially within the Medicare population. Cost saving measures are already being studied in the bundled payment program currently underway in certain geographic areas. The growth for OP total joint replacement is expected to grow rapidly, facilities both inpatient and outpatient need to be aware and involved in these changes in order to not only survive the revenue impact but to be sure it is a positive return to the overall healthcare system.

"However, unless hospitals come up with effective strategies to retain these volumes, factors such as independent surgeon ownership of ASCs, rising consumer demand for affordable pricing, and pending site-neutral legislation will lead to much of these volumes moving to ASCs."\(^4\)

Change is continual in healthcare as technology and clinical outcomes improve. It only stands to reason that the cost and reimbursement will decrease in relation to amount of care provided. Total joint replacements are becoming more common as the technology improves so do the recovery times; this in turn lessens the need for inpatient care.

**UPDATES ON THE CENTERS FOR MEDICARE AND MEDICAID (CMS) DISCHARGE APPEAL FORMS – Janet Ellis**

The new amended Important Message from Medicare (IM), CMS-R-193, and the Detailed Notice of Discharge (DND), CMS-10066 forms with instructions on usage are available for hospitals to provide to patients as of June 2017. These forms should be given to all inpatients with Medicare and Medicare Advantage plans.

The IM form gives patients information about their discharge appeal rights. Hospitals must give the IM form within two days of admission and again not more than two days before the discharge date. The second notice is not necessary if the initial form is given not more than two days before the discharge date, if the patient will be transferred to another inpatient setting, or if the patient’s Medicare Part A benefits are exhausted.

Those patients that wish to appeal the discharge decision must also receive the DND. The patient has a right to request a review of the decision to discharge. An expedited review is conducted by the Quality Improvement Organization (QIO). The DND must be given as soon as the patient makes this request. The form provides additional explanations as to why the discharge is appropriate and medical services are no longer medically necessary.

Hospitals are required to implement the forms by August 28, 2017. The IM form has an expiration date of 3/31/2020 and the DND form expires on 10/31/2019.

There are specific requirements that must be followed and documented when issuing the IM and DND forms and when a patient requests a QIO review. The instructions can be found in the CMS Claims Manual. Hospitals should assess their compliance and have detailed policies regarding the delivery and timeliness of the forms.

Reference:


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COMPLIANCE

BUYING A HOSPITAL, HOME HEALTH AGENCY, ASC, MEDICAL PRACTICE OR OTHER HEALTH CARE ORGANIZATION MEANS THAT THE FOUNDATION OF REVENUE CYCLE AND COMPLIANCE CAN BE THE AREAS HIDING THE PROBLEMS - Irene Torino

All across America, hospitals and physician groups are merging. Physicians are leaving their private practices to join hospital-based systems, or mega-groups. From 2014 to 2017 there were approximately 700 mergers, acquisitions, and joint ventures among U.S. hospitals and physician offices. For hospitals, ASCs, Home Care and other providers, the merging into larger entities has been fueled by many of the same issues. The changing reimbursement models, some which will begin in 2018, movement from fee-for-service to value-based reimbursement, reducing costs to provide care to patients, extending seamless care, and helping patients manage their own care.

Prior to the close of the contract, the purchaser wants to make sure that the entity being bought will provide revenue in the future. It is the multiple of an adjusted net revenue stream that is used to calculate the purchase price. So how legitimate are the current revenues? What are the risks for the future, and can the buyer be assured there are no hidden costs, liabilities, and legal/regulatory issues.

Due diligence is generally thought of as the purview of the CPAs and the lawyers. Both investigate and obtain assurances from the sellers on the numbers and the financial status of the organization. A few of them may venture into the world beneath just numbers. Questions remain on the supporting documentation, and care delivery patterns that may be outside of the expected norm. The way in which the organization operates to ensure and maintain compliance requires a much deeper focus, including: clinical, revenue cycle, coding, billing, and regulatory compliance requirements within the fabric of the organization.

One example comes to mind that proves this point: A hospital system in Florida reported to us (through their monthly management reports) that they audited their one and two day stay, and were 95% compliant. Needless to say, we were impressed, but needed to verify. Our audit found that the 95% related to the codes only (CPT and ICD-10) and only 50% of them qualified for admission.

Lack of compliance may mean that the organization (whoever owns it at that time), may be subject to repayments and penalties. Compliance includes many areas, such as use of properly credentialed staff, and providing the mandated supervision (within hospitals, home care, SNFs, medical practices) which can vary based on the type of provider. It may be simple or can be very complex. The complexity arises from different rules and regulations by type of entity, payer, provider and state.

NEW MARYLAND LAW FOR MEDICAL RECORDS – Diane Jordan

Effective October 1, 2017, a new law (House Bill (HB) 1468 / Senate Bill (SB) 584) was passed by the Maryland General Assembly which changes the circumstances under which a health care provider may disclose directory information and medical records without the authorization of the person in interest, including information that was developed primarily in connection with mental health services.

Summary: Unless the patient has restricted or prohibited the disclosure of directory information, a health care provider may disclose directory information to an individual who has asked for the patient by name.

A health care provider must inform a patient of the health care information that the provider may include in a directory and the persons to whom such information may be disclosed, and as soon as practicable, provide the patient with the opportunity to restrict or prohibit disclosure of directory information. If not practicable (because the patient is incapacitated or in need of emergency care or treatment), the health care provider may still disclose directory information if the disclosure is consistent with a prior expressed preference of the patient that is known to the provider and is determined to be in the patient’s best interest.

Further, a health care provider may disclose a medical record without the authorization of a person in interest to immediate family members of the patient or any other individual with whom the patient is known to have a close personal relationship, if the disclosure is limited to information that is directly relevant to the individual’s involvement in the patient’s health care and other conditions are met. Specifically, if the patient is available and competent before the disclosure, the patient must have been provided with an opportunity to object and either not done so (or the health care provider must be able to reasonably infer that the patient does not object). Alternatively, if the patient is not available before the disclosure is made, or objection is
not practicable because the patient is incapacitated or in need of emergency care, the provider must determine, based on the provider’s professional judgment, that the disclosure is in the patient’s best interest.

The bill also expresses the intent of the General Assembly that provisions in State law relating to the confidentiality of medical records (1) may not be interpreted to be more restrictive than the federal privacy regulations adopted under the federal Health Insurance Portability and Accountability Act (HIPAA); (2) are not intended to be in conflict with HIPAA; and (3) are to be interpreted in a way that is consistent with any federal regulations, policy guidance, and judicial decisions relating to HIPAA.

**Current Law/Background:** Health care providers may disclose specified directory information about a patient, without the authorization of a person in interest, unless the patient has instructed the health care provider in writing not to do so or the information was developed primarily in connection with mental health services. Unless the patient instructs otherwise or the records were developed primarily in connection with the provision of mental health services, health care providers may disclose medical records without the authorization of the person in interest to immediate family members of the patient or any other individual with whom the patient is known to have a close personal relationship if made in accordance with good medical or other professional practice.

**Definitions:**
- **Directory information** - information regarding the presence and general health condition of a patient admitted to or receiving emergency treatment at a health care facility. Information related to mental health services is specifically barred from disclosure.
- **Person in interest**
  - an adult on whom a health care provider maintains a medical record;
  - a person authorized to consent to health care for an adult;
  - a personal representative of a deceased person;
  - a minor, if the medical record concerns treatment to which the minor has the right to consent and has consented; or a parent, guardian, custodian, or representative of the minor designated by a court, in the discretion of the attending physician who provided the treatment to the minor under specified circumstances;
  - a parent of the minor generally, except if the parent's authority to consent to health care for the minor has been specifically limited by a court order or a valid separation agreement entered into by the parents of the minor, or another person authorized to consent to health care for the minor; or
  - an attorney appointed in writing by a person meeting another definition of person in interest.

The new law will align Maryland’s current law, which is more restrictive, to HIPAA.


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**CODING CORNER**

**SLEEP STUDY CODING – Robin Stover**

The OIG has included sleep studies in its annual Work Plan since 2012. There are several areas to keep in mind to assure compliant coding of sleep study services.

*Medical Necessity* – The symptoms that the patient is experiencing should be reported to support the necessity of a diagnostic sleep study until a definitive diagnosis can be made based on the results of the study. In the outpatient setting, a “probable”, “questionable” or “suspected” diagnosis should never be reported as a confirmed diagnosis. If the patient has already been diagnosed with a medically necessary condition to support a sleep study, such as narcolepsy or sleep apnea, worsening or recurring symptoms can be used to support the need for a repeat sleep study.

*Covered Diagnoses* – Medicare only covers three categories of diagnoses for a sleep study. They include sleep apnea, narcolepsy, and parasomnias. Many other insurance carriers require at least two symptoms before providing coverage. It is important to know what diagnoses are covered by the payer that is being billed.
**Credentials of Sleep Study Interpreter** – The physician who performs and bills for interpretation of a sleep study must be certified with either the American Board of Sleep Medicine or the American Board of Medical Specialties with a certification in Sleep Medicine.

**Sleep Study Frequency** – Medicare usually covers a follow-up sleep study if the patient experiences either significant weight gain/loss (>10% of body weight) or return of symptoms after initial positive response to a positive airway pressure device.

It is important to be aware of the diagnoses that support medical necessity of a sleep study for the insurance plan that is being billed. Physician documentation of the need for the study is integral to receive expected reimbursement for the study. Steer clear of the OIG!

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### AVOID CONFUSION FOR NEW PATIENT SUCCESS - E/M CODING – Dawn Homer

Stay diligent with the strict coding requirement you need to meet E/M encounters for new patients reflected in codes 99201-99205, or you could find yourself in a claim dispute.

Part B News has done a review of patient claims data and it shows that denials have been increasing over the past 5 years for new patient claims.

The increase of denials may be due to a lack of support for exam elements since some coders may be confusing the elements needed for an established patient versus a new patient. Some confusion may occur when a physician changes practices, or other doctors of the same specialty have seen the patient within the last three years.

Remember CPT guidelines require all three components for the new patient codes. 99204 and 99205 require a comprehensive exam which requires a review of at least eight organ systems or body areas according to the 95 E/M guidelines and at least nine if you are using 97 guidelines.

Missing by one bullet or body area causes the code to be lowered by one level.

Team work is a must. Increased communication between the front office and billing is the key to ensure that the coder knows for sure if the patient is New or Established. Some systems will give you the date of the last visit, which may help in coding the visit correctly.

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### SPECIAL ARTICLE SPOTLIGHT

**SOMETHING FOR EVERYONE IN THE PROPOSED 2018 FINAL RULE – Julie Leonard**

The proposed Final Rule for 2018 from CMS will impact all aspects of healthcare. CMS seems to be trying to ease the burden placed on healthcare providers while helping to increase the quality of care and maintaining payment levels for most providers.

“This final rule will help provide flexibility for acute and long term care hospitals as they care for Medicare’s sickest patients,” said CMS Administrator Seema Verma. “Burden reduction and payment rate increases for acute care hospitals and long term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need.”

**Quality Payment Programs (Meaningful Use, MACRA and MIPS)**

Within the Quality Payment Program, CMS has relaxed some of the requirements to participate in Meaningful Use. “CMS is adopting final policies to allow healthcare providers to use either 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT, for an EHR reporting period in 2018. This policy is based on the ongoing monitoring of progress on the deployment and implementation status of EHR technology certified to the 2015 Edition,

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as well as feedback by stakeholders expressing the need for more time and resources are needed for the transition process.\textsuperscript{5}

MIPS category weights will remain the same for FY 2018: Quality 60%, Improvement Activities 15%, Advanced Care Information (ACI) 25% and Cost 0%. “Practices with 15 or fewer eligible clinicians will receive an extra 5 point bonus to their final score just for submitting data on at least one performance category in an applicable performance period.”\textsuperscript{7}

Bonus points will be given for caring for more complex patients. “This is new for 2018 and would apply an adjustment of up to 3 bonus points by adding the average Hierarchical Conditions Category (HCC) risk score to the final score. This will award 1 to 3 points to clinicians based on the medical complexity of the patients they see.”\textsuperscript{6}

“A major accommodation to small practices was expanding the low-volume threshold for exemption from MIPS. For 2017, physicians who made $30,000 or less on Medicare Part B charges or saw 100 or fewer Medicare patients are exempt from MIPS quality-reporting requirements. For 2018, CMS proposes tripling the financial threshold, increasing it to $90,000, while doubling the patient threshold to 200.”\textsuperscript{9}

“Because CMS is proposing to make it easy to avoid the penalty (performance threshold at 15 points) the reward for MIPS eligible clinicians with a final score of 100 points could be around 3% percent (<$3,900 for a clinician with an average $130,000 of Medicare income).”\textsuperscript{10}

By easing the reporting and participation burdens CMS is encouraging quality of care over quantity of care in a push toward future payment models.

\textbf{Payment Adjustments}

An increase of almost 1% overall to the Inpatient Prospective Payment System (IPPS).95 \% is the final increase. The proposed change will affect patient payments for patients discharged between October 1, 2017 and September 30, 2018. The overall increase represents 2.4 billion dollars in an overall increase to Centers for Medicare and Medicaid (CMS) spending on inpatient hospital services.

“The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 1.2 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by a -0.6 percentage point required for productivity. This also reflects a -0.6 percent adjustment to remove the one-time adjustment of 0.6 percent made in FY 2017 for the FYs 2014–2016 effect of the adjustment to offset the estimated costs of the two midnight policy, a +0.4588 percentage point adjustment required by the 21st Century Cures Act, and the -0.75 percentage point adjustment to the update required by the Affordable Care Act.”\textsuperscript{11}

Medicare payments for disproportionate share hospitals would also be updated according to CMS’ final IPPS rule for 2018: 10 things to know Becker’s Hospital Review “CMS will use data from its National Health Expenditure Accounts instead of data from the Congressional Budget Office to estimate the percent change in the rate of uninsurance, which is used in calculating the total amount of uncompensated care payments available to Medicare Disproportionate Share Hospitals. CMS said this change will result in Medicare DSH payments increasing by $800 million in fiscal year 2019\textsuperscript{12}

\textbf{Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) will also be facing reimbursement changes.}

"Nationwide, most inpatients are treated in acute care hospitals, but some are admitted to LTCHs. In this final rule, CMS is updating the LTCH PPS standard Federal payment rate by 1 percent, consistent with the provisions of the Medicare Access and CHIP Reauthorization Act of 2015. This is the payment rate applicable to LTCH patients that meet certain clinical criteria under the dual rate LTCH PPS payment system required by the Pathway for SGR Reform Act of 2013. Overall, under the changes included in this final rule, CMS projects that LTCH PPS payments will decrease by approximately 2.4 percent, or

\begin{itemize}
  \item \textsuperscript{5} https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html
  \item \textsuperscript{7} http://www.grouponehealthsource.com/blog/cms-proposes-quality-payment-program-rule-for-2018-heres-what-you-need-to-know
  \item \textsuperscript{8} http://www.grouponehealthsource.com/blog/cms-proposes-quality-payment-program-rule-for-2018-heres-what-you-need-to-know
  \item \textsuperscript{9} https://assets.ama-assn.org/sub/advocacy-update/2017-06-29.html?utm_source=Selligent&utm_medium=email&utm_term=%25m%25d%25y&utm_content=Advocacy+Update_add1_06-29-17&utm_campaign=Advocacy+Update&utm_uid=9925790&utm_effort=
  \item \textsuperscript{10} https://mdinteractive.com/2018-mips-rules
  \item \textsuperscript{11} https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html#
  \item \textsuperscript{12} http://www.beckershospitalreview.com/finance/cms-final-ipps-rule-for-2018-10-things-to-know.html
\end{itemize}
Easing the Requirements for CAH and Prolonging the Rural Community Hospital Demonstration

A Notice Regarding Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement is included in the Final Rule for 2018. It does not change the documentation requirements for the clinicians but it does reduce the risk associated with documentation errors which do not constitute fraud and abuse.

"For inpatient CAH services to be payable under Medicare Part A, the statute requires that a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Based on feedback from stakeholders, CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers. In this final rule, CMS is reiterating the notification provided in the proposed rule that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017. This means that absent concerns of probable fraud, waste, or abuse, CAHs should not expect to receive medical record requests from QIOs, MACs, RACs, or the SRMC related to the 96-hour certification requirement."

The final rule also implements a statutory five-year extension of the Rural Community Hospital Demonstration. The Medicare Modernization Acct (MMA) requires that this demonstration be budget neutral. In the proposed rule CMS has adjusted the IPPS payment amounts to account for the added cost of this demonstration, spreading the budget neutrality across the payment system rather than macros the participant of the Rural Community Hospital Demonstration.

"The 21st Century Cures Act allows for hospitals that were participating in the demonstration as of the last day of the initial 5-year period, or as of December 30, 2014, to participate in this second extension period unless the hospital makes an election to discontinue participation. The statute also requires that no later than 120 days after enactment of the law, a request for applications be issued for additional hospitals to participate in the demonstration program for the second 5-year extension period, so long as the maximum number of 30 hospitals stipulated by the Affordable Care Act is not exceeded."

It is apparent that CMS is striving to relieve the burdens of reporting and technology and allowing for continuous care of the sickest patients. The Proposed Rule comments are open until September 11, 2017 after being finalized the proposed rule will go into effect on October 1, 2017. These are just some of the updates found in the Final Rule. With over 2,000 pages, there is a lot of information to be reviewed. Stay tuned….more to come in the following months.

OTHER ARTICLES OF INTEREST

THINKING OUTSIDE THE “BOX”…WELL, HOSPITAL – Charlotte Kohler

For anyone who has had to go to an emergency department in the last year, especially in the Spring during the “flu season”, the ED is very crowded. Then, add that all hospitals are struggling to reduce ED visits and especially readmissions. Reading about how an insurance company handled the need and reduced the costs, is really “thinking out of the box”. BlueCross BlueShield of New Mexico established a partnership with community paramedics. It’s the insurer's

13 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html#
15 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html#
16 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html#
Community Paramedicine program, which started out as a pilot project in the fall of 2015, and is targeted at Medicaid members who have either been identified as emergency room super-users or are at high risk for readmission within 30 days of being discharged from the hospital. What really got the program off the ground was that BCBSNM figured out a “claims-based approach” to pay for home visits. The result is the insurer has control over how many home visits are going to occur and who will receive them.

The recently published preliminary results show promising results: Since the program’s full launch in 2016, BCBSNM estimates that it saved $1.7 million—after taking into account the cost of the program itself. Among the 1,100 participating members, there was a 62% reduction in ER utilization and a 63% reduction in ambulance usage.

Further, the 30-day readmission rate among BCBSNM’s members has dropped from 15% to 11.2% since the paramedicine program began. Their Medical Director, Dr. Ross, cautions that there have been several programs centered on these issues, but believes the bulk of the results come from the paramedic program.

The linchpin is the proactive (rather than reactive) house call. Sometimes, there may be follow up visits planned. The program respects the patient by having the paramedic call first to make sure the member is agreeable to a home visit, and they don’t arrive in an ambulance. The paramedics have access to the patient information related to their diagnosis; who their primary care physician is and how to use primary care services; and how to reach a care coordinator with BCBSNM. Part of the program goal is to improve the patient to primary care doctor relationship often not in place with ER super-users because they tend to have a long-established habit of getting all their care through the emergency room. What is interesting is that the paramedics check patients’ vital signs, but typically don’t administer any other type of care.

These paramedic visits occur within 48 hours of discharge. For patients at risk of readmission, paramedics take the extra step of making sure they understand—and can follow—the hospital’s post-discharge care plan. That can involve ensuring they have a way to pick up any needed medications and know how to take them, and ensuring that they’re aware of and can find transportation to follow-up doctor visits.

The home visits encompass the added benefit of having the paramedics also conduct a home assessment to check, for instance, whether the residence has any hygiene issues, whether there are fall hazards and whether there’s food in the refrigerator.

There are other programs. For example, the North Memorial Health system in Minneapolis started a program in 2012 that used community paramedics to conduct home visits with patients who visited the ER nine or more times in a year.

ADDITIONAL INFORMATION

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