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.

Kohler Connection Webinars and Speaking Engagements:

- **3/5/18 and 3/6/18 -** Spring MD HFMA Conference in Annapolis. Charlotte Kohler, President, Kohler HealthCare Consulting, Inc. and Kristen M. Bohl, Esquire, Principal, Baker Donelson are speaking on "***You Need to Worry About the Stupid Things***", concerning compliance and the law centered around hospitals on supervision requirements and provider based charges.

New KHC Staff:

- ***Jessica Felder*** **is our new Office Manager effective 1/2/18 and will also be our new biller. She can be reached at our main office number, 410-461-5116 or jfelder@kohlerhc.com.**

- ***Sara Rivenburgh*** **has joined KHC as a Manager effective 1/9/18. She has over twenty years of experience in the medical administrative field, serving in both private physician practice and hospital settings. Most recently, she brought her extensive knowledge of medical practice and terminology to the hospital setting working with charge master and other reimbursement projects. You can contact Sara on srivenburgh@kohlerhc.com.**

- ***Susan Elaine Santoro*****, FACHE, MBA is a Managing Director effective 12/18/17 with a diversified industry experience including senior level positions as well as national and international management consulting to C-Suite executives. Leveraging a healthcare executive background, ten-year advisory experience at highly regarded professional services firms focused on assisting providers with transformation through strategic growth, performance improvement, and implementation. Susan can be reached at ssantoro@kohlerhc.com.**

- **Correction: For all of our Maryland 340b Hospital Clients.** Please note that you are exempt from the new 340b modifier requirement for January 1, 2018. [Source: 11/13/2017 Federal Register, page 52509].

- **Interesting Statistics Regarding Nursing Home Costs in Maryland**. The AARP reports that the median annual cost of a private room in a nursing home in Maryland is $113,333, while the median income for a household with a 60-plus resident is $53,401. (aarp.org/itssscorecard).

- **Free Online Pill Identifier Tool**. Provided at http://healthtools.aarp.org/pill-identifier or at https://pill-id.webpoisoncontrol.org/?gclid=Cj0KCQiA1afSBRD2ARIsAEvBsNn8C3lAWTXOeU6rf9zcDCcyN8WVjLQX1EgMmCDV5qZwrscNqvu7jyMaAiGHEALw_wcB#/intro

- **Jan 2018 Rehab Modifiers.** KHC is starting to hear from our clients that at least one payer so far (Blue Cross) is requiring the 96 and 97 modifiers for Rehab. For more information: http://www.asha.org/Practice/reimbursement/coding/new_codes_slp.htm

- **January 1 FY Imaging Modifier.** Per recent correspondence KHC received from the Center for Medicare and Medicaid Services, this modifier is not applicable for Maryland hospitals as they are not reimbursed under the Outpatient Prospective Payment System.

- **Let's Encourage MedPAC - "Kill" MIPS.** The weight of this program on physicians is great and the value is questionable. In a report from *Modern Healthcare*, the Medicare Payment Advisory Commission voted 14-2 to recommend the elimination of the Merit-based Incentive Payment System, with MedPAC policy analysts saying the system is too burdensome and complex for doctors and won't encourage higher-value care. MedPAC proposed replacing MIPS with a voluntary program, under which 2% of payments to clinicians would be withheld unless they agree to join an advanced payment model or choose to be evaluated as part of a larger group based on population-level quality, value and patient experience.

- **Many Reasons to be Concerned About Knee Replacements Off the Inpatient Only List.** For some Medicare beneficiaries, the idea of being able to have a knee replacement on an outpatient basis and then go home can be very appealing. Further there are many surgeons who prefer to do it on an outpatient basis. On the other hand, it means that each physician needs to evaluate the patient and the need for follow-up care both in a hospital and a rehab facility before the decision is made to go the route of outpatient surgery. Before, there were no documentation requirements to have the knee replacement procedure performed on an inpatient basis—it was required. Now there is a choice. If the knee replacement is performed on an outpatient basis, it means that the patient will not meet the three day requirement for rehab services. That means that all rehab services will end up being paid under professional services in some part and for most part by the beneficiary. This doesn't consider the impact to many hospitals that will be paid less for outpatient surgery even though the same services may be provided. It's time to take a look at this new "opportunity" and make sure that the physicians and the patients understand the impact of the outpatient surgery choice.

- **ICD-10 Code X31 = Exposure to Excessive Cold**

- Please follow KHC on Linked In: https://www.linkedin.com/company/kohler-healthcare-consulting-inc.

HCPro Books Authored by KHC Staff:

Long Term Care From A to Z, Written by KHC Staff— published in December 2016. The book is now available for sale thru: https://hcmarketplace.com/long-term-care-billing. See website for more details.

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

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

CMS, OIG AND MEDICARE UPDATES

PAYMENT CHANGES FOR 340B – Deanna Turner

CMS has finalized the 2018 final rule for Hospital Outpatient Prospective Payment System (OPPS) including a change in payments in the 340B program. In the media release[1] Seema Verma, Administrator of CMS, stated, "As part of the President's priority to lower the cost of prescription drugs, Medicare is taking steps to lower the costs Medicare patients pay for certain drugs in the hospital outpatient setting. Medicare beneficiaries would benefit from the discounts hospitals receive under the 340B Program by saving an estimated $320 million on co-payments for these drugs in 2018 alone."

The final rule will have an enormous impact on a large number of hospitals who acquire their drugs through the 340B drug discount program. CMS currently reimburses all hospitals for separately payable drugs at the standard average sales price (ASP) plus 6%. For 2018, the agency proposes a dramatic decrease in what it would pay hospitals participating in the 340B program for separately payable drugs, excluding those with pass-through status and vaccines, at ASP minus 22.5%. The current payment rate will continue for vaccines, and sole community hospitals in rural areas; children's hospitals and prospective payment system-exempt cancer hospitals will be excluded from this payment adjustment for 2018.

American Hospital Association (AHA) Executive Vice President Tom Nickels said, "CMS' decision in today's rule to cut Medicare payments to hospitals for drugs covered under the 340B program will dramatically threaten access to healthcare for many patients, including uninsured and other vulnerable populations."[2] The AHA is joining two other hospital lobbying groups — America's Essential Hospitals and the Association of American Medical Colleges — in a lawsuit against CMS over the payment cuts for 340B drugs.

THE EXPANDED MEDICARE DIABETES PREVENTION PROGRAM (MDPP) – Janet Ellis

In July 2017, the Centers for Medicare and Medicaid Services (CMS) presented the calendar year 2018 Physician Fee Schedule proposed rule outlining the expansion policies for the MDPP. The expansion policies were developed as a result of the positive outcomes from the previous MDPP. The results document that there was a reduction in developing type 2 diabetes with lifestyle changes by 58 percent. The effective date for the new program is April 1, 2018. MDPP services are available only once in an eligible beneficiary's lifetime. Participants must undergo a four month program of weekly meetings consisting of 16 sessions. A monthly maintenance schedule of six months will follow to be sure of adherence to healthy lifestyle changes. Monthly sessions for 12 months to follow will be offered. MDPP suppliers are required to use an approved curriculum and topics to present at the sessions which have been approved by the Centers for Disease Control (CDC).

The new policies would provide increased access for Medicare beneficiaries to diabetic preventive services, which would lead to enhancements in their health status, reduced costs for care, and a lowered rate of progressing to type 2 diabetes. It is expected that the services outlined in the program would be provided in-person. To be eligible for participation in the program, the participant must meet all of the following criteria:

- Enrolled in Medicare Part B
- BMI of at least 25 or 23 if Asian
- A1C value between 5.7 and 6.4 percent
- Fasting glucose-110-125mg/dL or a glucose tolerance test - 140-199 mg/dL
- Have not been previously diagnosed with type 1 or type 2 diabetes; other than gestational diabetes. Participants are still eligible if they are diagnosed with diabetes type 1 or 2 during the program.

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-01-2.html

[2] *http://news.aha.org/article/171101-cms-releases-2018-oppsasc-final-rule*

- Have not been diagnosed with end stage renal disease

Potential suppliers could start the enrollment process on January 1, 2018. Current Medicare suppliers need to enroll independently as MDPP suppliers. Prospective suppliers must pay a fee when they enroll. Reimbursement for these services will be made by Medicare. Suppliers will be required to authenticate each session attended, the types of services provided, and the amount of weight loss when submitting a claim. Medical records should be maintained and available for review by CMS for seven years. HCPCS codes have been designated to submit claims for payment.[3]

The lifestyle change program is led by a lifestyle coach. Coaches must obtain a National Provider Identification (NPI). Coaches cannot apply to be an MDPP supplier on their own. An organization must apply for recognition and be approved through the Diabetes Prevention Recognition Program (DPRP). Lifestyle coaches are trained to use the CDC approved curriculum.

Suppliers will receive reimbursement if the following requirements are met:

- The beneficiary is eligible
- The supplier meets all program requirements including accepting mandatory assignment
- Sessions furnished by an eligible coach
- Weight loss measurement taken in person during a session
- Beneficiary meets attendance or weight loss goals (includes at least 2 sessions per maintenance interval)
- The supplier is eligible for a bridge payment

For additional questions, CMS has created the specific email address mdpp@cms.hhs.gov. In addition, there are additional workshops and webinars through the American Association of Diabetes Educators [AADE].[4]
If you would like additional information and/or assistance with starting this program, please contact Janet Ellis at jellis@kohlerhc.com.

References:
http://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program
https://innovation.cms.gov/Files/fact-sheet/mdpp-cy2018fr-fs.pdf
Novitas website – Enrollment – Medicare Diabetes Prevention Program Enrollment
https://www.midiabetesprevention.org/documents/MI-MDPP-NACDD_3-21-17.pdf

BUNDLED PAYMENTS FOR CARE IMPROVEMENT ADVANCED – Julie Leonard

The Center for Medicare and Medicaid (CMS) has announced a new payment model that continues the trend away from fee-for-service and towards quality of care incentives. The Bundled Payments for Care Improvement Advanced (BPCI Advanced) is the most recent quality of care model for payment that providers may participate in.

"CMS is proud to announce this Administration's first Advanced APM," said CMS administrator Seema Verma. "BPCI Advanced builds on the earlier success of bundled payment models and is an important step in the move away from fee-for-service and towards paying for value. Under this model, providers will have an incentive to deliver efficient, high-quality care."[5] The Model Performance Period of BPCI Advanced will start on October 1, 2018 and run through December 31, 2023.

"BPCI Advanced aims to encourage clinicians to redesign care delivery by adopting best practices, reducing variation from standards of care, and providing a clinically appropriate level of services for patients throughout a Clinical Episode. BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare fee for services (FFS)

[3] Page 16 - https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-12-05-Diabetes-Prevention-Presentation.pdf
[4] https://www.diabeteseducation.org/dpp
[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-09.html

spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode, including outlier payments, will be part of the Clinical Episode expenditures for purposes of the Target Price and reconciliation calculations, unless specifically excluded."[6]

As with other quality of care payment initiatives, the BCPI Advanced is based on bundled payments for episode of care rather than payment for each encounter a provider has with a beneficiary. Not all providers are eligible to participate in the BCPI Advanced model - the following types of providers cannot participate in the BCPI Advanced model: "Exempt Cancer Hospitals, Inpatient Psychiatric facilities, Critical Access Hospitals, hospitals in Maryland, and hospitals participating in the Rural Community Hospital Demonstration and Participant Hospitals in the Pennsylvania Rural Health model are all excluded from the definition of an Acute Care Hospital for purposes of BPCI Advanced."[7]

- Currently CMS has a list of twenty-nine (29) Inpatient and three (3) clinical episodes eligible for the BCPI Advanced payment model: disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis *(New episode added to BPCI Advanced), acute myocardial infarction, back & neck except spinal fusion, cardiac arrhythmia, cardiac defibrillator, cardiac valve, cellulitis, cervical spinal fusion, COPD, bronchitis, asthma, combined anterior posterior spinal fusion, congestive heart failure, coronary artery bypass graft, double joint replacement of the lower extremity, fractures of the femur and hip or pelvis, gastrointestinal hemorrhage, gastrointestinal obstruction, hip and femur procedures except major joint, lower extremity/humerus procedure except hip, foot, femur, major bowel procedure, major joint replacement of the lower extremity, major joint replacement of the upper extremity, pacemaker, percutaneous coronary intervention, renal failure, sepsis, simple pneumonia and respiratory infections, spinal fusion (non-cervical), stroke, and urinary tract infection are all inpatient episodes of care, and Percutaneous Coronary Intervention (PCI), Cardiac Defibrillator, Back & Neck except Spinal Fusion are the three outpatient episodes of care.

For more information on the BCPI Advanced program, CMS has created the following home page: https://innovation.cms.gov/initiatives/bpci-advanced. There is also a frequently asked questions page: https://innovation.cms.gov/Files/x/bpci-advanced-faqs.pdf. CMS will also be offering an overview and application process information session on January 30, 2018.

CMS will continue the move toward reimbursement for quality of care and away from fee-for –service as mandated in the 2015 Medicare Access and Chip Reauthorization Act or MACRA which requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid in Medicare.

OIG SELF-DISCLOSURE PROTOCOLS (SDP) – Khalida Burton

Does your organization self-disclose Medicare and Medicaid overpayments? If the answer is no, maybe you should consider doing so. The OIG established a process for healthcare providers to voluntarily identify, disclose and resolve instances of potential fraud involving federal healthcare programs. These protocols were established to detail and prevent fraudulent and abusive activities. Why should providers self-disclose? The answer is simple: (1) self-disclosure establishes good faith with the OIG; (2) the providers' damages could be less. The OIG's general practice for SDP is to require a minimum multiplier of 1.5 times the single damages; and (3) self-disclosing may mitigate potential exposure regarding the timeliness of reporting and returning overpayments. Section 1128j(d)(2) of the Acts requires that a Medicare and Medicaid overpayment be reported and returned by the later of (1) the date that is 60 days after the date on which the overpayment was identified or; (2) the date any corresponding cost report is due, if applicable.

There are requirements for utilizing SDP; for example, providers must conduct internal investigations and report its findings to the OIG in its submission. If the internal investigation is not completed at the time of submission, providers must certify that the investigation will be submitted within 90 days of its initial submission.

For more information, please visit: https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp

[6] https://innovation.cms.gov/initiatives/bpci-advanced
[7] https://innovation.cms.gov/Files/x/bpci-advanced-faqs.pdf

CODING AND DOCUMENTATION CORNER

MODIFIERS 96 AND 97 – Simbo Famure

This year (2018) two new CPT modifiers have been introduced to specify if a service is habilitative or rehabilitative.

Modifier 96 - When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

Modifier 97 - When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

OTHER ARTICLES OF INTEREST

WHAT YOU DON'T KNOW CAN HURT YOU - EMPLOYEE SATISFACTION IN SMALL BUSINESS - Daria Malan

Satisfaction surveys are commonly thought of as an instrument in large corporations. Yet, nimble, small businesses can enact change more readily based on this invaluable data.

Why Should You Conduct An Employee Satisfaction Survey?

1. *It Provides Anonymity* - If you ask your staff how they're doing face-to-face, they're likely to say "just fine" and not much else. But, if you ask via an employee satisfaction survey in an anonymous format, you'll open yourself up to a world of insightful feedback.
2. *You'll Get Honest and Unbiased Feedback* - Don't assume you know how employees feel. A survey allows your employee to speak freely about your company. You'll be surprised at what you find out! While what they say may be hard to swallow, it's to your company's benefit to receive honest feedback. You may need to park your ego and listen.
3. *It's a Different Platform than a Performance Review* - Let's face it, using an employee satisfaction survey conducted at times other than performance reviews are a way to get more actionable commentary.
4. *You Can Reduce Turnover* - By allowing your employees to express themselves, you'll encourage their retention. Why? It's simple - they matter!
5. *Your Staff Will Be Engaged and More Productive* - You say you care about your customers, yet if your staff understands that you truly care about them too, they're much more likely to be engaged in your company's long-term goals.

Small businesses can engage our KHC consultants to measure your employee's level of satisfaction anonymously - We've done it many times! Here's our approach:

- ✓ Build individualized question set specific to you
- ✓ Administer confidential employee opinion survey
- ✓ Identify themes and barriers based on data
- ✓ Share findings/themes with leadership, then staff
- ✓ Collate and facilitate employee recommended action steps

Survey content question set will be designed to delve into the following overarching areas:

- ✓ What's working?

- ✓ What's not working?
- ✓ What are we doing that we shouldn't be doing?
- ✓ What should we be doing that we aren't doing?

Collection and collation of anonymous data will then be provided to provoke leadership to visualize:

- ✓ "Here's what"- the current situation
- ✓ "So what?"- implications
- ✓ "Now what?"- recommendations and next steps

To get started or obtain more information, contact Daria Malan, RN, MBA, LNHA, RAC-CT®, CPC®, at dmalan@kohlerhc.com or call her directly 410-598-1221.

AS TELEMEDICINE USE INCREASES, DOES THAT MEAN WE NEED A NEW MEDICAL SPECIALIST? WHY NOT A MEDICAL VIRTUALIST? - Charlotte Kohler

Two physicians, Drs. Michael Nochomovitz and Rahul Sharma of New York Presbyterian, published an article in the online *JAMA,* November 27, 2017, outlining the need to have physicians certified as being proficient in telemedicine care. Article Information . There are many citations that I have maintained from their article that may be interesting to our readers.

There are currently 860 000 physicians with active certifications through the American Board of Medical Specialties and 34 000 through the American Osteopathic Association. The reasoning behind development of a "specialty" is to leverage technology and new knowledge into a structured approach, which results in medical specialties such as geriatrics, palliative care, hospitalists, laborists, and extensivists, to name a few. These clinical areas do not yet have formal training programs or certification but are specific disciplines with core competencies and measures of performance that might be likely recognized in the future. Specific core competencies and curricula are beginning to be developed at some institutions, adding medical training for a specific discipline, knowledge of legal and clinical limitations of virtual care, competencies in virtual examination using the patient or families, "virtual visit presence training," and inclusion of on-site clinical measurements.

Since many of our clients are exploring unique uses for telemedicine (the delivery of health care services remotely by the use of various telecommunications modalities), we have been active in evaluating coding, documentation, licensing and regulatory issues surrounding the expansion of web-based services, use of videoconferencing in daily communication, and social media. Consumers of health care are factors driving exponential growth in telehealth, but it's still in its infancy in use and technology.

According to one estimate, the global telehealth market is projected to increase at an annual compounded rate of 30% between 2017 and 2022, achieving an estimated value of $12.1 billion.[2] Some recent market surveys show that more than 70% of consumers would consider a virtual health care service.[3] Based on early experience in primary care, one estimate suggests that 30% to 50% of visits could possibly be eligible for a virtual encounter.[4] A preponderance of higher income and privately insured consumers indicate a preference for telehealth, particularly when reassured of the quality of the care and the appropriate scope of the virtual visit.[3] Telemedicine is being used to provide health care to some traditionally underserved and rural areas across the United States and increased shortages of primary care and specialty physicians are anticipated in those areas.[4]

How is telemedicine being used? The changes in both physicians and the patients have resulted in more physicians and other clinicians delivering virtual care in almost every medical discipline. Second-opinion services, emergency department express care, virtual intensive care units (ICUs), tele-stroke with mobile stroke units, telepsychiatry, and remote services for post-acute care are some examples. Patients like the face-to-face features of communications with their providers. While in London this year, there are significant advertisements regarding telemedicine visits at a flat fee price (about $100 US).

Drs. Nochomovitz and Sharma are proposing the new specialty for the *medical virtualists* -- physicians who will spend the majority or all of their time caring for patients using a virtual medium. They have not proposed a set of core competencies. Already, some commercial insurance carriers and institutional groups have developed training courses.[5] They believe that it needs to be extended across a spectrum -- to nurses, medical students, nurse practitioners, physician assistants, pharmacists, social workers, nutritionists, counselors, and educators since this approach to care will require additional learned skills. It is possible that there could be a need for physicians across multiple disciplines to become full-time medical virtualists with subspecialty differentiation. Examples could be urgent care and even sub-specialist virtualists will be needed.

The authors even suggest that the use of telemedicine could reduce the number of emergency department visits that have

been continuously increasing.[6]

Telemedicine is not limited to the medical specialists. Surgical specialties, using remote surgery, have been more focused on tele-mentoring and guiding surgeons in remote locations. True virtual surgeons have operated robotically on patients hundreds of miles away.[7] Very important as there are limited specialists in many regions.

The authors point out that the "success of technology-based services is not determined by hardware and software alone but by ease of use, perceived value, and workflow optimization". They believe that "if advances in technology continue and if rigorous evidence demonstrates that this technology improves care and outcomes and reduces cost, medical virtualists could be involved in a substantial proportion of health care delivery for the next generation". One of the many waves of the future.

HIGHLIGHTS FROM THE 3RD ANNUAL CDM FORUM – Lauren Rose

KHC has enjoyed sponsoring the annual Maryland HFMA[8] Charge Master Forum for the past three years. We are pleased that this year's event was well attended and more interactive than past years. Collaboration appeared to be the theme as ideas were shared freely. A favorite moment occurred as the forum was transitioning from the discussion to the allocated time for networking. A director from one health system volunteered to help an analyst from another health system to better understand their charge master software. The atmosphere and conversations were purposefully kept casual to ensure every voice could be heard.

The largest areas of discussion focused on three topics:

Imaging Relative Value Units: Now that the state has moved to mirroring the Medicare Physician Fee Schedule (MPFS) Non - Facility Practice Expense Relative Value units (i.e. Non Facility PE RVUs) for certain rate centers, hospitals in Maryland are to use these RVUs for new CPTs not listed in the Appendix D. The challenge is that in some cases, such as with this year's chest and abdomen X-ray updates, the CPT being deleted is similar to the CPT being added, and the deleted CPT already has an RVU in the Appendix D. At this time, only CAT, EEG, MRI, NUC, RAD, and RAT rate centers require usage of the MPFS for new CPTs. The historical "similar service" approach may still be used if there is not a MPFS for the new CPT or if it is a rate center other than the ones listed. After this year, RES, PUL, and potentially the rehabilitative rate centers of PTH, OTH, and SLP may be added to this list, as they are currently under (and/or being considered for) review by a Relative Value Unit task force.

Cognitive Therapy: The American Medical Association deleted the time-based code for cognitive therapy (CPT 97532) building a more robust and non-time based code CPT 97127. The Center for Medicare and Medicaid Services is not recognizing CPT 97127 and built HCPCS G0515 which mirrors the deleted code CPT 97532. Some hospitals will be "swapping" the 97532 for the G0515 and addressing 97127 if/when payers do not recognize the G0515. Other hospitals will be building completely new charge codes for 97127 and building alternative logic to handle the G0515 requirement. Whichever method is selected, the G-code is time-based per 15 minutes and the 97127 is billable once per session.

Anti-Coagulation Clinic Visits: The new CPT 93793 raised some questions. For many years, hospitals have had regulated Anti-Coagulation clinics to monitor patients that are taking an anti-coagulant drug such as the drug Warfarin. When this service first started, hospitals were charging lab tests and clinic visits for these patients for each visit as these patients were receiving both a lab test and a clinic visit. Then, several years later, around 2009, Novitas issued guidance that said that hospitals could only charge for a clinic visit if the patient's dosage required a change. In response, hospitals continued to charge for the lab test, but only charged a clinic visit when the dosage changed. This new CPT (which does not require a dosage change) is making hospitals question this practice and to further complicate the situation, this new CPT is a Status Indicator B and may not be appropriate for hospital use. Hospitals are doing further investigative work on this service before making any changes to their current practices.

This year's event showed that through collaboration, we are able to easily share ideas and learn from each other. If you were unable to attend this year's event and would like a copy of the presentation and/or additional information about this event, please email Lauren Rose at lrose@kohlerhc.com.

[8] Healthcare Financial Management Association

IMPROVEMENT IN MENTAL HEALTH COVERAGES - Charlotte Kohler

The 21st Century Cures Act was supposed to be a springboard for fixing the problems the nation has in behavioral health services. This was signed into law over a year ago. So far there has been a report from the Mental Illness Coordinating Committee, as mandated by the Act that indicated a shortage of psychiatrists within 96% of all US counties. Plus the number of psychiatrists has decreased by 10% from 2003 to 2013. Another aspect of this law is to train all first responders on the best way to work with a person experiencing serious mental illness. It's amazing - approximately 35% of adults with serious mental illness in 2016 did not receive treatment. However, the new HHS Assistant Secretary position to oversee mental health and substance use disorder treatment services and ensure compliance with the Mental Health Parity Law has not been filled.

The Act also called for Congress to allocate $1 billion over the next two years to support state healthcare efforts. About half of the funding has been distributed. There are disputes between communities on how the amount should be allocated. With the efforts by Congress on budget and other matters, the Cures has fallen to a very low second place and there has been some discussion about reducing funding for the Community Mental Health Block grant funding.

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 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.*