KOHLER
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Putting the pieces together

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Welcome to our newest edition of Kohler HealthCare Consulting's "*Pieces for Success*". *We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.*

IN THIS ISSUE…….

TIDBITS, ANNOUNCEMENTS AND EDUCATIONAL/SPEAKING ENGAGEMENTS

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us at 410-461-5116.

KHC NEWS

Need Help With Your Charge Description Master (CDM)? KHC has expanded our list of services to best serve our clients. Many of our options are very budget-friendly and we would love to work with your team. For more information, please visit **www.kohlerhealthcareconsulting.com** or contact Lauren Rose at lrose@kohlerhc.com or 443-421-1930.

New White Paper on Telemedicine. Contact Jessica Felder at jfelder@kohlerhc.com for a copy.

HOT OFF THE PRESSES… KHC recently confirmed with Craig Dobyski of the Center for Medicare and Medicaid Services that Genomic Sequencing Procedures (CPT codes 81410 – 81479) are included in the recent laboratory date of service policy change. For a complete list of included CPT codes, please reference CMS Transmittal 4000 at:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4000CP.pdf.

KHC also confirmed that "non-patients" (i.e. patients where the specimen was submitted to the hospital, but the patient did not present to the hospital) are not included in this regulation even if the service is provided by an external laboratory, because each of the five requirements listed in the new Date of Service exceptions must be met. The first requirement states, "the test was performed following a hospital outpatient's discharge from the hospital outpatient department". In order for a hospital to bill for a service provided by an external laboratory for a "non-patient", the hospital must have an arrangement with the external laboratory in which case the laboratory is acting as an extension of the hospital, not as a reference laboratory. For a copy of the correspondence with CMS, please email Lauren Rose at lrose@kohlerhc.com. This regulation continues to cause confusion in Maryland as there are conflicts with current state regulations.

- **Ever Wonder Why Hearing Aids Are Not Covered By Medicare?** When Medicare passed in 1965, the assumption was that hearing loss was an inevitable part of the normal aging process so hearing aids and associated services were excluded from coverage. So either we know better now or there are many more of us who have hearing loss. Based on a recent AARP Bulletin article nearly 30% of people in their 50s suffer from hearing loss, and this increases to 45% for people in their 60s. For those that are in their 70s, more than two thirds have significant hearing loss. The downside of no coverage means that the average older adult waits 7 - 10 years to get a hearing device and even that is limited to only 20% to 30% of all adults who need a hearing solution. Unfortunately, hearing loss also translates into someone who may have a greater risk of losing their ability in brain function. You may have noticed that starting in 2017 there are now more over-the-counter hearing aids available and this will increase within the next three years because of the bill that Congress passed requiring the Food and Drug Administration to regulate these devices for over-the-counter sales.

- **Maryland CDM Forum.** The Maryland CDM Forum was established as an informal and interactive way for charge master professionals to share ideas, experiences, questions, and updates regarding charge master topics impacting hospitals in the state of Maryland. Participation in this group is private and 100% voluntary with a goal of helping each other navigate charge master issues. This group is not moderated. The opinions shared are not "official guidance" and official state and national regulations should always be referenced for charge master updates. Please send an email to Khalida Burton at kburton@kohlerhc.com if you or a colleague is interested in joining the forum.

- 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

CMS RELEASES NEW GUIDELINES ON E/M SERVICE DOCUMENTATION PROVIDED BY MEDICAL STUDENTS – Deanna Turner

Effective March 5, 2018 the Centers for Medicare and Medicaid Services (CMS) issued a revision to the Medicare manual allowing teaching physicians (TP) to use all student documentation for billable services provided that the teaching physician verifies the documentation.[1] In the past, only the medical student's documentation of Review of Systems and Past, Family, and Social History did not need to be re-documented by the teaching physician.

CMS has not changed the requirement that any contribution of the student must be performed in the physical presence of the teaching physician or a resident. The teaching physician must also still either personally perform or re-perform the physical exam and medical decision making but does not need to re-document.

What *will* change, however, is how those contributions may be documented in the medical record. Specifically, this revision will now allow the teaching physician "to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work."[2]

Initially, the potential benefit is that the provider is not required to re-document services already provided. However, combining the Medical Student, Resident, APP and Teaching Physician documentation, as well as defining who is to attest to what part of the documentation and what documentation from the TP is required for different levels of providers, is unclear.

To date, there has been no additional guidance on what will be an acceptable attestation by a resident or teaching physician when the documentation of a student is used to support a billable service. Providers may want to contact their Medicare Administrative Contractor (MAC) for additional guidance for this change.

[1] Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, B.
[2] MLN Matters Number: MM10412

THE THREE HOUR RULE FOR REHABILITATION NO LONGER MANDATED – Janet Ellis

There are many patients that require continued post-acute therapy in an inpatient rehabilitation facility. It was always understood that in order to qualify for inpatient rehabilitation services, patients must be able to participate in at least three hours of therapy a day. Medicare contractors would deny claims when patients did not meet the specific time standard. This is not appropriate.

The Centers for Medicare & Medicaid Services (CMS) has published new policy statements that went into effect on March 23, 2018 that would not permit a claim to be denied based solely on the lack of a patient completing three hours of therapy a day. Instead, contractors are required to review the medical record and make clinical assessments determining if medical necessity is met based on the patient's overall care and needs. CMS has clarified more than once that the rule was misinterpreted. Yet there have been continued denials and court cases that addressed the time issue that were overturned.

Reference: www.medicareadvocacy.org/medicare-info/rehabilitation-care/

CMS-1694-P[i] PROPOSED REVISION OF HOSPITAL INPATIENT ADMISSION ORDERS DOCUMENTATION REQUIREMENTS UNDER MEDICARE PART A - Deb Carr

Background

On April 24, 2018, the Centers for Medicare & Medicaid Services (CMS) issued its proposed rule for the CY 2019 Inpatient Prospective Payment System. CMS is proposing a policy change to FY 2014 final rule 42 CFR 412.3, which required, among other conditions be met, a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment. It was CMS's belief the physician order reflects affirmation by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary and also affirms the intent to admit the patient.

In this final rule, CMS acknowledged there would be a rare circumstance if the order to admit is missing or defective, and granted the medical review contractors discretion to determine from the content of the medical record that the intent to admit was satisfied.

CMS found that some otherwise medically necessary inpatient admissions were, during the case review process, being denied payment solely due to technical discrepancies such as missing practitioner admission signatures, co-signatures or signatures occurring after discharge.

Proposed Update

CMS noted that hospitals and physicians are already required to document relevant orders in the medical record to substantiate medical necessity requirements. In looking to reduce administrative burden on physicians and providers, CMS has concluded that if other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met and the hospital is operating in accordance with the Conditions of Participation (CoPs), medical review should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than an occasional inadvertent signature documentation issue unrelated to the medical necessity of the inpatient stay.

In Conclusion

CMS is proposing to revise the regulations at 42 CFR 412.3 to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.

CMS is not proposing any change with respect to the "2 midnight" payment policy.

FINANCIAL

IT TAKES A TEAM TO MONITOR PHARMACY CHARGES – Lauren Rose and Khalida Burton

Accurate pharmacy charging can be both a challenge and an opportunity for hospitals. Pharmacy revenue represents a large amount of revenue. Managing this process involves multiple disciplines (Pharmacy, Finance/Reimbursement, Patient Financial Services, Information Technology, etc.) working together towards a common goal. Without routine dictionary audits and claim reviews, pharmacy issues can go undetected. Undercharging may lead to higher mark-ups on other drugs. Overcharging generates patient complaints and payer audits. Particularly challenging areas with pharmacy include self-administered drugs, waste and the JW modifier, and injectable drugs that do not have a HCPCS code.

This article provides a few tips providers can utilize when monitoring pharmacy charges and preventing on-going issues:

Tip #1 –Ensure the project team understands the basic system transactions before beginning an audit. From the physician order - to the pharmacy dispensing the drug - to the provider administering the drug within the medical administration record ("MAR") - and all of the steps in between, each step in the continuum is critical for a transaction to pass successfully and accurately.

Tip #2 – Review individual dictionaries - Order dictionaries should be set up with descriptions that should be user friendly to the ordering provider. The systems and dictionaries must be linked appropriately to ensure the orders flows within each system accurately. The formulary must have medications accurately defined to ensure medication errors are mitigated. In addition, certain fields (such as the NDC code) are utilized for certain payers. The interface dictionary (between the formulary and the charge description master) is essential for billing and often contains the conversion factors used for transactional adjustments. The charge description master (CDM) is essential for billing, including the description, revenue code, Healthcare Common Procedural Coding System (HCPCS) code, price, etc.; and for internal general ledger reporting.

Tip #3 - Enlist the help of your software vendor and other stakeholders – Brainstorm on how to resolve issues and/or implement new regulatory updates as a team.

Tip #4 – Review and update policies and procedures - Implement robust policies and procedures for system maintenance (including verification steps) and be sure to update these documents annually and when systems are changed. Ensure these policies and procedures address quarterly coding updates and the necessary coordination of dictionaries for these updates.

Tip #5 – Training – Conduct comprehensive trainings to ensure staff not only understand the "what" and "how" but also the "why" of the updates they are making in the dictionaries.

When performing audits, try not to let the volume of items in the pharmacy dictionary be overwhelming. It is best to split the work into a manageable scope vs. attempting to do too much all at once. Create a work plan that clearly states the objectives and detail procedures. It is best to start with drugs that are frequently used and charged by the facility or under review by Medicare (highest risk) and move to the other drugs slowly but surely.

SPOTLIGHT ON MARYLAND

DOES THIS EMPLOYMENT LAW APPLY TO MY ORGANIZATION IN MARYLAND? – Daria Malan

Labor and employment laws give structure to the workplace, define what employees and employers are responsible for and, in some cases, outline federal regulations to give both parties necessary direction for resolving workplace conflict. Labor relations employment laws are designed to protect both the employer and the employee. Below are some of the most significant Maryland employment labor-relations laws that require compliance and apply to private employers. Be aware that there are certainly other MD laws an employer might need to follow that are not listed here.

Law	Covered Employers*
MD Continuation Coverage (mini-COBRA)	All employers
MD Equal Pay Act	All employers
MD Uniform Trade Secrets Act	All employers
Job Application Fairness Act	All employers, with some exceptions
MD Flexible Leave Act (MFLA)	Employers with 15 or more employees
MD Reasonable Accommodations for Disabilities due to Pregnancy Act	Employers with 15 or more employees
Fair Employment Practices Act (FEPA)	Employers with 15 or more employees
Parental Leave Act	Employers with 15 to 49 employees

*Where "All employers" is listed, there may still be limited exceptions, such as agricultural employers or employers that employ only family members.

Other helpful information from MD Department of Labor may be found at:

http://www.dllr.state.md.us/labor/emplaws.shtml

Maryland State Bar Association offers more information to the public on Labor Laws at:

http://www.msba.org/publications/brochures/workplacerights.aspx

THE DRAFT UPDATE FACTOR AND NEW TECHNOLOGY – Lauren Rose

As anticipated, this year's draft annual rate update factor was announced at the HSCRC meeting on May 9th. The draft update factor for hospitals (excluding Mount Washington and the specialty psychiatric hospitals[3]) is 2.29%. If approved, this factor will be applied to hospital global budgets for Fiscal Year 2019. This is net of additional revenue being allocated for pharmaceuticals and other hospital-specific adjustments.

In addition to the overall updates, Johns Hopkins Hospital will be receiving additional revenue for fiscal years 2018 and 2019. The JHH revenue update largely stems from new technology expenditures, including the new CAR-T cell therapy for cancer patients[4] and Spinraza treatments for spinal muscular atrophy patients[5]. In addition, HSCRC staff stated that CAR-T therapy costs will be discussed further with University of Maryland Medical Center as well.

These new therapies generated a lengthy debate regarding new technology. These technologies are developing and spreading quickly across the country. The need for fiscal responsibility to control healthcare expenditures while still encouraging new technologies that can treat and even cure diseases is a delicate balance. Maryland is often the "petri dish" for the nation where new reimbursement methodologies are explored in a smaller environment. It will be interesting to see what develops next for Hopkins, other hospitals in Maryland, and beyond Maryland's borders with these new technologies.

CODING CORNER

CODERS REVIEWING E/M AUDIT ERRORS WITH PROVIDERS –Simbo Famure

Most providers are often primarily focused on patient care. As coders, we know that coding can be complex and take a lot of time. A good way to connect with the providers and to educate and solve problems that involve coding can be to use the following approaches:

Conduct brief group meetings with all the providers - Once a month, conduct brief meetings with all the providers that should last between 30 minutes to an hour. Use this time to provide updates on general coding observations or a current rule or guideline that would be helpful to understand why certain procedures are coded a certain way or why specific diagnosis codes can only be used for certain procedures.

Explain the components for assigning levels for patient visits (Evaluation and Management Codes) – Due to templates being incorporated into electronic health records, many providers have learned how to document components of each patient visit. However, it is important to let the providers know what specific components are required for a variety of visits. For example, it is important in Initial Patient Visits for the provider to document enough information for a Detailed or Comprehensive History.

Answer questions and use non-coder language when explaining - It is always important to be available to answer questions especially when you make corrections to the provider's coding or require that they make changes to their documentation. As providers they need to understand how and why the work they have performed is assigned a particular code in a simple and basic way.

MODIFIER 59 – Julie Leonard

Modifier 59 is the modifier loved in all healthcare provider offices. Modifier 59 is also one of the most overused and abused modifiers in all of healthcare. As a result, Modifier 59 is also one of the areas of clinical review for most carriers and has been a focus of the Office of Inspector General and Centers for Medicare and Medicaid (CMS) dating back to 2005 and a recently as 2017. In order to use modifier 59 properly and not just to bypass the editing

[3] Mount Washington and specialty psychiatric hospitals will be receiving a rate update of 1.77%.

[4] For more information, see https://www.cancer.gov/publications/dictionaries/cancer-terms/def/car-t-cell-therapy

[5] For more information, see http://www.raredr.com/news/fda-approves-spinraza

software programs used in claims processing, there are a few things that need to be understood. The CPT Manual defines Modifier 59 as follows: Distinct Procedural Service; "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day."

According to the CMS Modifier 59 Article:
[https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf],

the documentation must support one of the following in order to be considered "distinct":

- different session,
- different procedure or surgery,
- different site or organ system,
- separate incision/excision,
- separate lesion, or
- separate injury (or area of injury in extensive injuries)

Modifier 59 should not be used when a more descriptive modifier is appropriate to explain the circumstance that supports a distinct service such as an anatomic modifier (LT, RT, E1-E4, FA-F9, TA-T9LC, LD, LM, RC or RI). Some payers will accept the "X" modifiers (XE, XS, XP, XU) in place of Modifier 59. It is recommended to check with contracted payers for regulations regarding the X Modifiers

Modifier 59 should not be appended to any Evaluation and Management services.

"Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites." (CMS Modifier 59 Article).

Modifier 59 is valuable modifier and serves a purpose when used correctly to communicate with the payer. Modifier 59 should never be used to bypass an edit when the medical documentation does not support the distinct procedural services.

PROFESSIONAL CONFERENCE NEWS

NEWS FROM THE HEALTH CARE COMPLIANCE ASSOCIATION MEETING – Charlotte Kohler

As usual, more excellent sessions were held than a person can attend. Some Items that are worth mentioning and many require legal advice and guidance:

- Very interesting and complicated consent as well as "mandated reporting" for ***behavioral health services***. 42 C.F.R. Part 2 provides significant requirements which should be reviewed. Ensure that these "additional" requirements are understood and handled. Another issue discussed was the need to specify exactly how EMTALA is applied within the Emergency Department – including transport of the psychiatric patient to another facility, which is very different than a medical transport.
- More physicians are losing their licenses because of prescribing – the standard that was "knowingly and intentionally" has now moved to "willful blindness" and is being followed by Federal Courts. Meaning that not asking the patient questions does not eliminate liability. [Katz case] Use the new CDC guidelines – there are several. For example, see: https://www.cdc.gov/drugoverdose/prescribing/guideline.html
- For DME, improvements in appeals to Medicare. Once one claim is appealed and a decision made, all other claims with the same issue in the backlog of appeals are deemed to be concluded as well. Comment made that 72% are generally won on an appeal.
- The OIG wants YOU to perform the data analytics before they find you. The use of data analytics is key to the federal government in identifying who to go after – and they have the "facts". Read: https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf

OTHER ARTICLES OF INTEREST

EMPLOYEE VS. INDEPENDENT CONTRACTOR – Khalida S. Burton

Have you ever wondered if the individual you contracted with is "really" an independent contractor? Should this individual have been treated as an employee? Did you know that receiving or issuing IRS Form 1099-MISC does not make a person an independent contractor under the Fair Labor Standards Act ("FLSA")? Even if designated an independent contract under another law (for example – tax law or state law), the individual may still be an employee under FLSA.

The Department of Labor ("DOL") has been cracking down on the misclassification targeting employers and industries that deliberately misclassify their workers in an attempt to cut costs. According to the DOL, if the worker is economically dependent on the employer, the worker should be classified as an employee and is able to reap the benefits of employee status. Companies must look at the totality of the worker's circumstances when classifying an individual as a contractor or employee. Misclassification can result in significant liability.

The IRS has provided guidance on determining whether individuals providing services are employees or independent contractors. Organizations must first know the business relationship that exists between you and the individual performing the services. The determination of whether an individual is an employee or an independent contractor is based on common law rules, which look at the relationship between the individual and the organization. The determination of worker status depends on several factors, including: the extent to which the organization receiving the services has the right to direct and control the individual on what is to be done and how it is to be done.

Ask the following questions in determining the appropriate status:

- Does your organization control what and how the individual does their job?
- Does your organization control how the individual is paid or reimbursed?
- Does your organization provide tools and supplies for the individual?
- Does your organization have written contracts governing benefits and etc.?
- Does the individual employee other individuals?
- Is the work provided by the individual a key aspect of your business?
- Will this work continue after the individual is longer there?

The proper classification of the independent contractor versus employer is not always straightforward. Correctly classifying workers before they perform services can save your organization from future headaches.

For more information:

Internal Revenue Service: Independent Contractor or Employee. Click here.

Department of Labor: Misclassification of Employees as Independent Contractors. Click here.

MARYLAND REQUIRES SICK LEAVE – Jessica Felder

The Maryland Healthy Working Families Act, a law that requires Maryland employers to provide accrued sick and safe leave to their employees, went into effect on February 11, 2018. According to the Society for Human Resource Management[6], the law applies to all employees in the State of Maryland that are at least 18 years of age and work a minimum of 12 hours per week. The law states that employees who meet these criteria are able to accrue 1 hour of sick and safe leave for every 30 hours worked to a total amount that is not to exceed 40 hours per year.

The availability of this accrued sick and safe time is required, but whether this time is paid is determined by company/employer size. Any employer with 15 or more employees must provide the leave as paid and employers with 14 employees or less have the option to provide the time as unpaid. To determine the employee

[6] https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/maryland-passes-paid-sick-leave-law.aspx

threshold for a company, the employer is to include all full-time, part-time, temporary and seasonal employees. The employer is only required to count those who are employees in the State of Maryland. If an employee is not located in Maryland they do not get included in the employer threshold amount.

While the general understanding is that all employees located in Maryland are eligible for these benefits, this is not accurate. There are 8 types of employees that are exempt from accruing sick and safe leave benefits and they are listed below.

1. *Employees who regularly work less than 12 hours a week;*
2. *Certain independent contractors;*
3. *Certain associate real estate brokers and real estate salespersons;*
4. *Individuals who are younger than 18 years of age before the beginning of the year;*
5. *Individuals employed in the agricultural sector in certain agricultural operations as defined in §5-403 of the Courts and Judicial Proceedings Article of the Maryland Annotated Code;*
6. *Certain construction workers covered by a collective bargaining agreement;*
7. *Certain employees working on an as-needed basis in a health or human service industry; and,*
8. *Certain employees of a temporary services agency.* [7]

Once time begins accruing, an employer may be concerned with the criteria in which time may be used by the employee. The State of Maryland Department of Labor, Licensing and Regulation have outlined this information on an employee poster which is available on their website and includes the following:

- *To care for or treat the employee's mental or physical illness, injury or condition;*
- *To obtain preventative medical care for the employee or the employee's family member;*
- *To care for a family member with a mental or physical illness, injury or condition;*
- *For maternity or paternity leave; or*
- *The absence from work is necessary due to domestic violence, sexual assault or stalking committed against the employee or the employee's family member and the leave is being used.*[8]

Additional information and sample policies can be found at: https://www.dllr.state.md.us/paidleave/.

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.*

[7] Department of Labor, Licensing and Regulation website: https://www.dllr.state.md.us/paidleave/paidleavefaqs.shtml#appel

[8] Text obtained for DLLR Paid Leave Model online at https://www.dllr.state.md.us/paidleave/paidleavemodel.shtml