BEST PRACTICES MINUTES
March 2, 2015 RIC/RAC Meeting

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt
Ms. Claire Owens

MR. ASHMORE: Claire Owens from Baptist Health System is going to start us off today with best practices for hospice. And then Karen Northcutt will share some updates with you.

MS. OWENS: Good morning. I am going to tell you a little bit about our journey, not necessarily best practices. And I have a couple of gentlemen here from Baptist as well that work directly with hospice, Jeff Butler in compliance and Brian Patterson from our corporate business office. And so they might get a shout or two because they know a lot more about this than I do.

But basically most of you know that last year we started getting these 07 audits. And it was about probably 2013 when the OIG put out a report for hospice related to JIP payments and the overuse of JIP payments. So as the perversity of health care reimbursement goes, you know, they push people towards hospice, hospice starts using the services, and then OIG comes in and says there must be a problem.

So that happened in the 2012/2013 time frame. Cahaba, according to its website, did some probe audits that showed a very high error rate related to the use of the 07 modifier. And of course, that's what we put on our Part A claims to indicate that that care is not related to the hospice service. So when a patient comes into the facility and they're on hospice, we put that on.

So about a year ago I was real geared up about two midnight. I thought, wow, this is where all our focus and our education will be. My department, fiscal integrity, we are a compliance department, so we had been working very diligently with our case management staffs to try to make sure that we understood, to the extent that we could, what was going on with two midnight.

And then, of course, at least at our four facilities, it wasn't a big deal. The probe and educate was relatively benign, you know, and we did not, even in our largest facility, have a whole lot of claims pulled. We were all very worried about getting the hundred charts pulled we got into that round. And it looks like even Round three folks that are advancing are not going to get a hundred charts audited. So that was all really good.

And then this 07 thing came out of the blue. As we looked back and did our wrap-up for 2014 for our audit committee at Baptist, we looked back and we saw the vast majority - well over 80 percent of the prepayment claims - were related to this hospice 07 billing indicator.

And so Jeff, who is a supervisor for our department, he worked with the nurse auditors and they started tracking these things. And there were several things that popped up related to this. And, again, if you have some different experiences, please feel free to share.

But the volume that I just spoke of related to these audits, they were very high dollar, some of them. We had claims out there $50,000, $80,000. Some of them were more long stay. It was very, very time-consuming.

And so we have one nurse auditor who specifically handles everything related to hospice for Baptist. Because there are many issues, it was multifactorial, it was not one thing if you got this fixed and then everything else was okay, so she became our in-house expert.

And for those of you that are going to the AlaHA/HFMA summit in Pelham next month, she's going to be on the panel. Because we want her to give you some more detail on this.

We also felt like we had to learn an additional set of regs. We only have hospice in one of our smallest hospital, Citizens Baptist is just starting to get into a little bit of providing as a hospice provider,

and we use an outside management company that does that. So we weren't really familiar with what their requirements were. So that was a challenge to get into their billing manual and kind of learn those regs and kind of get ourselves up to speed on what they need. So that was one of our best practice things was to learn that.

What was interesting in thinking about some of the issues that arose with this is normally when we are defending an appeal, you're dealing with one payer. You're dealing with Medicare. Or if it's a Medicare Advantage, you're dealing with whoever that commercial payer is. And in this case, with the 07s, you're kind of caught between two. Right? Is the hospice going to pay me or is Medicare going to pay me? So you had to work with both people.

Beneficiary death. So a lot of times, by the time it had gotten billed, the bill had been dropped, sometimes we had to go back and put the 07 on and then bill it again. And then it went through the process and got denied in the audit and got to us. The beneficiary had expired. We're now getting into things where the hospice is saying the beneficiary is liable. Well, by the time all these things happen, you could have perhaps missed a notice requirement issue. Right? So for a beneficiary death, they're going to probate a will. And if they're not going to probate it, then they may not have the assets that they would need to pay you anyway. So it's probably moot.

And then, finally, the patient understanding of hospice is payer. And we really found that that was a key issue. That when patients come in, especially in a debilitated state like they would be when they're coming in - they were already on hospice and then they're presenting to your facility - that there was a lack of understanding when our patient access folks reached out, that they thought Medicare is my payer. Right? Who's your insurance with? It's Medicare. They don't understand hospice - to them, it's like home health. You know, you wouldn't go to the hospital and say ABC Home Health is my payer when they asked you about insurance.

So those were some of the issues, kind of collectively, that we found. And when the dollars started adding up and hitting our reports around last May we started to try to get the word out. And the first thing was really reaching out to our CFOs and our finance people and saying this is a problem and it's big dollars and it's just building and it was a wave. And then getting with our CBO and understanding how the billing stuff worked - a lot of you already are those people - and then bringing in patient access, case management, palliative care, and contracting.

So those were really what we felt like we needed when we finally got everybody to the table and wrapped our arms around it, that's who we needed to have at the table. We needed compliance, we needed legal, we needed contracting, billing, patient access, case management, and palliative care.

We only had palliative care at our two larger hospitals. Our two smaller hospitals didn't have it. So we had to use case management. And the first thing we did was we generated a very simple little education sheet for case management and for the patient access folks. Because people had a general idea of how hospice works, but it wasn't nearly the depth that our billing folks really understood. And they had to kind of teach us, and then we went out and we did some additional homework and asked some questions of Cahaba and learned from that. So just getting that basic sheet out of what hospice is, how people elect, what the periods are, and then the way that you discharge from hospice.

So there's, like, five ways; revocation being one of the five ways. It was very important to distinguish between a discharge and a revocation. Because as you guys know, that's very different from a billing standpoint, so that our case management and our patient access folks really knew that those two things were not the same. So we wanted to make sure to get that out. We did some education, brought those folks in.

Then with our contracting and legal folks, it was very important - we had some good hospice partners in our market - to really work with them, especially the ones that were under contract with us and say, you know, this is going on. We're seeing this. We're going to be sending a lot of stuff back to you, and we need your help and your support in understanding what we're doing and why you're seeing this from us. Because they really hadn't. We took it on good faith. They said it's not related. We put the 07 on, and it would roll on through.

The other thing was we worked with our contracting folks to go to those payers and to the hospice companies and say, hey, if we are going to continue to do general inpatient care with you, you're going to have to pay us when you're supposed to. Because that was a big issue too, is that they just wouldn't pay.

So that was our first step, to get the education out, and that really helped a lot. Because as with everything, we wanted to kind of move it to the front end.

The other thing was that we had a huge focus with patient access and case management on using discharge planning. So one of the issues identified by billing was that the common working file is not always up to date. And I think hospice has five to ten days to do that, but they don't always get that done, especially if they're a smaller company. Right?

So we wanted to make sure that we have the early warning - I mean, I wanted red lights to flash and stuff. If somebody goes in - because you're supposed to do a discharge plan within 24 hours of admission. Right? So at least within 24 hours somebody - whoever is designated in your facility - in ours, it's generally case management. If they even whisper that they had hospice, that they were thinking about hospice, that someday hospice might be a part of it, we would swoop in and really do some front-end homework to find out whether or not they were truly on hospice or not.

We also did some modifications within our electronic medical record system (Epic) to have that information come up further so just basically page forming for our patient access folks, so that hospice information would be visible when they went in to register a patient. So that was also another thing that we worked on.

When we said, okay, this patient does have hospice and somebody from patient access would contact the hospice company to let them know that we have them down as a guarantor for that patient, when we did that notification, what was happening was many times the person who made that phone call was not clinical, was being told it's not related. So they would go ahead and put that 07. It would change over to Medicare. Now the case managers, when they go and run their role, this looks like a regular Medicare patient. I'm just doing my normal thing. And so it would not get caught. Right? It would look fine from that perspective.

Now what happens, we changed that to where if anybody is told that this is not related, it either goes to that palliative care nurse where we have that service line or it goes to the case management leader at the smaller facilities where they don't. And we have a nurse concurrently evaluating whether or not they agree with the care. And if the nurse looks at it and she says clearly this is not related, they got in a car wreck on the way home from doing some errands, then that's fine and they will accept the 07 indicator and it will roll on. But if there is a question about it, they contact and they try to start that dialogue. Because if we're going to have to take legal action on the end, we want to make sure that we have put them on notice early on that we think that they are liable for that claim. So contacting the hospice immediately if the 07 indicator is entered and to evaluate whether or not the 07 indicator is appropriate on the front end.

The other thing that we learned was that at the same time we were getting the two midnight stuff, the hospice billing rules changed for election. So that would have been back on October 1st of

2013. And that's when they started having to list out on their certification document comorbidities. And so that was really important because when we were looking at the Medicare FAQs on this, it's not just that one chief diagnosis that it's related to. It can be anything that was designated.

So the way that I understand it is when the hospice accepts that patient onto their service, it's that whole patient. It's not just that one diagnosis. So if they have CHF but they have a comorbidity of COPD and they're in for COPD exacerbation, that's related. And that was something that was really difficult.

And, again, another best practice, I would say, was when our nurse called the hospice company. Don't talk to the office manager unless she's clinical. Don't talk to the billing. If you need to, go to the director, because you need to be speaking to a clinician. Because what we were finding early on is they have liver cancer and this is sepsis. So there's no way that those two things could be related. And having that conversation with that person who is answering the phone is probably a waste of your time.

And then another thing that we had to work with was HIM. So we went on Epic a couple of years ago and splitting bills is a little bit more challenging apparently with an EMR than it was in their paper world. And so a lot of times we would find out that they would revoke, but we weren't having good communication with the hospice while they were there. So making sure, if you can obviously do it, it should be done while they're there concurrently. But if it wasn't, having to go back and split bills.

Lastly, one of the things that we found out was that there was some maybe customer service that the MAC had not gotten a lot of information that this was coming. And so many times the issue that I mentioned earlier about the common working file not being updated timely, they were just telling people put the 07 on there. It was an inappropriate use of 07, but it was used to grease the wheels. And unfortunately, that kind of got out into practice with a lot of the billers who had been around for a while knew that that would kind of bypass and it was what they had been told over time to do. And so now we know that every single one of those is going to hit on an audit, and we're going to have to fix it.

So to wind up, I would say, if you can, if you have that one resource, that you can make your hospice designee nurse that's going to write your appeals so that they can be educated. They can be a point person to work with, the billing staff and the patient access staff. That was a huge thing for us. And then having someone you can start to develop those relationships with the different hospice companies.

We did have an issue when the hospice company wasn’t under contract because they were saying, we're not responsible for it because we're not under contract review. This has been another big, big thing. And so when the patient didn't let us know that they were coming in and this is why again it is key to have that early warning system and put them on notice that that patient is there, especially if it is a hospice that you do not have a contract with.

So they were saying they basically went out of network. We had no notice and, therefore, we are not going to be liable for the bill. So we investigated ABNs. We talked to CMS and submitted a question to CMS about that. And CMS came back and said that because the beneficiary in their election of coverage waived all rights to Part A for hospice services related to their disease process, and, thus, no ABN is required because that waiver is built into the election language.

So, again, it's trying to really work with your hospice company and explain to them we need you to make sure to work with your patients and let them know that they're not going to have coverage. Because then, otherwise, the beneficiary could come back to liability. And, of course, they can't pay for it, and so it rolls back to us.

So those were some of the things that we've done. Any questions?

THE SPEAKER: I've seen cases where Medicare has done their review and denied it saying it's hospice related. We bill the hospice, and they're denying it. And I've actually called the hospice, and they said, oh, well, this isn't related. We're not going to consider it. You've got to appeal it to Medicare. I'm like, well, Medicare has already reviewed the records. There's no point in appealing it. It's clearly related to the hospice condition. And they flat out told me that they will not consider it again until I appeal it to Medicare.

MS. OWENS: And so we've had that as well. We had that experience. And we usually appeal at least a Level 1. Unless it's just on its face, you know. Because we like to have that to go to. Because we take that excerpt of what the nurse auditor from Cahaba says, and we put that in our letter to the hospice company. And, again, we're kind of laying it out from a legal argument so that, okay, number one we were denied by Medicare and here's another thing, you got paid. Medicare paid you, and you are not paying us. But your beneficiary had service, and here's a statement from Medicare, your provider, saying that this is related to your service. So it really becomes putting them in a box where they can't. So we do appeal at least to Level 1 to kind of kill that argument.

THE SPEAKER: Well, we've got a denial and we're actually including the information, from a Medicare review - the rationale that they put in as to why it's hospice related actually including an appeal from that put in as why it's hospice related. We're actually including that when we request hospice billing. And even with that, you know the denial information coming from Medicare , they're still insisting on an appeal, so we're going to do the appeals. But it seems like a stall tactic or something.

MS. OWENS: I think you're exactly right. I think it is a stall tactic.

MR. BUTLER: Who are you speaking with at the hospice?

THE SPEAKER: It's a new level manager at the hospice.

MS. OWENS: So I think where Jeff is going with that is we've had success with saying we want to talk to your corporate compliance people. Compliance people always are cautious, you know, make them twitch. You know, should we get in touch with your MAC? Because Cahaba isn't their MAC. Should we contact your MAC and talk to them about this?

So there are some other things that you can play. Or if you have inside counsel, so it's not going to cost you a fortune, maybe they would write a letter. And that's what we're doing.

The nurse who does our appeals is a nurse attorney. And so that kind of helps as well too just to kind of get them on that, get to that director, that higher level person.

THE SPEAKER: I'll say something too. We've had some success if you ask the hospice agency, we'd be happy to provide your argument to Cahaba. You review the chart. You tell us why you think it's related or not related, and then we'll include that in our appeal. And once they get that to somebody that's a clinical person who sits down and tries to write that argument, they're going to realize that this was related.

MS. OWENS: Wow. I love that. Shannon is so smart. So Shannon said that they've had success with, all right, you tell us. What's the argument? That's great. That's great. We can do that too.

THE SPEAKER: My question is how on target have the Cahaba reviews been? What percentage do you feel like you need to appeal? Are they, from your experience, pretty accurate on what they're saying is not related?

MR. BUTLER: Probably about 50 percent technical. But what happens is, you appeal the first one. And some of them that are just black and white, boom, you get those. But it's the ones that you have to continue to fight with.

And just like she said, we do the Level 1 appeal. Because technically once we do the Level 1 appeal, we have two denials from Cahaba. So they said initially they denied it and now they denied at the Level 1 appeal.

MS. OWENS: It's like we used the 07 because they revoked on day one, and we just used the 07 to grease the wheels or you need to do a split. So once you get those technical ones out of the way, that maybe the common working file wasn't updated or some kind of thing, then of the other half that are left over I think it's about half and half.

And so, again, the most that we can do to make sure to appeal if we think there is a good argument for why Medicare should pay that claim, to put that out there and direct that nurse auditor to Cahaba's attention to it. And I think they're very reasonable. I do not think that they are being extremely hard. But they need something to go on.

THE SPEAKER: There were a couple initially. I think we had one that Cahaba denied because they said the patient had a hospice diagnosis of a CVA. And the patient came in for an elective revascularization of their peripheral arteries. And they said the same disease in the arteries that causes leg problems caused a CVA problem. We did appeal it and we won, because I felt like that was really pushing the envelope to be unreasonable.

So you do have to have a clinical person to look at it and gauge that. Because some of them I do think are inappropriate decisions.

THE SPEAKER: I do want to just add, in addition to like Shannon said that they're doing, we're getting our physician advisor to talk to their medical director and asking them to write a letter. And that's been very helpful. Because at that point, when they have a conversation, generally their medical director is saying we're on it.

MS. OWENS: So her physician advisor is reaching out to the medical director at the hospice, and she's having really good success at that. I'm writing that down myself. That sounds like a really good plan as well.

SPEAKER: I think that one thing that will be very good too is when they do have a permanent medical director. I think that's going to be very helpful. And we're hoping that the new doctor will be here in July.

MS. NORTHCUTT: I do think that, for the most part, March is always kind of a slow part of the year because we're just now getting our heads wrapped around all the coding changes that happened and the bill edits and getting through so that everything will change usually with an update in July.

But I did want to go through a couple of things that are going to be in July, specifically with Medicare, and for those that are actually having to look at claims now for medical devices that are replaced at 50 percent of the cost or free. And right now we have to modify the bill form with a value code that's called an FD. And you're going to put how much credit or what you got credit for with the FD on the bill.

So Medicare has now realized that a lot of hospitals are getting devices that are no charge, and they are no charge either due to a clinical trial or they're just given as a free sample. So now we have existing condition codes if it is a replacement or it's due to a recall, and now condition code 53 if you got it at no cost and if you're in a clinical trial or if it's free.

So, again, this is going to be for a specific targeted list under Medicare for these devices, but I can assure you it's most cardiac devices for sure. You're looking at some listings. And if you need a list, I can actually send that to Peggy. Medicare understands we bill for the device and we bill for putting the device in. And that's the procedure.

Now, when we put the device in, all the reimbursement from Medicare is on the code for putting the device in, even though we bill the device. So if we get it free, they also have a thing on the bill that we have to have a device on the claim with the code for putting the device in or the claim is going to fail saying you don't have a device. All right. So if you got it free, what have you got to do? You've got to put either one cent or a dollar or whatever your billing system will allow you to put. So we have to bill the device even though it's free, and then we bill for putting the actual device in. We actually have to fill out the value code for what it was worth. And in this regard, we have to put condition code 53 on the claim form.

So that's the big deal now of whether or not it is a recall, whether it's a replacement, or whether it's a new initial insertion. And so that condition code 53 is going to be your initial insertion.

THE SPEAKER: Condition code 53, you said this is something that's brand new?

MS. NORTHCUTT: Yes.

THE SPEAKER: So 49 and 50 will still also need to be reported?

MS. NORTHCUTT: Yes. So your departments are going to have to tell you the reason when you're passing this through, you're going to have to know if it is a warranty problem, if it's a replacement prior to the lifecycle or as a recall. So those are 49 and 50. And they did not have a new code to communicate so that Medicare can recognize this is for the initial placement. Instead of a replacement, it is initial placement. So if you get it free or if you're in a clinical trial and you get this device placed, then you're going to have a 53.

So that's going to change most people's processes is where I'm going. So it usually takes the departments a little time to get it. And now that you're going to have to consider a new condition code a lot of hospitals will have a form that they fill out in the department, and that passes on to the billing level so that everybody is communicating this. And they'll have to have their form changed, number one.

THE SPEAKER: When is this taking place?

MS. NORTHCUTT: July. I think the implementation date is July 6. So we still have time. But from the brain damage that we have gone through just to get it on the bill correctly in the past, we've just got a little more. So I thought I would say that in March, so that by July, maybe we'll have that in order.

THE SPEAKER: I have a question regarding bioengineered skin substitutes. As the new ones are being available, the companies are making those free of charge to the patient. Since the payment for the procedure includes the product and there's not a HCPCS code yet assigned for some of the new products out there, how will you bill that? Will it be the same scenario?

MS. NORTHCUTT: On that particular issue, there are only certain CPT codes that this applies to. I don't know when Medicare is going to realize that we get other free stuff besides these devices.

But on this, if there is a particular listing of all the CPT codes for the insertion that is affected, they also have a listing on the inpatient side of a DRG that would be affected because they also do a reduction on your inpatient. If you did an inpatient, they'll do a reduction off of that DRG.

So skin substitutes, to my knowledge, are not on that device insertion list. So even if you didn't bill it, they're still going to pay you if you're billing a high cost skin substitute application code. So basically if you do that 15 XXX series, then they're going to pay you anyway.

THE SPEAKER: I don't know if other hospitals are seeing this. But we were having some issues that we were seeing the 3M not updating their systems with the new J1 status indicators. And I just wanted to put it out there for all the facilities to make sure to check on that. Do you have anything about this?

MS. NORTHCUTT: I haven't heard anything.

THE SPEAKER: It's actually on the front end with 3M. 3M sends the adjustments, like contractual adjustments and payer reimbursement and all that, it's calculating it incorrectly and sending it over to our PA system. So we are having to manually adjust that and all that before billing. So it definitely is going to affect reimbursement because it's all going to be calculated wrong and all that.

MS. NORTHCUTT: Right. So they're actually calculating incorrectly in your encoder.

THE SPEAKER: Yes. So just something for everybody to look out for and check.

MS. NORTHCUTT: And I had another thought speaking of modifiers and payment and everything else. As you all know, Medicare is trying to distinguish between a 59 modifier and more specific modifiers.

And Medicare has no additional guidance. They have some instruction on using the new X modifiers. It is not great. We've gone out and looked at some MACs to see what their definitions are. I got more confused. I got confused with Palmetto. I even went out last night to see if CMS has mandated its use and to see if there was any more instruction before I showed up today. And no, there

is not. And they have mandated again that you're not required to use the new modifiers but you can continue using 59 if you want to, but you can go ahead and use the X modifiers if you want to.

More instruction on the way. I don't know when that might be. And some of those modifiers are self-explanatory; some are not. There has been no word from Cahaba that it was mandatory. They did say that your MAC could mandate it. So we have had no instruction.

So just in case you're still working the 59 queue, it doesn't mean that everything gets one, but it doesn't also mean that you have to put the X modifiers on at this time. So I guess we'll know in the future.

And I did want to say too for the Blue Cross meeting today, one of their questions was to go over their payment transformation. I love that term. So they will be going over their payment transformation that starts transforming on July 1. That's why I'm just trying to come up with some things that are preemptive on the July 1.

I know that they've had many calls with the hospitals. And for those that don't have to deal with it, I was just going to give you an FYI of what the payment transformation means. And they did say that it was partly the request of the hospitals because the hospitals wanted more efficiency. They did not like the cost reports, and they wanted to be more transparent. All the hospitals want to be more transparent, and it's all about the hospital is why we're doing the payment transformation.

What it really means, we'll have inpatient and we have outpatient. An inpatient, as you know with Medicare, is paid by diagnosis-related group, MSDRGs. And basically it's Medicare adjusted. So it's severity adjusted.

And so a DRG says I came in with this. I also have these comorbid conditions. And so I'm a sicker patient, and I fall into this DRG. And Medicare is going to pay you a lump sum. Blue Cross, as everyone knows, reimburses on a per diem basis. So as many days as you're there is how Blue Cross calculates what your money is going to be.

Now, in most cases, there's a simple one per diem rate. Some will get an ICU rate but in general, from the cost reporting, it all comes down to you get a per diem rate.

What the good thing is that during this payment transformation, they do say that you're going to remain budget neutral. But what is going to transpire is that you're going to have multiple per diem rates based on how sick the patient is and what their length of stay is.

So in general, there's going to be six different DRG levels. They are going to calculate your base rate based on a Level 4 DRG. And what this means in the big picture is you're going to code this inpatient record, it's going to fall into a DRG, and that DRG is going to translate into a per diem payment level. So, again, they're going to pay you a different level based on how sick, the acuity, and how long the patient was there.

That it is very imperative now that when you are coding that principle and you're getting those secondary diagnosis codes for CCs and MCCs, this is actually going to mean something now, and it's going to mean a lot now for Blue Cross. Because if I'm a very sick patient with MSDRGs, I'm going to fall into a higher level DRG per diem payment rate.

THE SPEAKER: But are they going to be reading the rest of the diagnosis codes?

MS. NORTHCUTT: They're going to actually read them all. Your diagnosis codes will go through the grouper, it's going to assign a DRG, and that DRG is going to crosswalk to a level that is a per diem level. That's going to be specific to a hospital. So they're going to negotiate a per diem level - each hospital is going to have their own negotiation of what that is as far as what your acuity is.

THE SPEAKER: So they're just going based on the DRG assignment?

MS. NORTHCUTT: Yes.

THE SPEAKER: Nothing to do with principle diagnosis and multiple comorbidities.

MS. NORTHCUTT: Well, they're going to read them. Yes. Because they're going to have to group them. Now, it doesn't mean they're going to be able to adjudicate on those actual codes, but they are going to read your principle and secondary. They're going to send it straight through the grouper, just like you would in a hospital, to determine the DRG that they're going to crosswalk those per diem lists to.

And so it's crucial now that your Blue Cross coders are very aware of this because it's really going to affect how you are going to be paid in the future.

So on inpatient, along with our IT transition, we can go ahead and say what per diem rate and this is negotiated when your settlements are. When your contract is due for renegotiation and your finance people should already have a worksheet that they send out to try to look at your length of stay, the DRGs, and try to come up with what they think is going to be a negotiable per diem rate based on your DRG and how acute you are.

So that is on the inpatient side of Blue Cross. Does that make sense in general? How sick you are is going to relate to a DRG. That's going to relate back to a per diem. They said if they had to go and pay on a DRG like Medicare, that it would be too massive of a system change for them. So they're still going to pay per diem. They're not going to pay ever. They'll just pay you a flat DRG, that I can see, in the near future.

They hope that all of this will transcend pretty quickly on the DRG side. The outpatient now and those that live in the outpatient world.

THE SPEAKER: Did you say how many DRG levels there are going to be?

MS. NORTHCUTT: I have right here there's actually payment groups.

THE SPEAKER: I'm sorry. Per diem levels.

MS. NORTHCUTT: Yes. Six different groups. And then there is a behavioral one that I don't really know what that means. So I don't know how that goes into its own payment group. But they call them levels and these go into a payment group. Kind of like the grouper. It had groups on outpatient where you have outpatient surgeries.

If you're under an ASC POF, preferred outpatient facility - which 99 percent in this room are, that means that when you have an outpatient surgery and it's on their ASC POF listing, that CPT code that we bill actually goes into a grouping, and all similar CPT codes are paid the same price. Okay?

Now, what we have right now, if we perform a procedure that is not on the list and we are not POF, that claim converts to a percent of charges for the whole claim. So that's where they give us credit for that not being on the ASC POF list.

So their first thing in order to get this payment transformation for outpatients is to add many, many, many more procedures to the ASC POF list. So that's their first step is they're going to add more procedures so that we're not going to get a percent of charges on the procedures that are not on there.

And then secondarily what they want to do by 2018 is actually take all those CPT codes and put them on a fee schedule and go away completely from these groupings. So that could be good or bad based on whatever they come up with at the end of the day.

The next thing that they really are striving for is to put most things on a fee schedule. So outpatient in general will be fee schedule. Right now the only thing that I have not seen how they're going to work this on outpatients is emergency department, and I probably will ask them about that. Because right now usually in an emergency you're paid a percent of charges if I come to the ED and I'm a Blue Cross patient and I go home.

At the end of the day, they want everything fee schedule and outpatient and DRG-driven payment group levels on the inpatient side.

So I read through their answers, and it's a very short answer on the Blue Cross, if you look at it, as to what this actually means. I thought I would just go through what it is that I know. Again, this starts with those contracts on July 1, 2015.

Are there any cost report people in here? No? Okay.

It's supposed to make them happy at some point that they don't have to do a Blue Cross cost report. I've never had to deal with cost reports. So when they start talking about them, I just kind of glaze over and don't know what they're saying but that's supposed to happen by 2018. We'll see.

And I guess one of the last things to discuss and it was something just as a preemptive and a reissue of transition as far as ICD-10. Again, if it's accepted and at this point I feel 99 percent sure that we're going I-10. I'm going kicking and screaming. I know that I work with a lot of inpatient coding people that have been ready for three years and they've trained the trainer so much. You know, they're already sick of it because they have to keep going back and do dual coding. So I'm happy for that. And it looks like an eye chart to me with the beginning alphas and the numerics. And I am so old now that I have memorized all the diagnostic codes. So this is going to be a total rewrite for me.

But one thing that I found interesting in those that are dealing with billing and coding is they have reissued span billing instructions and it's SE 1408, which is going to be a MedLearn Matters transmittal. And it does give you directive on those span bills - how are you coding for a service that starts before October 1 and the patient discharges after October 1, with the implementation date of October 1, 2015? I have to keep telling myself that because I can't believe it.

But what I wanted to be clear on is that we are not split billing for inpatients, you do not split bill those. Okay. They do not accept I-9 and I-10 on the same claim. So you are actually going to bill that inpatient stay that spans over October 1 and code it with I-10. Okay.

So that is the final conclusion that Medicare came up with, that you would do that. So that will be helpful, I think, and because their system rejects any claim that is split on an inpatient with two coding systems will be returned to the provider. So I don't know how but just to make sure that we can prevent that on the front end. Systematically I don't know how that works and how your HIM grouper works. But in general, if it's driven by dates of service, we just need to know that.

The kicker comes when you have a 121 inpatient Part B only claim. They want those split. So you're going to split bill those into the from-through date through September 30, and then you're going to pick that back up on October 1. So that, in general, is how they're going to handle that.

And they did have one other thing, because I was actually curious as only a nerd can be, is what do you do with a three-day window? How does that work? And actually if you're going to combine that outpatient account that is related to that inpatient visit, all diagnostics are going to go on that inpatient. If therapeutic is related, then it will go on that visit.

But in the case that you are combining those to an inpatient, it's going to be the through date. So you're going to act as if that claim is all inpatient and you're going to bill it with I-10. Okay. So it's going to be like your normal inpatient. That span is inpatient and if you have a three-day window that spans, it's combined you're going to do I-10. And 121s are going to be a split bill.

And they didn't say it yet, but I would imagine that if you had recurring claims you'll have to definitely end all your recurring accounts in PT OT speech, radiation oncology. You just need to make sure it hits and that account is discharged and readmitted, that patient, on that October 1 because you can't drop that as I-9 codes. So I don't know if you do every 30 days. I have a lot that actually bill out monthly, they'll code it on that first week drop the claim on the 5th of the next month or whatever. So just make sure that that's a cutoff and that's a hard cutoff for your therapists and those that do the patient access for the recurrings.

MR. ASHMORE: Thank you Karen and Claire. I know everyone appreciates your information.