Revenue Cycle Update

May 2017

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Tip of the Month

The usage of proper taxonomy codes on claims is becoming critical as more and more payers start to edit and deny claims for missing or inappropriate taxonomy codes. Ensure that your organization has a plan and process in place for management of taxonomy codes in your patient accounting system and edits in place to catch missing or inappropriate taxonomy codes before claims go out.

Change is in the air

As you can see, we have changed the name of our newsletter to reflect a broader purpose. With so much change – or at least talk of change – happening in Washington, it is likely that the revenue cycle will be impacted, sooner or later. We want to use this monthly newsletter to provide thought leadership and practical advice to help our clients anticipate change and adjust processes in time to optimize performance.

We use a variety of venues to express thought leadership. Recently, Jennifer Swindle, our VP of Quality and Service Excellence, participated in a webinar of several Midwest chapters of the HFMA, on modifiers' impact to the revenue cycle. "It is important to remember that while there are two types of modifiers, pricing modifiers and informational modifiers, the informational modifiers can have just as significant an impact if not more on the revenue cycle and appropriate reimbursement," she told the audience.

Look for much more of this kind of insight in the coming months.

– Jesse Ford, CEO

Coding Corner

Under injury reporting, the 7th character, 'S,' is for a sequela, a late effect or complication of a previously treated condition. It should not be used during the healing phase or when a patient is seeking intervention for the current injury. One example would be a patient who has a traumatic low back injury that heals on its own, but long after, still suffers from chronic pain. G89.21 for chronic pain due to trauma would be the initial code and the S39.002S would show the pain is a sequela of the initial back injury.

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Illinois Medicaid (HFS)

Medicaid Managed Care Transformation

HFS is transforming its Medicaid managed care program. The revised program will extend into all counties in Illinois effective Jan. 1, 2018.

A recently issued RFP will award contracts to no fewer than four and no more than seven qualified, experienced and financially sound Managed Care Organizations (MCOs) to enter risk-based contracts for the program.

The program will expand managed care coverage to new populations, including special needs children and children under the care of the Department of Children and Family Services (DCFS). As a result more than 80% of Medicaid beneficiaries will be in a managed care health plan, an increase from the 65% who are currently enrolled in a managed care health plan.

The provider notice (published 4/7/17) can be viewed here.

*Action Needed: Providers should begin contract discussions when MCOs reach out to establish networks. This will ensure that providers can contract with the awarded MCOs and seamlessly adjust to the new Medicaid Managed Care Program without loss of reimbursement.

CPT Codes and Reimbursement Rates for Physical and Occupational Therapy Evaluations

HFS has made changes to physical therapy (PT) and occupational therapy (OT) evaluation CPT codes effective with dates of service on or after January 1, 2017.

The following physical and occupational therapy evaluation codes have been deleted and replaced with more specific codes effective with dates of service on or after Jan. 1, 2017:

- 97001 – Physical Therapy Evaluation
- 97002 – Physical Therapy Re-Evaluation
- 97003 – Occupational Therapy Evaluation
- 97004 – Occupational Therapy Re-Evaluation

The therapy fee schedule will be updated with the following new codes, short descriptors, rates, and maximum quantity amounts effective with dates of service on or after January 1. Hospitals that bill physical therapy as fee-for-service will continue to be reimbursed at the same rate as CPT 97001, regardless of which new code is billed.

CPT Code	Short Descriptor	Unit Price Child Age 0-20	Max Qty Child Age 0-20	State Max Child Age 0-20	Unit Price Adult Age 21+	Max Qty Adult Age 21+	State Max Adult Age 21+
97161	PT Eval Low Complexity	$12.99	8	$103.92	$9.00	4	$36.00
97162	PT Eval Moderate Complexity	$12.99	8	$103.92	$9.00	4	$36.00
97163	PT Eval High Complexity	$12.99	8	$103.92	$9.00	4	$36.00
97165	OT Eval Low Complexity	$12.99	8	$103.92	$9.00	4	$36.00
97166	OT Eval Moderate Complexity	$12.99	8	$103.92	$9.00	4	$36.00
97167	OT Eval High Complexity	$12.99	8	$103.92	$9.00	4	$36.00

Rates and maximum quantities for the new codes are based on the same therapy rate structure that was in place for the recently deleted codes. Maximum quantities billable continue to represent 15-minute increments and remain at two hours for children's evaluations, and one hour for adult evaluations.

Re-evaluations

The physical therapy re-evaluation CPT code 97002 has been replaced with 97164. The occupational therapy re-evaluation CPT code 97004 has been replaced with 97168. Previously, CPT codes 97002 and 97004 were listed on the Therapy Fee Schedule Crosswalk and linked to 97110 as the billable code for both PT and OT. The new re-evaluation CPT codes 97164 and 97168 will also be cross-walked to 97110, with the applicable modifier, as the billable code. Maximum quantities billable remain at one hour for both child and adult re-evaluations.

Claims Processing

A hold edit was implemented on Jan. 13 to temporarily suspend any claims received with one of the new PT or OT evaluation CPT codes. Those claims will be released back into processing for final adjudication once programmatic changes are implemented. Final adjudication will be reported on a future Remittance Advice. Once the held claims are adjudicated, providers will need to submit replacement claims for any services that were billed with an incorrect procedure code and/or quantity prior to notification of the above guidance.

The link to the provider notice (published 4/3/17) can be found here.

*Action Needed: Providers need to bill using the new codes and ensure that any services since Jan. 1 billed under the old codes are corrected and resubmitted if they were rejected.

Re-issue of Chapter HK-200, Handbook for Providers of Healthy Kids Services

The department has re-issued the Handbook for Providers of Healthy Kids Services to include changes to the Vaccines for Children (VFC) program, updated provider enrollment information and the incorporation of ACA-endorsed Bright Futures recommendations.

The provider notice can be viewed here.

*Action Needed: Providers are strongly encouraged to review the entire document for awareness of current policy regarding the VFC program and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program guidelines.

Indiana Medicaid (IHCP)

Updated Provider Modules

IHCP has updated several its provider modules to incorporate the changes from IndianaAIM to Core MMIS and all corresponding terminology, contact information, and processes. The following modules have been updated in the last month:

- National Correct Coding Initiative
- Long-term Care
- Transportation Services
- Financial Transactions and Remittance Advices
- Surgical Services
- Presumptive Eligibility
- Hospital Presumptive Eligibility
- Hearing Services
- Home Health Services
- Injections, Vaccines, and other Physician-Administered Drugs
- Vision Services
- Family Planning Eligibility Program

The new provider modules can be found here.

*Actions Needed: Providers should review the new modules and ensure they are aware of and following the guidelines included within.

Illinois Managed Care Plans

BCBSIL Predetermination of Benefits Requirement for Sleep Studies for Federal Employee Program (FEP) Members

Effective for dates of service on or after Jan. 1, 2017, predetermination of benefits is required by BlueCross BlueShield Illinois for sleep studies (polysomnography) conducted in settings other than the home (including but not limited to hospitals, skilled nursing facilities, clinics and sleep labs) for Federal Employee Program (FEP) members.

Predetermination of benefits requests for sleep study services for FEP members are processed through a BCBSIL Clinical Health Medical Management review. Predetermination of benefits requests and electronic medical record attachments may be submitted online through iExchange®, or by faxing a predetermination of benefits request form and clinical information to 888-368-3406. Additional information on iExchange is available in the Education and Reference Center/Provider Tools section of our website at bcbsil.com/provider. The predetermination of benefits request fax form can be found in the same section of the provider website on the forms page. Clinical information submitted should include clinical data as to why a home sleep study is contraindicated.

Additional Reminders for FEP Members:

- Sleep studies performed in the home do not require a predetermination of benefits.
- Obtaining a predetermination of benefits through BCBSIL is waived when traditional Medicare or other insurance is primary.
- The sleep study service provider must have the appropriate licenses and credentials necessary to conduct sleep study services.
- The sleep study services must meet the medical necessity guidelines.

The Blue Review can be found here.

*Action Needed: Providers should ensure they are obtaining predetermination of benefits for sleep studies done outside the home for FEP patients.

BCBSIL Provider Claim Summaries (PCSs) are now available on Availity

Provider Claim Summaries (PCSs) are now accessible through the Reporting On-Demand application, located under the BlueCross BlueShield of Illinois-branded Payer Spaces section on the Availity™ Web portal. The paper PCS is also referred to as the voucher, explanation of benefits, or claim payment & remittance information.

The effective date to discontinue mailing of paper PCSs has been delayed from March 1, 2017, to a future date sometime this year. More information will be made available regarding the paper mailing when a date is determined.

Exception requests to receive paper PCS mailings will continue to be reviewed. These requests may be submitted via email to PECS@bcbsil.com.

The information can be found in the Blue Review.

*Action Needed: Providers who want to continue to receive paper PCS mailings should submit an exception request. If not, providers should ensure staff are aware of this change and accessing the PCSs online.

IlliniCare Updating Demographic Info

IlliniCare Health has partnered with LexisNexis to ensure that provider demographic data stays current for providers and members. Providers will receive a joint email from LexisNexis and the American Medical Association (AMA) requesting attestation that their demographic data is current. By updating demographic information in the AMA portal, providers can ensure that correct information is implemented across all Medicare and Marketplace payers who are also using the AMA portal.

An email has been sent with a unique hyperlink to register with the AMA and LexisNexis. If demographic data has changed, providers need to update it at that time. Attestations are due within two weeks of receipt of the request. These updates are also required by the Centers for Medicare & Medicaid Services (CMS) and is covered in the Participating Provider Agreement with IlliniCare Health.

See the notice here.

*Action Needed: When providers receive the email from the AMA and LexisNexis, they should register, review and update their demographic information if necessary.

Meridian Requests Providers Update their Info Quarterly

Meridian is asking for providers to validate or update their information quarterly. Providers can contact Meridian at any time to verify and update your demographic or practice information.

There are several options for verifying and/or updating info.

- Calling the Provider Services Help Line: 866-606-3700, 855-827-1752 (Advocate only)
- Faxing the Provider Services Help Line: 313-309-8530
- Emailing providerupdates@mhplan.com
- Contacting your local Provider Network Development Representatives
- Completing the online provider change form
- Mailing information to MeridianHealth Corporate Provider Services 1 Campus Martius, Suite 700 Detroit, MI 48226

The provider notice can be found here.

*Action Needed: Providers should verify and/or update their information with Meridian through one of the methods listed above.

Molina Prior Authorization Requirements

Effective July 1, 2017, Molina will require prior authorization for some specialty pharmacy, home care and home infusion, outpatient hospital procedures and genetic counseling and testing. The updates will be reflected in the Molina Prior Authorization Codification List.

Requests for prior authorizations for these provider-administered medications must be faxed to (866) 617-4971 using the Medical Prior Authorization Form. Providers should review the “Prior Authorization Codification List,” available online at www.MolinaHealthcare.com for a full listing of the HCPCS codes that require a prior authorization.

The provider notice can be found here.

*Action Needed: Providers should ensure that staff are aware of these changes and start obtaining prior authorization for these services starting 7/1/17.

Molina Requires Electronic Claim Submission

Molina is moving to electronic provider support services. Effective July 1, 2017, Molina will require that providers submit claims electronically. Paper claims submitted after July 1 will be denied.

The notice and additional information can be found here.

*Action Needed: Providers should start submitting claims to Molina electronically if they have not already done so, effective 7/1/17.

Next-level Physician Assistant Billing Guidelines

In accordance with the Physician Assistant Practice Act of 1987 (225 ILCS 95/), physician assistants can perform procedures under the supervision of a physician in one of two ways as described below.

The managed care contracts between HFS and each of the MCOs provides the organizations flexibility in contracting with healthcare service providers when coordinating care with patients. As a result, services supplied by Physician Assistants are allowed to be billed and either reimbursed 1) directly, or 2) under the supervising physician.

Physician Assistants Enrolled in the Illinois Medical Assistance Program

Physician Assistants are allowed to bill and receive reimbursement directly when serving as the rendering provider so long as the Physician Assistant is registered in the Illinois Medical Assistance Program. To facilitate accurate Encounters submission in this scenario, MCOs require that performed services are to be billed with the enrolled Physician Assistant's name and NPI as the rendering provider in box 24J of the CMS - 1500 claim form / Loop 2310B on 837p electronic submission or in box 56 of the UB-04 claim form / Loop 2310D on 837i electronic submission.

Physician Assistants Not Enrolled in the Illinois Medical Assistance Program

If the Physician Assistant is not registered in the Illinois Medical Assistance Program, they will be able to perform procedures under the care of a supervision of a Physician enrolled in the Illinois Medical Assistance Program per 225 ILCS 95/. To facilitate accurate Encounters submission in this scenario, MCOs require that performed services are to be billed with the enrolled supervising physician's name and NPI as the rendering provider in box 24J of the CMS - 1500 claim form / Loop 2310B on 837p electronic submission or in box 56 of the UB-04 claim form / Loop 2310D on 837i electronic submission.

Enrollment Requirements

As per the ACA requirement, Physician Assistants are required to register with HFS as a Medicaid Provider in order to render services to Illinois beneficiaries and receive reimbursement. These providers should follow HFS guidelines to register and certify in IMPACT. IMPACT.Illinois.gov. Once registered, Physician Assistants are identified as Provider Type 089 on the HFS Provider Affiliation File sent weekly to MCOs.

The notice and additional information can be found here.

*Action Needed: Providers should ensure they are following the NextLevel Health physician assistant billing requirements.

CMS / Federal Update

Medicare Outpatient Observation Notice (MOON)

Included previously in the March 2017 Industry Update

The MOON is a standardized notice to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH).

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

Medicare Outpatient Observation Notice and accompanying form instructions are available by clicking here.

CMS informed Medicare Advantage plans of the MOON instructions via a Health Plan Management System email blast. MA plans are to follow the MOON instructions available at the link above.

All hospitals and CAHs are required to provide the MOON, per CMS guidance, beginning no later than March 8, 2017.

*Action Needed: Providers should be prepared to provide MOON notices as required by no later than March 8th.

Medicare Access and CHIP Reauthorization Act of 2015

Included previously in the March 2017 Industry Update

In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 was signed into law. The following five bullets highlight the major changes coming as a result of this law.

- Repeals the Sustainable Growth Rate methodology for determining updates to the Medicare physician fee schedule.

- Establishes annual positive or flat fee updates for 10 years and institutes a two-tracked fee update afterwards.
- Establishes a Merit-Based Incentive Payment System that consolidates existing Medicare fee-for-service physician incentive programs.
- Establishes a pathway for physicians to participate in alternative payment models, including the patient-centered medical home.
- Makes other changes to existing Medicare physician payment statutes.

*Action Needed: Providers should be aware of the changes coming with this law, evaluate how these changes may impact their revenue cycle, and prepare for these changes where necessary.

CMS announces New Comprehensive Primary Care Plus Payment Model

Included previously in the March 2017 Industry Update

CMS announced in April that it would be replacing the existing CPC program with the new and improved Comprehensive Primary Care Plus (CPC+) payment model. “Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.). The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making. CPC+ is a five-year model that will begin in January 2017.” More information is available and will be provided through the CPC+ webpage located here.

*Action Needed: Many details related to the five-year, multi-payer program remain forthcoming, but providers should start looking into this program and evaluating what it means for them and whether or not to apply for the program.

OIG Work Plan Topics

Included previously in the March 2017 Update

****ALERT: The following topics are on the OIG work plan. We recommend that providers take a sample of accounts that may be impacted and perform an internal audit to assess exposure and plan accordingly prior to OIG involvement.*

Hospital: Inpatient Claims for Mechanical Ventilation

The OIG will review Medicare payments for inpatient hospital claims with certain MS-DRG assignments that require mechanical ventilation to determine if MS-DRG assignments and the resultant Medicare payment were appropriate. Specifically, the OIG is looking for instances where mechanical ventilation was billed for when the required 96 hours or more of ventilation was not provided. There must be 96 hours or more of mechanical ventilation provided in order for it to qualify for Medicare coverage.

Hospital: Selected Inpatient and Outpatient Billing Requirements

The OIG will review Medicare payments to acute care hospitals to determine compliance with selected billing requirements and recommend recovery of overpayments where identified. The review will be focused on those hospitals with claims that are at risk for overpayments.

Hospital: Nationwide Review of Cardiac Catheterizations and Endomyocardial Biopsies

The OIG will review Medicare payments for right heart catheterizations (RHCs) and endomyocardial biopsies billed during the same operative session and determine whether hospitals complied with Medicare billing requirements. Specifically, the OIG is looking to identify instances where hospitals were paid for separate RHC procedures when the services were already included in payments for endomyocardial biopsies.

Hospital: Review of Hospital Wage Data used to calculate Medicare Payments

The OIG will review hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments. The OIG is aiming to identify incorrectly reported wage data which was used to develop wage index rates.

Hospital: Medicare Payments during MS- DRG Payment Window

The OIG will review Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays were allowable according to the guidelines associated with the inpatient prospective payment system. They are looking to identify where certain items, supplies, and services furnished to inpatients and covered under Part A should not have been, but were billed separately to Part B.

Physicians: Anesthesia Services - Payments for Personally Performed Services

The OIG will review Medicare Part B claims for personally performed anesthesia services to determine whether they met Medicare requirements. Specifically, the OIG will review whether Medicare payments for anesthesia services reported on a claim with the “AA” service code modifier indicating a service personally performed by an anesthesiologist service met Medicare requirements. Reporting an “AA” modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare paying more than appropriate.

Payments to any service provider are disallowed unless the provider has furnished the information necessary to determine the amounts due.

Physicians: Anesthesia Services – Non-covered Services

The OIG will review Medicare Part B claims for anesthesia services to determine whether they were supported in accordance with Medicare requirements. Specifically, they aim to determine if the beneficiary had a related Medicare service that they consider "reasonable and necessary," which is required for Medicare payment.

Physicians: Prolonged Services – Reasonableness of Services

The OIG will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. They are looking to identify instances where a prolonged service was billed for and Medicare requirements were not met. The necessity of prolonged services is considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code.

Selected Provider Notices

Illinois Medicaid (HFS) Notices

Medicaid Managed Care Transformation

CPT Codes and Reimbursement Rates

Handbook for Providers of Healthy Kids Services

Indiana Medicaid (IHCP) Links

Provider Reference Materials

Illinois Managed Care Notices

Blue Review Newsletter

Illinicare: Updating Demographic Data

MeridianHealth: Methods to Verify or Update Your Information

Molina Healthcare Provider Memorandum: Additional Prior Authorization Requirements Beginning July 1, 2017

Molina Healthcare Provider Memorandum: Molina Healthcare to Implement Electronic Claims Filing Requirement Starting July 1, 2017

NextLevelHealth Provider Memorandum: Physician Assistant Billing Guidelines

CMS

Medicare Outpatient Observation Notice (MOON) Instructions