Revenue Cycle Update

June 2017

salud revenue partners

June 2017

In this issue:

Tip of the Month

Providers can expect to experience a growing number of audits on high dollar claims to review appropriateness of charges and room and board. Hospitals should review their charge master and evaluate how well they are capturing charges.

Bridging the Generational Divide to Keep Staff Up-to-date

By Jesse Ford, CEO

With revenue cycle complexity continuing to grow, there seems to be an endless need to keep staff up to speed and able to put best practices into play. Unfortunately, the vast array of payers, each with their own anomalies in claims responses, use of claims adjustment segment and remark codes and, often, differing terminology on their websites and in correspondence, make it nearly impossible to keep up with defining optimal processes, let alone effectively train staff on them. It's just as challenging to ensure that staff retain what they learn.

As a revenue cycle services company, Salud Revenue Partners knows our most precious asset is our people. We have embarked upon a quest to have the best trained staff in the industry, so we've been researching and analyzing opportunities to improve. We review the quality of staff work to identify additional training needs, and incentivize quality results. Salud has an extensive library of training materials, schedules frequent training sessions, and has ongoing quality reviews followed by immediate feedback and advice.

Continued on page 3

Coding Corner

Conditions with 'Causal Relationships'

Per the AHA and the Coding Clinic, the word "with," as indicated in ICD10-CM, should be interpreted to mean "associated with" or "due to" when it appears in a code title. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular. For example: Diabetes, diabetic (mellitus) (sugar) E11.9 with chronic kidney disease E11.22. The subterm "with" in the index should be interpreted as a link between diabetes and any of those conditions indented under the word "with." The physician documentation does not need to provide a link between the diagnoses of diabetes and chronic kidney disease to accurately assign code E11.22.

Illinois Medicaid (HFS)

Medicaid Managed Care Transformation

Included previously in the May 2017 Revenue Cycle Update

HFS is transforming its managed care program. The revised program will extend its Medicaid managed care program 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 into risk-based contracts for the Medicaid managed care 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 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 revenue.

Indiana Medicaid (IHCP)

IHCP Allows Providers Until Sept. 1, 2017, To Update Rendering Provider Linkages

The IHCP has received a number of inquiries from providers about claim denials for explanation of benefits (EOB) 1010 - Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider and resubmit. As announced in previous IHCP publications, claims billed for services performed by a rendering provider not linked to the specific service location on the claim will deny for EOB 1010.

IHCP policy requires rendering providers to be linked to the specific locations where they render services for a group practice. Further, a rendering provider's services may not be billed for a service location to which he or she is not linked.

IHCP will temporarily convert EOB 1010 to a "post-and-pay" status, meaning that the system will allow claims and claim details with this issue to pay, but the EOB 1010 message will continue to post on the RA, so providers are aware the problem exists. This temporary workaround will be in place through August 31, 2017, allowing providers ample time to link rendering providers to the appropriate group locations to support proper claims adjudication. Effective Sept. 1, 2017, the EOB 1010 will revert to a denial status.

Providers should review their RAs in detail, note any EOB 1010 messages, and make the necessary rendering provider updates to the affected service location profiles. Providers are encouraged to submit rendering linkage updates as soon as possible, to allow for processing before Sept. 1, 2017.

Providers should watch for upcoming IHCP publications for instructions on viewing and updating rendering providers in the Provider Healthcare Portal.

The provider notice can be found here.

*Actions Needed: Providers must ensure that the provider profile for each group location has the correct rendering providers linked with accurate effective and end dates.

Updated Provider Modules

IHCP has updated a number of their 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:

Mental Health and Addiction Services
Third Party Liability
Medical Policy Manual
Interactive Voice Response System

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.

Bridging the Generational Divide (Continued from the cover page)

We also seek feedback from our team, which has uncovered an important finding; even as we dedicate more resources and attention to training, employees may not be satisfied with it. Perhaps our biggest challenge in training and retention is adapting our approaches to engage the four generations in our workforce; traditionalists, baby boomers, Gen Xers and Millennials.

Millennials want just-in-time learning

In the article "Designing Learning for Millennials," the author, Akanksha Sharma, writes: "While most companies are still clinging to the traditional formal and sporadic talent development practices, they do not resonate with how Millennials prefer to learn today. Millennials choose to learn in new and different ways. For them, formal learning doesn't contribute much to substantial retention and they expect more informal, just-in-time learning sources to acquire and assimilate knowledge. For them, context is more important than content."

Other authors echo this message, adding that baby boomers may favor more traditional and static training methods like PowerPoint presentations and handbooks, while younger workers may gravitate towards more interactive, technology-based forms of learning. Others contend that new methods of training, preferred by Millennials, work well for all generations.

Understanding the need for interactive training tools does not solve the challenge of keeping training up to date in a highly dynamic healthcare environment. At Salud, we decided that we needed to create a new approach, and change our culture, through a few guiding principles:

- Employees need to be personally accountable for their education and career development
- We must provide tools for employees to learn what they need to know
- We must continuously maintain the tools

Participatory education

We are transforming our culture to ensure that staff can independently resolve the challenges they face.

As part of our transformation, Salud increased employee involvement in developing their tools. Instead of top-down process improvement, we engage interested staff and gave them permission to spend time on research and problem-solving instead of focusing only on worklists. Our collaborative teams created tools to guide decision-making, but using language and categories that they defined and understood.

We also reinforced structures that ensure staff can communicate what they want, when they want, and the way they want, such as through individual and group meetings, suggestion boxes, and semi-annual staff satisfaction surveys.

By monitoring our environment and adapting to generational differences, we at Salud are more effectively navigating our complex training environment, advancing the skills and satisfaction of our most valuable asset, our people.

Illinois Managed Care Plans

BCBSIL Medicaid Claims: National Drug Code (NDC) Billing Update

BlueCross BlueShield of Illinois (BCBSIL) is implementing Medi-Span® as its National Drug Code (NDC) validation source. This implementation will help ensure that the BCBSIL system is aligned with the system adopted by HFS to validate use of appropriate NDCs on Blue Cross Community Options, or BCBSIL Medicaid, claims.

BCBSIL follows HFS billing guidance for outpatient services that relate to NDCs. A current list of services that require an NDC can be found on the HFS website.

If you are a BCBSIL independently contracted provider who submitted a BCBSIL Medicaid claims that denied recently for invalid NDC, please resubmit your claim after validating that any NDC codes billed are appropriate for the services rendered and also active for the date(s) of service. A timely filing waiver has been temporarily granted to allow impacted providers to resubmit the claim(s).

Please note that Vial Level NDC edits have caused significant rejections for claims submitted 1/1/17 and after. This will be addressed when Medi-Span is implemented.

The notice can be found here.

*Action Needed: Providers should validate and resubmit claims that recently denied inappropriately for invalid NDC. If you have had rejections due to vial level NDC issues since 1/1/17 stay tuned to see how this will be addressed with the implementation of Medi-Span.

BCBSIL Code Auditing Software Implementation Rescheduled

In December BCBSIL published a notification regarding additional code auditing software that was originally scheduled for implementation on April 23, 2017. BCBSIL has rescheduled this additional code auditing software implementation for May 21, 2017.

As noted previously, this software will further enhance the auditing of professional and outpatient facility claims for correct coding according to Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT®) and Centers for Medicare & Medicaid Services (CMS) guidelines. Upon implementation, providers may use the Claim Inquiry Resolution tool, available on the Availity™ Web Portal, to research specific claim edits.

This does not apply to government programs claims.

The notice can be found here.

*Action Needed: Upon implementation, providers may use the Claim Inquiry Resolution tool, available on the Availity™ Web Portal, to research specific claim edits for non-government claims.

BCBSIL Medicaid: Electronic Claim Rejections for Revenue Codes 0944 and 0945

Institutional electronic claims (837I transactions) for members enrolled in any of the below mentioned Medicaid plans that were submitted with revenue codes of 0944 and 0945 and an inpatient place of treatment may have been rejected erroneously for missing accommodation codes.

- Blue Cross Community MMAI (Medicare-Medicaid Plan)
- Blue Cross Community Integrated Care Plan (ICP)
- Blue Cross Community Family Health Plan (FHP)
- Blue Cross Community Managed Long Term Supports and Services (MLTSS)

An example error message that providers may have received for these rejected claims is as follows: “Accommodations Service Line: Required; must be entered on inpatient claims.”

Please note that this issue was resolved on April 27, 2017, and providers impacted by these rejections may now resubmit the affected claims.

See the notice here.

*Action Needed: Providers who received rejections for this issue should resubmit the affected claims.

BCBSIL MMAI 15D Denials

Due to incorrect application of Ambulatory Procedure Listing (APL) editing logic to MMAI claims, approximately 12,500 claims rejected in error from Nov. 1, 2015, to Aug. 1, 2016. BlueCross BlueShield of Illinois (BCBSIL) is working on a project to reprocess affected claims and anticipates having a full claims report soon. Data on the specific claims adjusted should be available shortly thereafter.

Included in the IHA Memorandum released May 12, 2017.

*Action Needed: Providers who experienced these erroneous 15D denials should watch for additional information on how these claims will be reprocessed.

BCBSIL Authorization Rejections

BCBSIL's system was applying authorization requirement edits in error to services such as IUD, long-acting reversible contraceptives, and group/individual psychotherapy. Any impacted claims will be reprocessed without the edits. BCSBIL is still working to identify all claims in need of adjustment. BCBSIL has provided a list of CPT/HCPCS codes that will be adjusted.

This information was included along with the list of impacted codes in the IHA Memorandum released May 12, 2017.

*Action Needed: Providers who experienced these issues to identify their impacted claims and ensure that they are reprocessed without the edits.

New Provider Portals for FHN and CCAI

Both FHN and CCAI have new provider portals. Neither allows for claim status inquiry at this time though it should be available soon, but the portals can currently be used for reporting admission notifications, submitting and obtaining authorizations or referrals, and looking up historical authorizations.

FHN Portal information can be found here.

CCAI Portal information can be found here.

*Action Needed: Providers should register for the FHN and CCAI portals and utilize them to assist with authorization and eventually claims status once available.

IlliniCare Requests for Reconsideration, Claim Disputes and Corrected Claims

If a provider has a question or is not satisfied with the information they have received related to a claim there are four effective ways providers can contact IlliniCare Health:

1. Contact Provider Services at 1-866-329-4701 or your Provider Relations representative. Providers may discuss questions regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim. The claim must be clearly marked as "RESUBMISSION" and must include the original claim number or the original EOP must be included with the resubmission. Failure to mark the claim as a resubmission and include the original claim number (or the original EOP) may result in the resubmitted claim being denied as a duplicate, a delay in reprocessing, or denial for exceeding the timely filing limit.

Submit Adjusted or Corrected Claims should be mailed to:

IlliniCare Health
Attn: Corrected Claims
P.O. Box 4020
Farmington, MO 63640-4402

3. Submit a Request for Reconsideration. A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical review. The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name. The documentation must also include a detailed description of the reason for the request.

Submit Requests for Reconsideration to:

IlliniCare Health
Attn: Reconsideration
P.O. Box 4020
Farmington, MO 63640-4402

4. **Submit a Claim Dispute Form**. A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration. The Claim Dispute Form can be found here. If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps for escalated reconsideration. IlliniCare Health shall process, and finalize all adjusted claims, requests for reconsideration, and disputed claims to a paid or denied status within 45 business days of receipt.

Submit Claim Dispute Forms to:

IlliniCare Health
Attn: Dispute
P.O. Box 3000
Farmington, MO 63640-3800

The notice and additional information can be found here.

*Action Needed: Providers should utilize one of the four ways described above to contact IlliniCare if they have a question or are not satisfied with the information they have received regarding a claim.

CMS / Federal Update

Provider Enrollment Revalidation Look Up Tool

In order to streamline the provider revalidation process and reduce the burden on providers, CMS has implemented some process improvements including a new Provider Revalidation Look Up Tool. The tool can be found here.

Medicare providers must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due-date at the end of a month, and posts the revalidation due in the upcoming six months online to be viewed using this tool. A due date of "TBD" means that CMS has not set the date yet.

For more information, please check the notice here. The tool was last revalidated on May 5, 2017.

*Action Needed: Providers should utilize the provider revalidation look up tool to determine if/when their providers are up for revalidation.

Medicare Outpatient Observation Notice (MOON)

Included previously in the May 2017 Revenue Cycle 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 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 May 2017 Revenue Cycle 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 May 2017 Revenue Cycle 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 May 2017 Revenue Cycle 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

Indiana Medicaid (IHCP) Links

IHCP Allows Providers Until September 1, 2017, To Update Rendering Provider Linkages

Provider Reference Materials

Illinois Managed Care Notices

National Drug Code (NDC) Billing Update for BCBSIL Medicaid Claims

BCBSIL Medicaid: Electronic Claim Rejections for Revenue Codes 0944 and 0945

FHN's Provider Portal Is Here

IlliniCare: Requests for Reconsideration, Claim Disputes, & Corrected Claims

CMS

CMS Manual System: Medicare Claims Processing

Medicare Revalidation List

Revalidations list