Revenue Cycle Update

July 2017

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In this issue:

Tip of the Month

HFS has many services that are listed on the practitioner fee schedule as "hand-priced." When billed electronically without following the hand - priced guidelines these are sometimes mistaken as non-covered services. Refer to the practitioner handbook key for specific billing guidelines to ensure proper reimbursement. This is particularly relevant for oncology services.

Performance counts more

A recent article in Becker's Hospital Review underscores Salud's mission in helping healthcare providers optimize revenue cycle performance instead of simply looking to cut costs. The article cites an Advisory Board analysis showing that the average 350-bed hospital could gain up to $22 million in additional revenue by putting more focus on improving revenue cycle management. The firm said hospitals are losing 5% of margin to commercial payer underpayments, denials and suboptimal contracts.

Advisory Board recommends hospitals take positive action to respond to new market forces of increased patient consumerism, aggressive commercial denials and higher physician engagement on documentation instead of poorly executed integrations that waste resources.

We could not agree more. We work every day to cultivate a culture of continuous improvement in our engagements. Our clients often realize improved revenue cycle performance, including 2% to 4% improvement in hospital cash collections and 10% to 40% improvement in physician collections.

Trying to cut your way to profitability may work in the very short run, but those organizations that take the time to do the hard work of performance improvement reap greater returns, while keeping morale and staff loyalty high.

– Jesse Ford, CEO

Coding Corner

Facilities can lose revenue if wasted drugs are not reported appropriately. The JW modifier is used on a Medicare Part B drug claim to report the amount of drug or biological that is discarded and eligible for payment under the discarded drug policy. The modifier is only to be used for drugs in single dose or single use packaging. Accurately capturing the wasted drugs with a JW modifier can improve accuracy of reimbursement and allow facilities to recoup the money spent on drugs.

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Illinois Medicaid (HFS)

Medicaid Managed Care Transformation

Included previously in the June 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 January 1, 2018.

A recently issued RFP will award contracts to no fewer than four (4) and no more than (7) 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.

UPDATE: The RFP timeline has been pushed back, resulting in a delay of awards. Per a June 9th update, the oral presentations which were supposed to occur in the first part of June are now expected to occur sometime in early July.

The update notice can be found 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 Extends the Intensive Outpatient Program to Managed Care Benefit Plans

IHCP is extending Intensive Outpatient Program (IOP) services to all Medicaid managed care benefit packages, including those under the Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise programs. IOP services include substance abuse treatment and psychiatric treatment, as needed by the member. The IOP will encompass all services that fall under the intensive outpatient umbrella, regardless of terminology. This change applies retroactively to dates of service on or after Feb. 1, 2017.

Providers can now submit claims to managed care entities (MCEs) for IOP services for DOS. Claims submitted after the timely filing limit should include a copy of this publication as an attachment and should be submitted within 90 days of publication. More information regarding specific billing requirements and payment methodologies can be found in the bulletin.

Specific billing questions should be referred to the appropriate MCE. Contact information is available on the IHCP Quick Reference Guide at indianamedicaid.com.

The IHCP bulletin can be found here.

*Actions Needed: Providers should be aware that Intensive Outpatient Services are now covered for their managed care patients. Services already provided can now be billed for and services can be provided and covered. Check the bulletin to ensure that the proper billing guidelines are followed.

Updated Provider Modules

IHCP has updated a number of 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 past month:

- Member Eligibility and Benefit Coverage
- Right Choices Program
- Inpatient Hospital Services
- Home and Community-Based Services Billing Guidelines
- Medicaid Rehabilitation Option Services
- Presumptive Eligibility for Pregnant Women

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 Government Programs – Overpayment Recovery Process

A new overpayment recovery process was implemented for Blue Cross Medicare Advantage℠ and Blue Cross Community Options℠ (Medicaid) claims processed after Jan. 1, 2017. Please read below some important reminders related to this change:

- The Electronic Refund Management and Claim Inquiry Resolution tools on Availity™ are no longer available for government program claims.
- Request for refund letters are sent by mail when overpayments are identified on government program claims.
- Please review your request for refund letter closely and remit your payment to the address indicated on the letter. Include a copy of your refund request letter along with your payment.
- If you identify an overpayment and wish to send a voluntary refund, please proceed as noted below. Include appropriate documentation to identify your request (e.g., a copy of your Provider Claim Summary, or the Explanation of Benefits).

For claims paid prior to Jan. 1, 2017, or if you are unsure of the original claim payment date, send your refund payment to:

Health Care Service Corporation
25718 Network Place
Chicago, IL 60673-1257

For claims paid on or after Jan. 1, 2017, send your refund payment to:

Health Care Service Claims Overpayment
29068 Network Place
Chicago, IL 60673-1290

The notice can be found in Blue Review here.

*Action Needed: Providers should ensure that they are following these guidelines for BCBSIL government programs if they are not doing so already.

IlliniCare VFC Recoupment Project

IlliniCare completed its system configuration to reflect the updated Vaccines for Children (VFC) billing guidelines that were effective Oct. 1, 2016. At that time, they notified providers that they re-adjudicated to the appropriate reimbursement, according to the HFS fee schedule. Providers were asked not to resubmit correct claims until an internal project was completed.

During the time IlliniCare was scoping the project, it noticed that providers were overpaid for services rendered, therefore the plan will be recouping those payments. This project may impact dates of services prior to Oct. 1, 2016.

For more information about the VFC program, please click here.

*Action Needed: Providers should expect any overpayments that they received for services prior to October 2016 on VFC-related services to be recouped.

New Provider Portals for FHN and CCAI

Both FHN and CCAI have new provider portals. In addition to authorization information, claim status inquiry is now available through these portals for most services.

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 claims status.

CMS / Federal Update

Provider Enrollment Revalidation Look Up Tool

Included previously in the June 2017 Revenue Cycle Update

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 revalidation tool was last updated on May 15.

*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 June 2017 Revenue Cycle Update

The Medicare Outpatient Observation Notice (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 Aug. 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 have been required to provide the MOON, per CMS guidance since March 8.

*Action Needed: Providers should be providing MOON notices as required.

Medicare Access and CHIP Reauthorization Act of 2015

Included previously in the June 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 June 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 June 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 bulletin

Provider Reference Materials

Illinois Managed Care Notices

Blue Review - Overpayment Recovery Process Reminders

Vaccines for Children (VFC) program - Private Stock Vaccines (Title XXI)

FHN's Provider Portal Is Here

CCAI's Provider Portal Is Here

CMS

Medicare Outpatient Observation Notice (MOON) Instructions

Medicare Revalidation List

CMS: Revalidations