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Did You Know?

Transitioning to an EHR does not hurt short-term inpatient outcomes, according to a study of several Boston institutions.

True or False?

Critical care or vent management is separately billable on the same date as surgery.

T or F?

Check next month's issue for the answer!

Last month's answer is: **False**

Trick question! Pain catheter or Dura-morph follow-up visit is not billable until the 2nd day.

Bundled-Payment Expansion Brings Providers More Risk, Opportunity

CMS announced a proposal recently to put three new episodes of care under mandatory experiments with bundled payments, potentially compelling hundreds of additional hospitals into becoming financially accountable for what happens to Medicare patients long after they leave the hospital. It was just one in a series of steps in an effort to move Medicare and the entire industry toward models that pay for the quality of healthcare rather than the quantity of services.

But the nature of the care in the new proposal—treatment for acute myocardial infarction (heart attack), coronary artery bypass grafts, and treatment for hip or femoral fractures—constitutes a bigger ask for the participants, which haven't been chosen yet. And for hospitals with limited experience with bundles, the brisk pace of the transition could pose additional challenges. Nonetheless, many are cheering the aggressive adoption of mandatory bundles because, they say, it gives them a framework to provide better care for patients. Some counter that hospitals should have seen this coming. "They've had plenty of time to prepare," said Josh Luke, a University of Southern California professor and founder of the National Readmission Prevention Collaborative and the National Bundled Payment Collaborative. "They should start preparing for the next bundle."

Rather than resisting, providers will be asking the CMS to create similar programs that involve other specialties. That's because the agency proposed last week that the programs would qualify as advanced alternative payment models under MACRA—meaning practices participating in them would be exempt from the law's quality-incentive framework and be eligible for an additional bonus on their fee-for-service payments. "From a lot of the conversations I have with specialists and specialty societies, I can conceive that almost every surgical or medical area will want something here," acting CMS Administrator Andy Slavitt said. "We don't want to just push the market," he added. "We want the market to pull us and show us when they're ready."

CMS Previews How Hospitals Will Fare With New Star Ratings

Before the release of much-anticipated star ratings for overall hospital quality, CMS has now published data showing how those star ratings are distributed across hospital characteristics, such as size and status. The data shows that hospitals of all kinds, such as teaching hospitals or safety net institutions, can vary in quality as indicated by star ratings, the CMS said. " We hope that by releasing our analysis of the impact of the overall star ratings on different types of hospitals, we are able to clarify our ratings and address any questions or concerns about the data from stakeholders," the agency said.

Out of 4,599 hospitals, just 2.2%, or 102 institutions, received a five-star rating, while 20.3% received four stars, 38.5% received three, 15.7% earned two stars and 2.9% received a single star. For 20.4% of hospitals, the star rating was deemed not applicable, a status conferred on hospitals that did not meet minimum reporting thresholds.

The major difference in star ratings by teaching status was that 24.2% of non-teaching hospitals were listed as non-applicable for overall star ratings, compared with 8.8% of teaching hospitals. Safety net hospitals had a slightly lower mean rating—2.88 stars—than non-safety net hospitals, which earned 3.09 stars on average. Hospitals eligible for disproportionate share hospital payments also ranked slightly lower on average than hospitals that were not eligible for DSH payments, receiving 2.92 stars versus 3.47.

Internal Audits

By Kelly Dennis

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Practices are often too busy with day-to-day work to conduct internal audits. However, if your practice has a compliance plan, it generally outlines a required audit frequency. Do you know what your compliance plan requires? Your practice may be required to conduct both pre-submission (claims reviewed *before* filing to the insurance carrier) and post-submission (claims reviewed *after* filing to the insurance carrier) audits at regular intervals, such as semiannually.

An internal audit is simply an objective review of the anesthesia services billed to monitor the accuracy of claims. It should be performed by a qualified employee – such as the office administrator, manager, certified coder (other than the employee who coded the services), the compliance officer, a physician, or a combination. Each practice determines the number of charges or percentage of claims to be reviewed for each provider or by date of service. The practice should also determine how to make appropriate corrections and, depending on the internal audit results, whether to contact legal counsel. Although the standard compliance plan typically requires a practice to undertake all claims auditing with legal counsel, the practice may have modified the plan to require legal counsel consultation only during certain times, for example during an external audit.

A simple pre-submission review should compare the codes and modifiers billed with the documentation on file. Because the auditor reviews this information before submitting the claim, corrections are made during the review process and corrective actions should be taken and conveyed to staff. For example, a review determined the coder mistook the acronym "TKA" for a total knee arthroscopy (01400 base value - 4) rather than a total knee arthroplasty (01402 base value -7). The practice should take several corrective steps:

1) Change code, if applicable. Different physicians may be using different acronyms;

2) Ensure acronyms in your practice are clearly defined; and

3) Request a report of 01400 and 01402 claims filed within the past 18 months to verify accuracy or confirm whether this was a repeated error.

Important areas to review are anesthesia time, concurrency, signatures and documentation of medical direction criteria – all hot topics for anesthesia services. Depending on your software concurrency reporting capabilities, it may be necessary to review an entire day of concurrency if your practice includes residents, certified registered nurse anesthetists (CRNAs), anesthesia assistants (AAs), or student registered nurse anesthetists (SRNAs). It is important to understand that concurrency calculations must include all patients, regardless of insurance. While some carriers allow a combination of up to four concurrent cases, graduate medical rules differ and allow up to two cases when residents or SRNA's are involved. Teaching documentation should clearly show who is teaching the SRNA as payment for teaching varies between teaching anesthesiologists and teaching CRNAs!

Whether conducting a pre- or post-submission review, keep documentation of all steps taken in a compliance file. Even if your practice only reviews once a year, make certain the time frame agrees with the written compliance plan. The adage, "It is better not to have a compliance plan, than to have one and not follow it," is particularly true for anesthesia practices, as anesthesia billing rules are often vague and ambiguous.

About The Author

Kelly Dennis has 33 years of experience in anesthesia coding and billing and speaks about anesthesia issues nationally. She has a Master's Degree in Business Administration, is a certified coder, with special certification in anesthesia coding, and a certified instructor through the American Academy of Professional Coders. She is an Advanced Coding Specialist for the Board of Medical Specialty Coding and serves as lead advisor. She is also a certified health care auditor and has owned her own consulting company, Perfect Office Solutions, Inc., since November, 2001.