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Combating a Cash Flow Crisis: Unique Ways to Find Lost Revenue

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AGENDA

Outpatient Insights

1. Hypoglossal Nerve Stimulation
2. UHC OP Observation Policy for Facility Claims

Inpatient Insights

3. Tricare TPL
4. Revenue Protection for IP Short Stays

Modifiers Matter

5. Kissing Iliac Stenting
6. Device Procedure Bypass List
7. Commercial Payers & NCCI Edits

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25,000+
employees

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OUTPATIENT INSIGHTS

1. Hypoglossal Nerve Stimulation (HNS)

Each Medicare Administrative Contractor has the same Local Coverage Article (LCA) for HNS

- For NGS: LCA A57092
- Requirements: Sleep Apnea DX G47.33 + BMI DX Z68.1 to Z68.34
- HNS is non-covered for beneficiaries with a BMI >= 35

Coding Conundrum:

If the LCA requires a BMI diagnosis demonstrating a "normal" BMI, yet coding guidelines state "BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity)," how can the BMI codes be appropriately assigned for HNS?

Lost Revenue Cause

Missing required BMI DX for HNS Coverage

Example $$ Impact

CPT 64582
Zero Pay

$29,000 Loss
per claim

1. Hypoglossal Nerve Stimulation (HNS)

The ICD-10-CM Guidelines for Coding and Reporting also state, for outpatient encounters:

"*Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.*"

For HNS, since treatment should only be rendered to a patient with a BMI of less than 35, **a BMI diagnosis code (Z68.XX) would meet the definition of a reportable diagnosis for outpatient encounters**.

Go-Forward Recommendation

Outpatient CDI Initiative

- Partner with physicians to ensure that BMI, and the linkage of BMI to the medical necessity of HNS, is documented

Lost Revenue Cause

Missing required BMI DX for HNS Coverage

Example $$ Impact

CPT 64582
Zero Pay

$29,000 Loss
per claim

2. UHC OP Observation Policy for Facility Claims

- UHC requires that all observation services and charges be reported on a single line in Revenue Code 762
- If observation spans two days, the date of service to be reported on that single line should be the date that observation care begins (see UHC Policy Number 2023R6013C)
  - This is in line with Medicare's billing requirements!
- To prevent denials: **implement a bill edit to only allow 1 line of observation in Revenue Code 762**
- To bypass: **delete any additional lines of observation and associated charges, resubmitting the claim ensuring you only have one line of observation billed total with all units and charges**

Lost Revenue Cause

Claim-Level Denial when reporting Observation Hours on separate lines

Example $$ Impact

Zero Pay due to OBS Denial (Payment Depends on K)

$6,000 Loss *per claim*

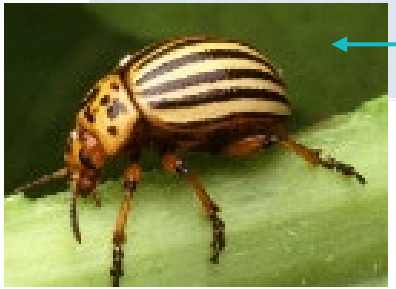
INPATIENT INSIGHTS

3. TRICARE Third Party Liability

Lost Revenue Cause

- When patient is unresponsive to the form request, claim remains completely denied
- Written off to patient non-compliance

Description	ICD-10
Included Diagnosis codes	Code ranges of **S** and **T** ending with the 7th character of A ranges category
Excluded Diagnosis codes	S00.02 - S00.97, S10.1 - S10.97, S20.1 - S20.9, S30.82 - S30.877, S40.22 - S40.879, S50.32 - S50.879, S60.32 - S60.879, S70.22 - S70.379, S80.22 - S80.879, S90.42 - S90.879, T15.1, and T16.



Example $$ Impact

Zero Pay due to TPL Denial
(Payment Depends on DRG)

$20,000 Loss
per claim

4. Revenue Protection for IP Short Stays

If services are medically necessary, but denied for LOC, consider:

- Appeals
- Arbitration (don't be afraid to dispute!)
- Rebilling as Outpatient
  - CMS ABREBILL guidelines as industry precedent (10+ years!)

Contract Considerations

- Ensure managed care contracts do not prohibit pursuit of outpatient reimbursement for LOC denials
- Consider incorporating an agreed upon benchmark for IP

Lost Revenue Cause

Failure to pursue Outpatient reimbursement for medically necessary services deemed NMN IP

Example $$ Impact

Failure to get OP reimbursement for denied IP TKA

$12,000 Loss
per claim

4. Revenue Protection for IP Short Stays

Approach Appeals Strategically; Track Outcomes

- Monitor payer behavior

Consider collectability when deciding whether to appeal or rebill as outpatient

When prioritizing appeal volume, consider targeting procedures deemed by Medicare or TRICARE as Inpatient Only

- Inpatient Only procedures tend to be more complex, often requiring longer post-op monitoring and recovery
- Appealing for Inpatient payment on these types of procedures is often more successful

Example $$ Impact

Failure to get OP reimbursement for denied IP TKA

$12,000 Loss
per claim

4. Revenue Protection for IP Short Stays (MA)

New 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) released this April that will specifically affect Medicare Advantage payers.

MA must provide coverage for an inpatient admission when:

1) The admitting physician expects the patient to require hospital care that crosses two midnights
2) The physician determines that the patient will not need to stay 2 midnights but still determines that inpatient level of care is warranted (as a case-by-case exception)
3) When the procedure is specified as Inpatient Only, regardless of length of stay

Lost Revenue Cause

Medicare Advantage plans historically failing to comply with Medicare-specific coverage guidelines

Example $$ Impact

Zero Pay due to MN denial from lack of documentation

$20,000 Loss *per claim*

MODIFIERS MATTER

5. Kissing Iliac Stenting

Lost Revenue Cause

Coding guidance not updated to reflect current MUE Values and Medicare billing requirements for bilateral procedures

Outdated Guidance: *When the same territory(ies) of both legs are treated in the same session, modifiers may be required to describe the interventions. Use modifier 59 to denote that different legs are being treated, even if the mode of therapy is different.*

Prior to 11/1/2018 → MUE of 2

12	360	OPERATING ROOM	37221	093018	1	1000000
13	360	OPERATING ROOM	3722159	093018	1	1000000

11/1/2018 to Present → MUE of 1

12	360	OPERATING ROOM	3722150	010121	1	2000000

Example $$ Impact

37221 x 2
denied for MUE

$16,000 loss
per claim

6. Commercial Payers & Device Procedure Bypass List

- CMS continues to expand the Device-Dependent Procedure list (OCE Edit 92)
- However, some procedures on the list such as **repair, revision, or removal codes**, may not require a device in practice
- **Modifier CG** can be appended to the device-dependent procedure CPT to attest that no device was used
- CMS updates the bypass list quarterly, and changes are often retroactive
- Many Commercial Payers now apply Device Edits when processing claims
- Is your system set up to identify codes that are that can be billed with modifier CG on non-Medicare claims?

Lost Revenue Cause

Reporting a device-dependent procedure without a device HCPCS code or Modifier CG results in Commercial Denial

Example $$ Impact

CPT **27696**
(Repair of Ankle Ligaments)
without device or modifier CG

$6,000 loss
per claim

7. Commercial Payers & NCCI Edits

- Many Commercial Payers now apply NCCI Edits when processing claims
- Is your system set up to identify Col 2 codes that may require a modifier on non-Medicare claims?

Lost Revenue Cause 1

- Reporting Column 2 Codes without appropriate modifier, resulting in a denial of line-item charges

Overturning the Denial

- Submit Corrected Claim (TOB 137) with modifier, when appropriate

Example $$ Impact

Reporting 93458 without appropriate modifier

$5,000 loss *per claim*

7. Commercial Payers & NCCI Edits

- Many Commercial Payers now apply NCCI Edits when processing claims
- Is your system set up to identify Col 2 codes that may require a modifier on non-Medicare claims?

Lost Revenue Cause 2

- Commercial payer denies line-item charges even when appropriate modifier is reported

Overturning the Denial

- Appeal; or,
- Submit Corrected Claim to reallocate charges*

**See Medicare Claims Processing Manual, Chapter 4, Section 180.2*

Example $$ Impact

Reporting 93458 without appropriate modifier

$5,000 loss *per claim*

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QUESTIONS?

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THANK YOU

CMS proposes 340B remedy paired with 16 years of OPPS offsets

Why this matters

- Significant financial impact to all hospitals paid under OPPS
- Likely litigation - Budget neutrality as a requirement vs reverse engineering a claw back
- AHA's comment letter to CMS

"The AHA is grateful for HHS' attentive proposals for how to repay 340B hospitals fully, promptly, and with the least administrative burden."

"HHS should not pursue any "budget neutrality adjustment." If it does, it should 1) drastically reduce the overall amount; 2) delay any recoupment until 2026 or later; 3) finalize the current aspect of the proposal that would spread the "adjustment" across 16 years (or more); and 4) recoup funds in a way that does not lead to a MAO windfall at the expense of hospitals and health systems, which in no way benefits the SMI Trust Fund."

How does CMS plan to repay hospitals for 340B cuts?

- One-time lump-sum payments to 340B hospitals for 2018 – 2022 discounts taken (~$9B)
  - Amounts to include beneficiary coinsurance
  - Payment w/in 60 days of CMS notification
  - CMS released payment estimates by provider (see Addendum AAA)
- Total repayments ($10.5B) offset by -0.5% non-drug OPPS payment reduction for 16 years starting 1/1/25
  - New hospitals (> 1/1/18) exempt

60-day comment period ended 9/11/23
CMS to finalize prior to release of the OPPS Final Rule

Source: https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/hospital-outpatient-regulations-and/cms-1793-p

Rate setting not keeping pace with pipeline of high-cost gene therapies

Why this matters

- Innovative, costly, and unlike anything we've ever seen
- New FDA-approved gene therapy products:
  - Zynteglo | Beta-Thalassemia | $3M
  - Hemgenix | Hemophilia B | $3.5M per dose
  - Elevidys | Duchenne Muscular Dystrophy | $3.2M
  - Roctavian | Hemophilia A | $2.9M one-time
  - Lantidra | Type 1 diabetes | $300k annually
  - Vyjuvek | DEB skin disorder | $631k per year
- Complicated evolution of applicable codes, billing requirements, and payment structure (NTAP vs New DRG vs Outlier)
- Hospital charging practices matter more than ever for future rate-setting

Prime Therapeutics is aiming to support Medicaid plans in managing gene therapies

Prime Therapeutics' approach to assist Medicaid plans comes in the form of Value Plus, which assists states in negotiating value-based contracts with drug manufacturers. Under these arrangements, the drugmakers will refund a portion of the treatment's cost to the state should they fail to meet desired outcomes

- Fierce Healthcare Sept '23