News to Note – Late December 2019

- The Journal of the American Medical Association retracted a study they published looking at the efficacy of an intensive program for patients hospitalized with COPD. The patients met with a nurse educator during their admission and had contact with the nurse after discharge every two weeks for 3 months. They measured all hospitalizations and ED visits. When first published, the data indicated great success with the program. But then the authors did a re-analysis of the data and found the data sets were reversed. The intervention group who received more attention and more teaching had significantly more hospital visits.

- Does your health system own a physician practice and bill with code G0463? Pay attention and then check your Observation claims for a payment reduction! When a patient is seen in an employed physician’s office, the facility fee for the clinic visit is billed with G0463. That code is subject to a site neutral payment reduction of 30%. If that same patient is referred to the hospital for observation, the hospital includes the G0463 code on the observation claim and here’s where things could go awry. According to a revenue integrity specialist at one hospital, the presence of the G0463 code on an Observation claim with at least eight hours of Observation service hours led to the Comprehensive APC for Observation being paid but the total payment was reduced by 30%! If you find the same kind of situation is happening at your hospital, go talk with your Medicare Administrative Contractor (MAC).

- The CMS discharge planning regulation is in effect but we still do not have the data necessary to offer quality and resource use data for all post-acute providers as required. At the keynote address of the American Case Management Association Leadership Conference last month, Jean Moody Willilams, Deputy Director of the Center for Clinical Standards at CMS was asked how hospitals should manage this situation. Her response was to do what you can with the data available and you’ll be ok. So, if anyone happens to be surveyed and is cited for not presenting the patient with all data, her email address, which she openly shared, is jean.moodywilliams@cms.hhs.gov.
In the proposed version of the discharge planning rule, CMS was going to require that the process be developed with input from nursing leadership, medical staff, and other pertinent services. After receiving comments that this was too prescriptive, CMS decided not to adopt this and instead stated that hospitals should review their discharge planning process on a regular basis. They determined it would be unduly burdensome to establish a specific time frame for the review but also stated, “while we are not establishing a specific timeframe requirement in order to preserve flexibility for hospitals, we would recommend that a hospital do its periodic review every 2 years at a minimum.” So, it would be burdensome to tell you how often to review your process… but you should review your process at least every two years, according to CMS. Noted!
* The news above in addition to many other points of interest for Physician Advisors and other leaders in health care can be heard weekly during Dr. Ronald Hirsch’s Monday Rounds segment on RACmonitor.com’s Monitor Monday webcast/podcast. Learn more at https://www.racmonitor.com/monitor-mondays-podcasts/welcome