Maryland
Hospital Association

November 29, 2018

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

On behalf of our 63 member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to provide the Health Services Cost Review Commission (HSCRC) feedback from its November 5 meeting on National Correct Coding Initiative (NCCI) edits.

Background
On July 1, the Centers for Medicare & Medicaid Services (CMS), began applying certain outpatient NCCI billing edits to Maryland and other non-Outpatient Prospective Payment System (OPPS) hospitals, from which they were historically exempt. Maryland's hospitals are required to comply with the HSCRC's rate setting methodologies and charging requirements.

On September 14, MHA sent a memo to Dennis Phelps, associate director of audit and compliance, outlining our concerns with the implementation of these billing edits. This included a request to continue to suspend the edits, or, to allow a minimum grace period of one year before implementation. In September, Novitas, the Medicare Administrative Contractor (MAC) for Maryland, agreed that the state's hospitals did not receive sufficient notice of this change. CMS and Novitas agreed to suspend the billing edits from October 1 through December 31, to give Maryland's hospitals time to comply.

Issues Identified
On November 5, representatives from Maryland's hospitals, MHA staff, and Phelps met to discuss implementation issues and the feasibility of complying with the billing edits by January 1, 2019.

Three major issues were identified:

1. **Medicare Requirement to "Bundle" Services Contradicts HSCRC Charging Guidelines**: The Medicare edits now require Maryland's hospitals to "bundle" charges, or not bill separately for services that are "secondary" to the primary service or procedure. Historically, the HSCRC has required separate charging for separate services. The costs and revenues of the secondary services are reported in rate centers other than the primary service.

The Medicare requirement to bundle electrocardiogram (EKG) services with operating room (OR) or other procedures is one example. Standards of care require an EKG before and after some surgeries and procedures.

- **HSCRC Charging Guidance** - Hospitals charge separately for the resources used in the OR — OR minutes x rate per minute — plus the resources used to administer the EKG — EKG Relative Value Units (RVU) x rate per RVU. The charges and underlying costs used to develop these charges are in separate HSCRC rate centers.

- **New Medicare Billing Edit** - The newly applied NCCI billing edit will reject a claim with an EKG charge that is related to the OR charge. The edit, previously applied only to hospitals subject to OPPS based on Ambulatory Payment Classifications (APCs), does not allow a hospital to bill separately for these services.

In this case, **the newly applied billing edit conflicts with the HSCRC requirement to align underlying costs with charges on a rate center basis**. There are hundreds of similar examples using the newly applied edits.

The group discussed several options to address the issue and their risks:

Options	Risks
Convert or revise several HSCRC rates to correctly match costs and charges to comply with Medicare billing rules. In this example, EKG charges (and costs) would be reclassified to OR, and the EKG RVUs related to OR procedures would be removed.	With hundreds of conflicting issues among rate centers, it is not feasible to complete this work by January 1. Underlying costs would have to be reclassified among rate centers to realign rates appropriately. **HSCRC staff and hospitals must also implement a process to monitor changes and remediate these changes quarterly when billing edits are updated.**
Add charges for related services to the primary service, but do not bill separately for the related service. In this example, EKG charges would be added to OR charges and billed to Medicare as part of the OR charge without billing separately for EKG. HSCRC reporting of EKG RVUs and charges could remain unchanged.	Adding charges from another rate center to the "primary" rate center is likely not permissible under Medicare billing rules. **Clear guidance from the HSCRC and CMS would be required for this approach.** This would also require significant lead time to program billing systems and train departmental staff to know when charges require bundled or separate billing.

Remove the separate charge for the related service from the bill. In this example, if the EKG is not a separate and distinct service, the charge is removed from the bill. A modifier is applied if it is a separate and distinct service. This option would be combined with option 1 to be fully and appropriately implemented.	**Removing charges will inappropriately reduce hospitals' net revenue —** even under a Global Budget Revenue (GBR). If the charge is removed and not reported to the HSCRC as separately billable, the hospital could raise prices on other services to retain the same GBR. Under OPPS (and IPPS), the effect of bundled charges is not particularly meaningful because the hospital receives a fixed payment for a particular APC (or diagnosis related groups). In Maryland, this is not the case, and net revenue is lost. Hospitals would also require significant lead time to successfully implement this change.

2. **Compliant Charging for Separate Services Requires Work Flow Changes:** The second major issue is the change in coding requirements and underlying documentation, when separate and distinct services occur on the same day. The newly applied billing edit requires a modifier on the Medicare bill to indicate that both services provided were appropriate on the same day.

As an example, a patient may visit a hospital-based clinic the same day he or she receives infusion or chemotherapy services. Before July 1, Medicare claims did not require a modifier or supporting documentation to justify that it was appropriate to bill these services on the same day. To successfully comply with this requirement, hospital staff must assure that the visit is charged appropriately — with or without the modifier — and the medical record documentation must support the use of the modifier.

This change in workflow requires a significant level of training and education for back office coding and billing staff, as well as front line departmental staff. This requirement has not applied in Maryland because the state's hospitals have always been required to charge separately for identifiable and billable services. It is not likely that all Maryland hospitals will be able to comply with this requirement by January 1.

3. **Medicare's New Billing Requirements Could Change Other Payer's Approaches**: Hospitals could implement changes to satisfy Medicare, only to "turn off" these types of edits for other providers. Over the years, the HSCRC issued several memorandums specifying that Maryland's hospitals were exempt from certain NCCI edits due to differences in charge structures. As a result, other payers could not force Maryland's hospitals to comply with these edits. Should Maryland's hospitals and the HSCRC change charge structures to

comply with Medicare edits, clear guidance would be required to prevent other payers from implementing conflicting edits.

For example, the Emergency Medical Treatment and Labor Act (EMTALA) needs to be billed separately. As reflected in the EMTALA billing guidance issued by HSCRC in 1999 and as discussed in the November 5 meeting, EMTALA screening charges should be reported as a separate revenue code. The new Medicare billing edits now require emergency department charges to be billed under one charge code.

Medicaid and Medicaid managed care organizations (MCO) often pay EMTLA screening because many visits are later determined to be "not medically necessary." From a clinical care standpoint, hospitals screen everyone that comes through the emergency department. Some hospitals have begun bundling charges to comply with the new Medicare billing edits. As a result, several hospitals report complete emergency room department charge denials by certain Medicaid MCOs, including the portion for EMTALA screening that is bundled in the charge — **even though the screening is required by law**. It is likely that other Medicaid MCOs and commercial payers will follow Medicare's lead to require bundling of emergency department charges, resulting in an increase in hospital denials.

Conclusion

We understand HSCRC staff believe Maryland's hospitals should be held to the same compliance standards as hospitals nationwide. We agree that our hospitals should be held to appropriate standards. However, Maryland's hospitals and the HSCRC must align charging and billing practices for all payers, including Medicare, in a way that complies with the state's regulatory system. **Complete compliance by January 1 is not feasible, particularly if several unit rates require revenue, expense, and RVU reclassifications by that deadline**. More troublesome will be the need for **HSCRC staff and hospitals to address new edits on a quarterly basis**, which may require substantial changes to HSCRC charging rules and allowable hospital rates. HSCRC staff and hospitals should not invest significant resources to comply with complex billing requirements that conflict with Maryland's regulatory system. These resources can be better deployed as we seek to reduce Medicare's Total Cost of Care per beneficiary.

Maryland's hospitals continue to believe the most prudent course of action is to convince CMS to remove these edits because Maryland's hospitals are subject to different charging requirements under HSCRC rules. To comply with quarterly updates, HSCRC staff and hospitals would have to monitor changes and possibly reclassify revenues and adjust rates multiple times each year. If the edits remain in place, Maryland's hospitals would require one year before the implementation to allow time to convert and reclassify HSCRC categorized services, train staff, and remediate billing systems.

Thank you for your consideration of these important issues. Should you have any questions, please call me directly at 410-540-5060.

Sincerely,

Brett McCone
Vice President

cc: Dennis Phelps, Associate Director
Donna Kinzer, HSCRC Consultant