Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

A Newsletter for Physicians, Hospital Outpatient & Their Support Staff Addressing Medical Reimbursement Issues

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APC/APG Update

We continue the discussion of Transmittal 82, February 8, 2008, to Publication 100-02, Medicare Benefit Policy Manual in this issue. CMS has issued several other important documents during the first quarter of 2008.

1. Transmittal 1417, January 18, 2008, to Publication 100-04, Medicare Claims Processing Manual,
2. Transmittal 1419, January 18, 2008, to Publication 100-04, Medicare Claims Processing Manual,
3. Transmittal 1445, February 8, 2008, to Publication 100-04, Medicare Claims Processing Manual, and
4. S&C-08-12, February 8, 2008, State Operations/Survey & Certification Group.

The Survey & Certification Group document relates to revised interpretative guidelines for Hospital Conditions of Participation (CoPs). In this issue, we will also start to discuss some of the topics from Transmittal 1445. Any hospital personnel involved with observation services should read and study Transmittal 1445.

RAC Program Issues – Part 2

Editor's Note: This article continues a series of articles discussing the issues being addressed through the CMS RAC audits.

Here are two more key issues for the RAC audits and associated action steps.

DRG Transfer Rule

Over the past ten years, CMS has significantly expanded the DRG Transfer Rule so that hundreds of DRGs are subject to possible payment reduction. The basic idea is that if a patient is in the hospital and is discharged to skilled nursing or home health services, then this process is considered a transfer instead of a full discharge. Thus, there is potentially a payment reduction. With the per diem approach, if the patient is in the hospital for three days, there are four per diems (double the first day plus the remaining days). If the four per diems are less than the geometric mean length of stay (GMLOS) for the DRG, then there is a payment reduction.

As long as hospitals assign the correct discharge status, the payment reduction will be calculated through the DRG grouping process. Other than incorrectly assigning the discharge status, hospital personnel may not know that a patient is going to skilled nursing or to a home health program at the time of discharge.

For home health, this is particularly difficult, because the hospital may have no way to track this type of situation. CMS has been queried about this and has given the following:

> ***Response: We [CMS] recognize there may occasionally be cases where a hospital believes it is discharging a patient to home or another setting not included in the postacute transfer definition, and a physician orders postacute care for the patient without notifying the hospital. Although these cases would be considered transfers under this provision, we do not believe that such instances, where they occur truly without knowledge of the hospital, constitute fraudulent actions. As we indicated in the proposed rule, we intend to monitor postacute care cases to evaluate whether such situations occur with unlikely frequency at specific hospitals and we will investigate the circumstances in those instances.*** (63 FR 40980)

Note that CMS is saying this is ***not fraudulent***, but it is still ***an overpayment***, and the RAC audits will certainly look at this type of situation. Preparing for this potential situation requires special audits and follow-up to determine if there are instances in which this is occurring.

Three-Day Inpatient Stay Qualifying SNF Coverage

In order for a Medicare beneficiary to qualify for skilled nursing services, there is a 3-day, inpatient qualifying

period that is required. Once again, ***medical necessity*** is the key issue. The contention is that the full three days was not medically necessary. For instance a patient could have been discharged after two days, but because three days is needed to qualify for SNF services, the physician kept the patient in the hospital an extra day.

Note that observation days do NOT count toward the SNF qualifying days. This situation exacerbates the issue of using observation in lieu of inpatient admissions. A physician may be assessing a patient who could possibly first go to observation for two days after which a decision might be made to admit as an inpatient. After a day or two as an inpatient, the patient is ready to be discharged for skilled nursing services, but they will not qualify for SNF coverage.

Thus, a physician may opt to admit the patient immediately in case the patient might need to go to skilled nursing.

Just as utilization review is heavily involved in the observation versus inpatient issue, utilization review needs to carefully assess the medical necessity of inpatient stays for patients that might be going for skilled nursing services. While cases must be individually considered, compliance personnel should look for any patterns.

> Case – **3-Day Stays** – The Apex Medical Center has the good fortune to have a group of orthopedic surgeons that perform knee replacements both unilaterally and bilaterally. An audit limited to Medicare patients has been conducted, and some disturbing data has been uncovered. Only a few patients did not go for skilled nursing services. Additionally, most of the cases had exactly three day stays while a few were in the hospital for four days.

Hopefully you are not in this kind of a situation, but this is the type of statistic that would greatly interest RAC auditors.

Preparing for this potential challenge involves conducting an audit to see if there are many 3-day stays just prior to skilled nursing services. In other words, take all of the cases in which the patient is discharged to skilled nursing and develop a frequency analysis. If there is a relatively high frequency of 3-day stays relative to 2-day stays and 4-day stays, then a sampling of cases is certainly in order.

In conducting such an audit you will be challenged by judging the medical necessity of the stay. Were the three days really medically necessary, or was the patient held primarily to qualify for coverage of the skilled nursing services? Note that it does little good to judge these situations after the fact. Utilization review must intervene dynamically as these situations are occurring.

Editor's Note: We will continue the discussion of these issues and the necessary preparation for the RAC audits in future Newsletters.

OPPS Update – Key Definitions – Part 2

Editor's Note: This is the second part of an article discussing important definitional guidance from CMS through Transmittal 82, February 8, 2008, to Publication 100-02 – Medicare Benefit Policy Manual. Note that while this Transmittal is titled relative to OPPS, CAHs are also included.

CMS continues the discussion of 'incident-to' for hospital coverage and payment.

> ***To be covered as incident to physicians' services, the services and supplies must be furnished by the hospital or CAH or under arrangement made by the hospital or CAH (see section 20.1.1 of this chapter). The services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of treatment of an illness or injury.***

Note the phrase 'under arrangements'. As noted in the Transmittal, under arrangements is referenced in § 201.1, but to obtain a definition you must go to Publication 100-01, Chapter 5, §10.3, that is, the Medicare General Information, Eligibility, and Entitlement Manual.[1]

The definition for under arrangements is not highly informative other than the directive that the provider who is obtaining the under arrangement services is fully responsible both clinically and for payment from the Medicare program.

Note: The Provider-Based Rule, 42 CFR §413.65, has a prohibition for hospitals providing 'under arrangement' services. The exact meaning of this prohibition and/or the extent to which the prohibition is to be applied has never been explained by CMS. Based on what little we have, it appears that CMS is trying to say that a hospital (i.e., provider) cannot establish an under arrangements process that is for billing purposes only. For example, a

[1] If you have never looked at the various definitions, then a few minutes review may be in order. Without the definitions, none of the rules, regulations, CFR entries and the *Federal Register* make much sense.

turn-key therapy services arrangement[2] in which there are no hospital personnel involved clinically.

From Publication 100-01, Chapter 5, §10.3, we have:

> ***Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services.***

While this does not give us complete insight as to where the line is drawn between covered versus non-covered *under arrangements,* some guidance is better than none. If we apply the above comment to our turn-key therapy operation, it is quite likely that such a therapy operation would still be under some form of professional responsibility. For instance, most likely there will still be a physician on the hospital's Medical Staff Organization that oversees the therapy services operation.

For our discussion, the next paragraph in the Transmittal, we will parse the paragraph into two parts.

> ***The services and supplies must be furnished in the hospital or at a department of the hospital which has provider-based status in relation to the hospital under 42 CFR §413.65 of the Code of Federal Regulations. The services and supplies must be furnished on a physician's order (or on the order of nonphysician practitioners working within their scope of work and the state and local policies) by hospital personnel and under a physician's supervision, as described below. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician responsible for care of the patient.***

While this statement appears to be straightforward, there are some hints that there are two different categories or locations in which services can be supplied. Namely:

- In the hospital, or
- At a department of the hospital under 42 CFR §413.65.

This division is not strict. For instance, page 50080 of the August 1, 2000 Federal Register indicates that at least certain departments in the hospital fall within the '*department of the hospital under 42 CFR §413.65*' concept.

Because the provider-based rule imposes special obligations on provider-based clinics that are off-campus, we generally divide provider-based organizations into three different categories:

- In the hospital,
- Out of the hospital but on campus, and
- Off campus.

While this may seem to be a highly academic issue, see the discussion of physician supervision below. Note that, up to this point in time, services provided in the hospital or on the campus of the hospital, physician supervision has been assumed. Only in situations in which the services are off-campus has the issue of physician supervision been an issue.

> ***However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment.***

This statement could certainly raise some issues. However, it is unlikely that a physician would simply order a service and not be involved (and/or an on-call physician be involved) in following up. For instance, a physician may order a blood transfusion or an injection, but the physician would typically be informed and would monitor the situation. Thus, this statement is not unreasonable although care should be exercised that physicians do document their care even if such documentation is outside the hospital's documentation.

> ***The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises. The hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished at a department of the hospital which has provider-based status in relation to the hospital under 42 CFR 413.65 of the Code of Federal Regulations, the services must be rendered under the direct supervision of a physician who is treating the patient.***

[2] A typical turn-key therapy services operation would be where a hospital contracts with an outside company to provide all physical and occupation therapy services without any hospital personnel being involved clinically or administratively. Basically, the hospital is only billing for the services.

This statement is poorly written and raises significant concerns! The intent of the first statement appears to conform to the previous concept that physician supervision is assumed in the hospital or on the hospital campus. But the word that is used is 'premises'. What, exactly, are hospital premises? This language is typically used in the provider-based rule relative to properly identifying an off-campus facility as being part of the hospital. In other words, a patient entering the provider-based clinic knows that they have entered hospital premises. We also have the word 'property' used in EMTALA. So what is the relationship between:

- Premises,
- Campus, and
- Property?

CMS goes on to state that the physician supervising the services may be from a department different from the ordering physician. This is consistent with the concept of simply having some qualified practitioner available as necessary.

The next statement represents a significantly new policy. CMS seems to be trying to say that if you are off-campus, then there must be direct physician or practitioner supervision. This is consistent with the provider-based rule requirement that off-campus situations require direct supervision. But then, CMS is now stating that the supervising physician must be ***the physician who is treating the patient.*** **This changes everything!!**

Here is a simple case and then a more comprehensive case on the same theme.

Case – **Series of Injections** – An elderly patient uses the Apex Family Practice Clinic that is a provider-based clinic. Her physician has ordered a series of weekly injections. She presents on Friday for her weekly injection. A nurse performs an assessment, judges that the patient can have the injection and then provides the injection. While there is a physician at the clinic, her treating physician is not present.

Case – **Infusion Center** – The Apex Medical Center has established an off-campus infusion center. Various types of injections, infusions, blood transfusions and even some chemotherapy are provided. The main staff consists of nurses, and Apex has a nurse practitioner on duty at the infusion center. Thus, supervision by a qualified practitioner is being maintained.

The new policy embedded in this definition would not allow the organizational structuring in either of the two above cases.

> ***"Direct supervision" means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.***

Gratefully, this definition of direct supervision is simply a recital of previous language that has been widely used by CMS.

Note that CMS is establishing significant policy changes in these definitions. The ability to make definitions is enormously powerful. The real question in analyzing this Transmittal and the associated changes to the Medicare Benefits Policy Manual is whether or not CMS intended to make such policy changes. Perhaps the phraseology used in these definitions was not intended to change policy. If this is the case, then these definitions need to be carefully reworked with precise language and correlated definitions.

Questions from Our Readers

Question: A patient presents, and hydration is ordered for four hours. During the second hour a drug is infused. Is this drug infusion concurrent to the hydration?

The way in which the CPT coding conventions have been established, the answer appears to be 'no'. Hydration is set off by itself in CPT (i.e., 90760+90761). Also, using the hierarchy embedded within the infusion and injection codes, infusion therapy of a drug will always be ranked above the hydration.

Thus, the correct coding for this question appears to be 90765 + 3*90761. However, this makes the assumption that the time during which the infusion therapy is being provided negates the use of 90761. In theory, the physician ordered (and justified) the hydration for 4 hours, which was done. Except the hydration during the time of the drug infusion would seem to be incidental. That is, the patient had to be hydrated (to some degree) during the drug infusion.

Thus, we see the use of three times the 90761 versus four times 90761.

Editor's Note: This is an interpretation. If anyone has seen guidance to the contrary, let us know!

Question: Do we need to use the "-59" modifier on 90772, the IM/SQ injection code?

The general answer to this question is 'no'. Of course, this answer is qualified as being theoretical. If you are having problems with CCI edits in the injections and infusions area, then you will need to consider the use of the "-59" modifier. If you have the 'primary vs. secondary' logic in place through the careful choice of codes, you should have no problem.

The 90772 code basically stands alone outside the 'primary vs. secondary' logic for many of the codes in this section of the CPT Manual. Thus, the number of IM/SQ injections that are provided would be coded regardless of other injection and infusions.

Note that injections and infusions continue to be problematic for most hospitals. Monitor coding, billing and reimbursement closely.

Question: What is the citation for the fact that the DRG transfer rule does not apply to Sole Community Hospitals?

See the Provider Reimbursement Manual, Part 2, Section 3630.1 where line 7 of the cost report is discussed. There is the key statement:

> ***"For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period."***

The trick to understanding this citation is that the phrase 'sum of the DRG weights' does not state 'the sum of the *transfer adjusted* DRG weights'. You will need to read through this section of the PRM carefully. It is always difficult to recognize what is not present as opposed to what is present.

Question: We have a case in which the nurse documents an IVPB, but there is no documentation of the time. Thus, we are reverting to the minimum time of one hour and using 90765. Is this correct?

The process of reverting to the lowest code is correct. However, in this case the guidance from the FIs is that the lowest level is that of an IVP is an IV injection. Obviously, hospitals must continue to work on documentation including start and stop times for infusions.

Editor's Note: In the next edition of this Newsletter, we will discuss injections and infusions further. There appears to be new guidance in Transmittal 1445 dated February 8, 2008.

Current Workshop Offerings

Editor's Note: The following lists a sampling of our publicly available workshops. A link for a complete listing can be found at:
http://www.aaciweb.com/Sept2007June2008EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2008 Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information. Workshop planning information can be obtained from our password protected website.

A variety of Webinars and Teleconferences are being sponsored by different organizations. Instruct-Online, AHC Media, LLC, Accuro Health and the Eli Research Group are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008. This calendar is updated frequently as presentations are scheduled. Note that most of these sponsors can also provide these sessions in CD/DVD format. Thus, if you are not able to participate at the scheduled time, you can still obtain the information and listen at your leisure.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2008. Contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for May 6th is "T***he Emergency Department and APCs".*** The presentation will run from 9:30 a.m. to 11:00 a.m. EDST.

Dr. Abbey has completed his eighth book, "***Compliance for Coding Billing & Reimbursement: a Systematic Approach to Developing a Comprehensive Program***" This is the 2nd Edition published by CRC Press. ISBN=978156327681. There is a 20% discount for clients of AACI. See CSmith@aaciweb.com for information.

Contact Chris Smith concerning Dr. Abbey's books:

- **Emergency Department Coding and Billing: A Guide to Reimbursement and Compliance**
- **Non-Physician Providers: *Guide to Coding, Billing, and Reimbursement***
- **ChargeMaster: Review Strategies for Improved Billing and Reimbursement**, and
- **Ambulatory Patient Group Operations Manual**
- **Outpatient Services: Designing, Organizing & Managing Outpatient Resources**
- **Chargemaster Coordinator's Handbook** is currently in preparation.

A 20% discount is available from HCPro for clients of Abbey & Abbey, Consultants.

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FOR UPCOMING ISSUES

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****** ACTIVITIES & EVENTS ******

Compliance Reviews are being scheduled for hospitals and associated medical staff concerning the various areas of compliance audits and inquiries. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement.

Interventional Radiology, Catheterization Laboratory and Vascular Laboratory a Challenge? Special studies are being provided to assist hospitals in coding, billing and establishing the Charge master. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about preparing for the RAC audits? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.