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

You should have the updated Integrated Outpatient Code Editor (I/OCE), Version 11.1, in place through your APC grouper software. The NCCI Edits are at Version 16.0. Be certain to review the two update Transmittals for APCs and the I/OCE:

1. Transmittal 1927 – March 5, 2010 – 'April 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.1'
2. Transmittal 1924 – February 26, 2010 – 'April 2010 Update of the Hospital Outpatient Prospective Payment Sy7stem (OPPS)'

O'Connor Hospital Ruling

A RAC appeals case stemming from 2004 has now reached the Medicare Appeals Council. The next step in the appeals process is Federal Court.[1]

At issue are four claims judged by the RAC as not justified for inpatient admission and associated services. Thus the RAC demanded return of the inpatient payments as overpayments. The Administrative Law Judge (ALJ),which is the appeals step before the Medicare Appeals Council, ruled that three of the claims were justified and medically necessary. The fourth claim was judged as not medically necessary for inpatient admission, BUT the services provided would have met the requirements for observation services.

Note: This appeal involves the very sensitive and broadly based issue of short-stay inpatient admissions that should have been observation. The Medicare program has never adopted formal standards for inpatient admissions. Thus, any short-stay inpatient admission can be questioned and there is no definitive way to know that the admission is proper. (See associated article on an OIG study addressing the RACs.)

CMS's stance on this type of situation is that the hospital has lost all reimbursement. If a hospital determines after the fact or an auditor determines for them after the fact, then the only billing is a Type of Bill 110 for a no-pay claim. In theory there might be some incidental services that would not be part of the inpatient claim, but basically all reimbursement is lost.[2]

The ALJ ruled that the observation services should be paid in lieu of denying payment for the inpatient services. CMS appealed stating that there was an error in law.

"*In its referral memorandum to the Council, CMS asserts that the ALJ erred as a matter of law by ordering Medicare payment for "the observation and underlying care" provided to the beneficiary because those services are not separately billable under Part A."*

From the ruling:

The Council does not agree that the case contains an error in law. The position advanced by CMS in its memorandum is inconsistent with the guidance set forth in the CMS Manuals.

CMS has expressly stated that Part B payment may be made if Part A payment is denied.

The ruling goes on to discuss various Medicare rules and regulations supporting the fact that CMS should make payment for the observation services that will offset some portion of the inpatient overpayment.

"*In this case, the provider submitted a timely claim for services which was paid under Part A. When the RAC reopened the determination on the initial claim at issue here, it had the same plenary authority to process and adjust the claim as it did when that claim was first presented and paid. The RAC's revised initial*

[1] See "The Medicare Recovery Audit Contractor Program" authored by Dr. Abbey. CRC Press, ISBN: 1-4398-2100-8.

[2] For instance, see "Hospital Guidelines for Outpatient Observation Services", AdminaStar Federal, Inc., December 2002 Medical Director's Corner.

determination states that the beneficiary met the criteria for outpatient observation status."

"*Consistent with the CMS manual provisions discussed above, the* ***contractor shall work with the provider to take whatever actions are necessary to arrange for billing under Part B****, and thus, offset any Part A overpayment. The contractor shall issue a new initial determination upon effectuation*." (Emphasis added.)

Clearly, the ruling indicates that when the RAC reopened the determination, everything starts over. Thus, if there should have been some other payment, then the claim should have been adjusted, and the proper payment credited against the overpayment.

Understandably, CMS is very concerned about this type of interpretation. If this interpretation holds up (assuming CMS does not take this to court), there are significant issues of reduced overpayments and then complicated processing issues. Let us take an example.

Case Study 1 – In the afternoon, Sam, a retired rancher, has been brought to the Apex Medical Center's ED. He is complaining of chest pains and a severe headache. An extensive workup is provided at the ED including laboratory testing, cardiology testing and extensive radiology tests including a CAT scan. Sam's attending physician decides to admit him as in inpatient due to a probably cardiac event.

The next morning, Sam is feeling much better. Virtually all of his symptoms are now abated. Additional testing indicates no problems, and Sam is discharged just before lunch.

Because this was an inpatient admission, all of the diagnostic testing and services provided in the ED are included on the inpatient claim[3], at least as charges, although there would be no CPT coding reported. Now if a RAC determined that this whole episode should have been an outpatient observation case, we will need to go back and determine what payment should have been made on the outpatient side. This will require rebilling and recoding the case with all the CPT codes for the various ED and diagnostic services along with the observation.

Once the rebilling is accomplished, then the amount that should have been paid for the ED services and the observation can be determined. Just the process of rebilling the case with proper codes is significant. Quite likely, a significant portion of the inpatient overpayment will be offset by the outpatient payment.

Let us take the concept of using what should have been paid and applying that payment against the overpayment by extrapolating to other types of situations.

Case Study 2 – The Apex Medical Center has just received a RAC determination that there was a claim that paid $400.00, but an incorrect CPT code was used. That is, the code used was not justified by the documentation. The RAC is demanding repayment of the $400.00. Apex checks and discovers that a different code should have been used that would have paid $320.00. Unfortunately, this claim is outside the time period whereby it can be refiled.

If we use the intent of the ALJ ruling, which is being upheld by the Medicare Appeals Council, then the overpayment amount is actually $80.00. Because the RAC reopened the case, the $320.00 payment can be used to offset the $400.00 overpayment. But how will the proper code and corrected claim be developed and recognized and by whom?

The concept enunciated in the ruling can also be applied to current types of situations. Take Case Study 1 and modify the facts by having utilization review (UR) intervene in the case just before Sam is discharged from the hospital. Presume that UR, with the physician's concurrence, by using Condition Code 44 changes the case to observation. Recent pronouncements from CSM[4] have stated that the observation services can only be billed from the time the doctor orders the observation. The ALJ ruling *appears to imply* that the observation should be considered back to the beginning of the episode of care occasioning the inpatient admission.

Bottom-Line: Whether CMS will appeal this ruling into the Federal court process is not known. If it is appealed, this issue could be tied up in the courts for years. There are two potentially major issues:

i. There are tens of millions of dollars in recouped overpayment that may need reconsideration.
ii. The process for reconsideration is quite complex and will take significant effort on the part of providers and Medicare contractors.

Be certain to follow any further developments in the O'Connor Hospital case. Whatever the outcome, it should be interesting! You can download the ruling from:

www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf

[3] See the DRG Pre-Admission Window process whereby all diagnostic services and related therapeutic services must be bundled into the inpatient claim.

[4] See CMS Q&A #9973.

GAO Report on RACs – Part 1

CBR compliance personnel have long worked to identify and address fundamental issues in which there are substantive questions about coding, billing and the claims adjudication process. While inadvertent or episodic errors have always been of concern, questions surround the fundamental propriety of coding and billing in certain circumstances and have been particularly perplexing because guidance is not available, guidance is not clear, guidance is inconsistent, and sometimes guidance is misleading. This situation has now been recognized through a GAO study and resulting report.[5]

CMS conducted the RAC demonstration project as an extended learning event. One of the key issues identified was that there are some fundamental coding, billing and reimbursement issues. These are issues that were discovered repeatedly by the RACs and amounted to hundreds of millions of dollars in overpayments. However, CMS did not identify or respond to these fundamental issues. One of the main issues is that of short-stay hospital inpatient admissions.

CMS did develop a spreadsheet, the IPPP or Improper Payment Prevention Plan, after the completion of the demonstration project. This is an internal document to which the GAO had access when the audit was conducted.

For instance, from page 19 of the report we have:

> "*The lack of accountability and adequate processes for ensuring corrective actions are taken have resulted in most of the RAC-identified vulnerabilities that led to improper payments going unaddressed.*"

A most interesting footnote on page 19:

> "*This information is based on our analysis of the data recorded on the IPPP and we did not verify the accuracy of it. Although CMS listed some corrective actions in its evaluation report of the 3-year demonstration, issued in June 2008,* ***most of the actions listed were vague and did not address the root causes of payment errors****.*" (Emphasis added.)

These fundamental CBR issues certainly can be identified through root cause analysis, namely, by simply drilling down through the identified vulnerability as indicated by significant and repeated recoupments. CMS can then develop guidance, education, training and/or enhanced adjudication software to help prevent identified types of errors.

If CMS has not followed up on specific fundamental issues, the GAO calls them vulnerabilities. Then hospitals, physicians and other healthcare providers can continue easily to make the same mistakes without even knowing mistakes are being made. An associated issue for healthcare providers is obtaining answers to sometimes perplexing coding and billing issues. When questions arise and a MAC is contacted, the answer to the specific question may be, 'Well run the claim through the system to see if it goes through'. Thus, the judgment for the correctness of the claim and the associated coding and billing is whether the claim will be processed through the adjudication logic without edits or errors occurring.

It is interesting to note that if a hospital or physician files a claim under known policies and guidelines and the MAC processes and pays the claim, which appears to verify correctness of the claim, that years later the claim may be judged to represent an overpayment. While there is an overpayment, what has really happened is that the MAC may have incorrectly paid the claim. The healthcare provider has not knowingly done anything wrong. The MAC has paid the claim incorrectly, most likely due to incomplete and inconsistent guidance from CMS. However, it is the healthcare provider who will be held accountable for the alleged overpayment.

Editor's Note: In future issues we will continue to discuss the findings from the GAO audit.

The 'Complications Rule' & the Medicare GSP

Medicare has an extensive global surgical package (GSP) for physicians. Among the many features of claim adjudication and thus payment under the GSP is the so-called ***complications rule***. Over the years, CMS has tried to develop the concept *normal complications*. The idea is that if a surgeon performs surgery, and then if situations arise during the surgery or even after the surgery, then these events will not be separately paid if they are normal complications of the surgery.

Needless to say, developing such a definition for payment purposes is next to impossible because the concept of *normal complications* is a clinical issue not a payment issue. Complications can arise due to a number of different reasons including specific issues of anatomy, patient condition and even skill of the surgeon.

Thus, CMS uses a different criterion, namely, the *return to the operating room* concept. Even with this concept

[5] 'Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight', GAO-10-143 issued March 2010.

there can be significant interpretive issues that arise. For instance, if a re-operation, that is, the same procedure must be performed and it is during the initial operative session, then there is no additional payment. However, if the same procedure must be performed during the post-operative period, then payment under the complications rule would apply.

If additional surgical services, due to complications, are required during the initial operative session, then these additional surgical procedures would be paid with multiple surgical discounting. However, if additional surgical procedures are required that necessitate return to the operating room, then the payment process under the complications rule apply.

> **Note**: While subtle, keep in mind that the Medicare GSP concept applies only when the same surgeon, or a surgeon from the same group,[6] provides the re-operation or additional surgical services.

Just how is payment calculated under the complications rule? Here is the key statement:

> If a patient is returned to the operating room as a result of complications, Medicare pays the value of the intra-operative services of the surgery performed to treat the complications.

Thus, instead of using the typical discounting to a 50% payment, only the intra-operative percentage of the RVU under the Medicare physician fee schedule (MPFS) is paid. That is, the pre-operative and post-operative percentages are not considered.

> **Case Study 3** – Sam has just had an orthopedic surgery performed. This procedure typically pays the surgeon $800.00. Later in the day, complications from the surgery are noted and Sam is returned to the operating room for an additional procedure which normally pays $350.00.

In Case Study 3, the complications rule would apply in order to pay for the second surgery. To calculate the actual payment we need to have the pre-, intra- and post-operative percentages. These percentages are listed in the MPFS. For our purposes, assume:

- Pre-Operative – 10%,
- Intra-Operative – 70%, and
- Post-Operative – 20%.

Thus, the surgeon will not receive the $350.00, but will receive 70% of $350.00 or $245.00. Note that if the multiple procedures discounting is in place, the surgeon would receive 50% or $350.00 or $175.00.

For claims adjudication the key element is the "-78" modifier. The "-78" modifier drives the application of the complications rule payment process. From CPT:

> "**78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure a Related Procedure During the Postoperative Period**: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.

The description of the CPT modifier "-78" introduces a new word, namely *related*. Now a natural question is whether or not being *related* and being a *complication* are the same. At issue is that we are using clinical terms to define payment formulas. This type of process generates significant compliance issues because unusual cases always seem to arise.

In this case, the Medicare program would be wise to develop the payment formulas based on the CPT terminology, that is, define what *related* means as opposed to what a *complication* means.

The foregoing discussion has focused on the surgeon's providing services that fall under the GSP. There are two other healthcare providers that can become involved in this process, namely:

1. Anesthesiologists, and
2. Hospitals.

For anesthesiology there is a surgical package, but it is much less detailed than the general global surgical package. The key issue of the anesthesiologist or CRNA (Certified Registered Nurse Anesthetist) is whether or not the patient has been released from recovery. Anesthesia has responsibility from the time anesthesia is induced to the time th patient leaves the recovery area. If there is a return to the operating room that results before the patient is discharged from recovery, the original encounter is still in process. However, if the patient has been discharged from recovery and is elsewhere (possibly a medical/surgical bed) when there is a decision to return to the operating room is made, then for anesthesia there is a new encounter initiated.

Circumstances for hospitals are different from that for physicians or the anesthesiologist.. If this is an inpatient surgery, then if there is a return to the operating room

[6] This is a billing concept relating back to NPIs and Medicare billing privileges.

before the patient is discharged, the inpatient encounter is ongoing. However, if this is an outpatient surgery and the patient has been discharged, the return to the operating room is a new encounter even if on the same date of service. However, there are many convoluted situations that may occur, which can challenge the overall payment process.

Case Study 4 – Sarah is at the Apex Medical Center to have outpatient surgery. The surgery appears to have gone according to plan. Sarah is in recovery for four hours and then is taken to the pre-/postoperative room for further rest before discharge. While in the postoperative room she develops significant pain, the surgeon is called and a decision is made to return her to the operating room for further surgical care.

Now in Case Study 4 we need to determine how the surgeon, anesthesiologist and the hospital are affected by the process of returning to the operating room. GSP for the surgeon would indicate that this is a return to the operating room, and we will assume it is for a related reason. Thus, the "-78" modifier will be used, and payment for the second surgery will be calculated under the complications rule.

For the anesthesiologist, this appears as a new episode requiring anesthesia. Sarah was discharged from recovery to the pre-/postoperative room. For the hospital, Case Study 4 does not represent a new encounter because Sarah has not been fully discharged from outpatient status. While the "-78" modifier will be used by the hospital, the second, presumably lesser surgery, will be discounted at 50%.

Note: For our case studies we will assume that there are no NCCI edits encountered relative to the surgeries themselves.

Bottom-Line: The so-called *complications rule* is a payment process that is part of the Global Surgical Package, which, in turn, is part of the Medicare Physician Fee Schedule. The key trigger for payment processing using the complications rule is the return to the operating rule either on the day of the surgery or during the post-operative period. Note that as with other parts of the GSP, this applies only to the surgeon who is performing the surgery and then the surgery involving the return to the operating room. The "-78" modifier drives this whole process.

Additionally, careful consideration must be given to how the anesthesiologist and then the hospital are affected relative to instances in which there is a return to the operating room.

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:
www.aaciweb.com/JantoDecember2010EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2010. Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information.

A variety of Webinars and Teleconferences are being sponsored by different organizations. Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, and the Eli Research Group are all sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2010.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2010. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for May 18th "***Supplies, Devices and Compliance"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's latest book:

"***The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers***" is now available for purchase. This is a companion volume to

"***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition.

Both of these books are published by CRC Press of the Taylor & Francis Group.

A 15% discount is available for subscribers to this Newsletter. For ordering information contact Chris Smith through Duane@aaciweb.com.

Also, Dr. Abbey has just finished the second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second in the series addresses fee schedule payment systems and should be available shortly. The third book in the series is devoted to prospective payment systems and is currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below.

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Schedule your Compliance Review for you hospital and associated medical staff now. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement. These reviews also assist in preparing for the RACs.

Worried about the RAC Audits? Schedule a special audit study to assist your hospital in preparing for RAC audits. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Duane@aaciweb.com

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned about maintaining coding billing and reimbursement compliance? Contact Mary Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com.