

## Medical Reimbursement Newsletter

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

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### APC/APG Update

The next major event for APCs will be the *Federal Register* entry for the proposed rule regarding changes for CY2013. Hopefully this *Federal Register* entry will be out sometime in June. CPT may also have significant changes for CY2013.

### Predictive Modeling of Medicare Claims

In the October, 2010 edition of this Newsletter, see pages 56-57, a new provision in the Small Business Jobs Act of 2010 (SBJA) was discussed. Since that time CMS has been working on developing the analytics engine that is necessary to process claims prior to payment.

CMS has contracted with Northrop Grumman to develop the algorithms and analytics engine. Northrop is working with National Government Services and Verizon's Federal Network Systems. From MLN Matters #SE1133:

*"As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns."*

If some sort of unusual billing activity is occurring, then claims can be flagged for a more thorough review before payment is released. This process augments pre-payment reviews and still utilizes analysts that will assess the type of activity. According to SE1133:

- *Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.*

- *If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.*
- *Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and Zone Program Integrity Contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.*

Healthcare providers of all types are interested in better understanding the risk scores that are generated. Obviously, these risk scores depend solely on the algorithms that are used to check and analyze claims. CMS is indicating that providers will not be able to challenge their risk scores, but the usual administrative processes will be available to appeal administrative actions or overpayment recovery efforts.

Presumably, risk scores and the algorithms being used, over time, will become available to healthcare providers. Also, developing what will amount to tens of thousands of algorithms will take significant effort over several years. As with all other aspects of healthcare, the various checks and analytics applied will need to change as coding, billing and claim adjudication changes are implemented.

As with other auditing activities, audit questions will arise, and CMS may need to issue new, more specific guidance. The new guidance will be considered clarifying guidance as opposed to any sort of changed guidance. This way the new guidance can be applied retroactively.

While healthcare providers study and track what is happening with the predictive modeling, being able to

apply the same types of analytics to the provider's own claims databases would certainly be useful. If healthcare providers can apply the same, or at least similar, analytics, then potential problem areas can be identified and remediated before any recoupments are demanded.

**Bottom-Line:** Hospitals, clinics and other healthcare providers should carefully track the development and application of these predictive analytics. This is just another layer within all of the auditing activity relative to overpayments.

## Cardiovascular Interventional Radiology Continuing Coding Changes

Starting in CY2011 the CVIR code structures in CPT are undergoing a major change which is continuing in CY2012. The current code structure appears temporary for some sequences so there will probably be more changes in the coming years.

One new code sequence involves catheterization of the renal artery(s) or accessory renal artery(s). The new sequence is:

- CPT 36251 – Selective Catheterization Renal Artery - Unilateral
- CPT 36252 – Selective Catheterization Renal Artery – Bilateral
- 36253 – Superselective Catheterization Renal Artery – Unilateral
- 36254 – Superselective Catheterization Renal Artery - Bilateral

In past years we have had the venerable sequences:

- CPT 36215-36218 - Thoracic or Brachiocephalic Branches
- CPT 36245-36248 – Abdominal, Pelvic or Lower Extremity Branches

While the renal arteries are now being separated out for coding purposes, there are some significant changes that are not readily apparent. First of all the conscious sedation annotation, that is, the bulls-eye or  $\odot$ , has been applied to the new sequence as well as to the 36245-248 sequence. For some reason CPT has not chosen to use the conscious sedation annotation for the 36215-36218 sequence.

In the second change, there are no longer associated radiology supervision and interpretation (S&I) codes for the renal catheterizations. Previously, we had the 75722 and 75724 for renal angiography. Thus, the radiological S&I is now being bundled into the selective and superselective renal catheterizations. In previous years

the APC payment for these services was made through the radiology codes with the catheterization codes being Status Indicator "N" for packaged payment.

If purely diagnostic services are provided, which include the CPT 36251-36254 sequence, payment must be made for these codes as opposed to the now deleted radiology codes. For APCs we have:

SI=Q2, APC=0279, Relative Weight = 29.7209, and Payment = \$ 2,080.94

This is essentially the previous payment for the radiological S&I. The status indicator of Q2 means that if any other SI="T" service is performed, then these renal catheterizations will be bundled.

This new sequence really illustrates that cardiovascular catheterizations are being bundled, and movement is away from component coding (i.e., surgical plus radiological codes). Also, the concept of diagnostic procedures being bundled into therapeutic service (e.g., angioplasties, atherectomies and/or stent placements) is definitively being followed.

Look for continuing changes in coming years for the CVIR code sequences. Cardiovascular services will be a major growth area with the Baby Boom generation reaching the point at which cardiovascular services are demanded. Thus, hospital coding, billing and compliance staff will need carefully to devote appropriate resources to this service area.

## O'Connor Hospital Ruling - Revisited

In the April, 2010 issue of this Newsletter, see pages 19-20, the O'Connor Hospital Ruling was discussed. This case originated from the original demonstration RAC activities. The RAC contention was that an inpatient admission was not appropriate, and recoupment was demanded. This case, at the ALJ (Administrative Law Judge) level, resulted in a ruling that directed Medicare to pay for the observation services that were justified. Thus the recoupment would be reduced by the amount of payment that should have been made for the necessary observation services.

CMS appealed the ALJ ruling to the Medicare Appeals Council (MAC). Interestingly, the council concurred with the ALJ's ruling and made no change. The next step in this process is for CMS to appeal to the federal court level. However, there is no readily available information on where this case now stands.

The fact that the council concurred with the ALJ in that the observation should have been paid, or at least reduced the inpatient recoupment, runs very much

counter to the way the RACs and CMS have addressed these cases. Basically, the RACs have demanded repayment and the hospital has little recourse because the timely filing deadlines have been exceeded relative to re-filing a claim for the observation services.

A key element in the O'Connor Hospital ruling involves actions that can occur when a case is reopened.

*"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."*

Because there should be a part B payment, that is, the payment for observation, then the Part B payment can offset the Part A payment which was deemed not medically necessary.

Now this case involves a Part A hospital admission versus a Part B observation service. However, often when a RAC requests repayment of a service, particularly on the basis of lack of medical necessity, there is a service that should have been paid. Thus, this concept has fairly broad applicability for virtually all types of healthcare providers including physicians and clinics.

Thus, when rebuttal documents and appeals are developed, reference to the O'Connor Hospital ruling should be made, as appropriate to lay the groundwork for future changes in this area. While this ruling specifically addresses an inpatient admission that should have been classified as outpatient, there is the general issue of being able to address payment relative to reopening a given case. This more general reopening interpretation occurs in cases in which a given service may not be medically necessary, but some lower paying services was necessary and should be paid. At least the lower paying services should offset part of the recoupment demand.

Readers should be watchful for further information concerning the O'Connor Hospital ruling and/or applicability of the re-opening concept for developing offsets to recoupment demands.

### The "-24 Modifier

The proper use of the "-24" modifier is an easy target for the RACs and other federal auditing programs. Only physicians use this modifier, and then the modifier is used only on E/M codes.

The CPT description for modifier "-24" is:

**"24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service."

This modifier is **not available** on the hospital outpatient side because under APCs (Ambulatory Payment Classifications) there is no post-operative period.<sup>1</sup> On the hospital side, if there is a patient encounter on a date of service after the date of the surgery, then this is a new outpatient encounter.

For instance, if a individual presents to a hospital's ED with a laceration on the arm, the individual will be provided with medical screening examination (MSE)<sup>2</sup>, and then the laceration will be repaired. If the patient returns five days later to have the sutures removed, there is a new hospital encounter. However the ER physician (or ER physician group) has been paid for the post-operative services.

The "-24" modifier is used by physicians to indicate unrelated services in a post-operative period. The two issues for the correct utilization of this modifier are:

1. Same Physician, and
2. Unrelated E/M Services.

CPT interprets same physician to mean not only the given physician but also a physician of the same specialty in the same group. Actually, CPT goes a step further in that the same subspecialty must be attained.<sup>3</sup> For instance, see the definition of a new patient versus an established patient. While this specialty versus subspecialty can be argued, for the Medicare program the language involves the same specialty in the same group practice.

The second issue is subjective and relates to the question of whether or not the E/M services in a post-operative period are related or unrelated to the surgery that generated the post-operative period. In the small example in the ED that was provided above, the removal of the sutures would certainly be related to the surgical procedure of repairing a laceration.

The "-24" modifier is an easy target for auditors including the RACs. Claims easily can be identified by filtering on

<sup>1</sup> See the November 1, 2002 *Federal Register* page 66793 (67 FR 66793).

<sup>2</sup> As required by EMTALA (Emergency Medical Treatment and Labor Act).

<sup>3</sup> See the 2012 CPT Manual for updated language.

the “-24” modifier and the documentation reviewed for selected cases. What the auditors are checking is for any mistaken use of the “-24” modifier. For instance, in our laceration example above, the patient may present back to the same ED eight days later and be seen by a completely different ER physician. The professional billers may find that the claim is rejected as which point the “-24” modifier is appended presuming that the original service was provided by a physician elsewhere.

On the clinic side, a patient may be returning to a clinic several weeks after an orthopedic procedure that has a 90-day post-operative period. The physician may indicate that the E/M services provided are not related, but the documentation may not be clear on the separation of services from the original surgery.

Note that there is a tie in between the “-24” modifier and the global surgical package (GSP) modifiers, namely, the “-54”, “-55” and “-56” modifiers. For example, going back to our little laceration repair case, the patient may go to their own primary care physician for the suture removal and wound recheck. While the primary care physician should use the laceration repair code with the “-55” modifier, the claim may be coded with the “-24” modifier to ensure that the claim goes through adjudication. Obviously, this is incorrect use of the “-24” modifier.

### **Enrollment Delays & the CMS-855s**

Please note that there are an increasing number of concerns being raised about getting routine Medicare enrollment through the process. Activities that should take a few weeks are being delayed to the level of several months. With the brunt of the revalidation submissions it appears that the MACs (Medicare Administrative Contractors) are well behind in processing the various CMS-855 forms. This is particularly true for initial application for enrollments of physicians and non-physician practitioners.

Anticipate that these delays may become even longer as we all work through the revalidation process. If you anticipate new physicians/practitioners joining a practice or if you need to re-file your 855-A or 855-B due to ownership changes or tax identification number (TIN) changes, then start the process well in advance if at all possible.

Note that there are some limitations on how far in advance you can file enrollment forms. For instance, for physicians you are generally not allowed to file more than 30 days prior to the start date. CMS may change this in the future. Be certain to work directly with your MAC if you have anything unusual or need to address issues in advance.

### **Medicare Odds & Ends**

CMS has announced that the new start date for ICD-10 is October 1, 2014. While hard to predict, there may be further delays down the road. We will all just have to wait and see. For the time being, simply prepare as-if this is the final implementation date.

### **Questions from our Readers**

*Editor's Note: Questions from our readers are encouraged. Those asking questions are kept anonymous. Also, suggested answers should be assessed*

**Question: We are a payer that sponsors a Medicare Advantage plan. For Medicare beneficiaries under our plan, we simply adjudicate outpatient claims using APCs and the Medicare Physician Fee Schedule (MPFS). We are receiving both a 1500 professional claim and a UB-04 claim for hospital-based clinics. How can we know that these are being correctly billed as hospital-based clinics?**

For sponsors of MA plans there are significant concerns about provider-based clinics and the fact that two claim forms are filed that must then be adjudicated. Medicare knows about any provider-based clinics through the CMS 855 enrollment forms. For those entities that sponsor MA plans such information may not be readily available.

MA plans do need to adjudicate claims appropriately. For provider-based clinics this means that the place-of-service (POS) must be reported accurately on the CMS-1500 claim form in order to apply the site-of-service differential to the physician payment. If a MA plan is receiving both claims for the same patients, then due consideration should be given to verifying that the given hospital has attained provider status for given clinic operations.

This same issue will arise when the “-PD” modifier goes into effect for freestanding, physician clinics that are wholly owned or wholly operated by hospitals. This is the 3-Day Payment Window. MA plans will be receiving claims from what are normally freestanding clinics. Unless there is some sort of information flow to the MA plans, these sponsors will not know about the status of these wholly owned or wholly operated freestanding clinics.

MA plans may want to include provisions in their contracts with Medicare so that information about provided-based clinics and wholly owned or wholly operated clinics is available. This way the MA plans can be reasonably certain that both technical component and

professional component claims are being processed correctly.

**Question: CMS is indicating that at the national level there is a trend for the ED E/M levels (i.e., 99281-99285) to skew more toward the level 4 and level 5 codes. What should hospitals be doing to avoid future compliance issues regarding correct E/M levels in the ED?**

The questions about proper coding for the ED levels (CPT 99281-99285) and clinic levels (99201-99205 for new patients and 99211-99215 for established patients) are arising more often. CMS has indicated that there is some shift toward the higher levels, that is, levels 4 and 5 for hospital emergency departments.<sup>4</sup>

Reading between the lines, CMS is indicating that CMS itself will probably not issue any E/M coding guidelines for hospitals. For the past two years CMS has alluded to having the AMA develop guidelines. Also, there has been no guidance since 2001 concerning the proper use of the “-25” modifier. Concern continues to grow in that the technical component E/M levels and the “-25” modifier will shortly become major compliance targets for the RACs and other federal auditing programs.

Hospitals are left to their own discretion when developing their own internal guidelines for mappings into the various levels. There are two related hospital concerns:

1. Are the mapping that are being used appropriate, and
2. Are we generating statistically appropriate frequency distributions?

Presuming that a given hospital has an appropriate mapping(s), the frequency distribution of the different E/M levels for the ED and provider-based clinics really depends on the type and frequency of presentations to the ED and clinics. Unless you can quantify the types of presentations there is no real way to determine if the frequencies of the various E/M levels is appropriate.

For instance, a large metropolitan hospital may legitimately have more high level ED encounters relative to small urban area that may have more low level ED encounters because of a lack of clinic facilities. If there is no meaningful way to quantify the types and frequencies of encounters, then the mapping(s) may be skewing encounters toward the higher levels. Hospitals should certainly be prepared to address RAC concerns in the near future including the distinct probability that statistical extrapolation will be used.

<sup>4</sup> See the November 30, 2011 *Federal Register*, page 74345 (76 FR 74345).

## 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/JantoDecember2012EdCal.htm](http://www.aaciweb.com/JantoDecember2012EdCal.htm)

On-site, teleconferences and Webinars are being scheduled for 2012. Contact Dr. Abbey at 515-232-6420 or e-mail at [DrAbbey@aaciweb.com](mailto:DrAbbey@aaciweb.com) for information.

A variety of Webinars and Teleconferences are being sponsored by different organizations including the Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, Colorado Hospital Association, Hospital Association of Pennsylvania, and the Eli Research Group. Please visit our main website listed above for the calendar of presentations for CY2012.

The Georgia Hospital Association is sponsoring a series of Webinars each month. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or [CHughes@gha.org](mailto:CHughes@gha.org). The webinar scheduled for May 8<sup>th</sup> “**E/M Coding and Compliance**” that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's 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”**, 2<sup>nd</sup> 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](mailto:Duane@aaciweb.com).

Also, Dr. Abbey has finished the fourth book in a series of books on payment systems. The first book is: **“Healthcare Payment Systems: An Introduction”**. The second book addresses fee schedule payment systems and the third in the series addresses prospective payment systems. The fourth, and final, book in this series addresses cost-based, charged-based and contractual payment systems.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

E-Mail us at [Duane@aaciweb.com](mailto:Duane@aaciweb.com).

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**EDITORIAL STAFF**

**Duane C. Abbey, Ph.D., CFP - Managing Editor**

**Mary Abbey, M.S., MPNLP - Managing Editor**

**Penny Reed, RHIA, ARM, MBA - Contributing Editor**

**Linda Jackson, LPN, CPC, CCS - Contributing Editor**

Contact Chris Smith for subscription information at 515-232-6420.

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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.**

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