Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

August 2010– Volume 22 Number 8

ISSN: 1061-0936

APC/APG Update

For APCs each year seems to bring some sort of unusual changes. For CY2011 we have the usual evolutionary changes, and now we have some unusual changes through the new healthcare reform act, namely the Patient Protection and Affordable Care Act (PPACA). Thus, those involved with APCs will need to study a number of different issues surrounding APCs including proposed changes relative to physician supervision.

The August 3, 2010, *Federal Register* discusses a number of different issues. Note that you have until August 31, 2010 to submit your comments to the various proposals surrounding APCs. Several of these issues are discussed in this Newsletter.

Note also that the Medicare Physician Fee Schedule (MPFS) update *Federal Register* was published on July 13, 2010 with the comment period ending on August 24, 2010. Future issues of this Newsletter will discuss some of the proposed changes for the MPFS.

Mandatory Compliance Plan

The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, is thousands of pages long, and we really are just starting to sort things out. One of the provisions is that healthcare providers and suppliers are required to have compliance plans. This requirement is found at §6401(7)(B).

Over the past decade, CMS and the OIG (Office of the Inspector General) certainly have provided a great deal of guidance for developing compliance policies and procedures. Much of the discussion has centered on various coding, billing and reimbursement issues. Compliance should be maintained. However, there has been no requirement to have a formal compliance plan, as such.

While larger organizations such as hospitals, skilled nursing facilities, and home health agencies have developed corporate compliance plans to some degree of formality, smaller healthcare providers have not. Now is the time for all healthcare providers that bill the Medicare and/or Medicaid programs to formalize a compliance program. These compliance programs will be general, but much of the emphasis will revolve around coding, billing and reimbursement issues.[1]

For corporate compliance programs there have been seven key principles that were taken from the Federal Sentencing Guidelines.

1. Compliance standards and procedures,
2. Oversight responsibility,
3. Delegation of authority
4. Employee training,
5. Monitoring and auditing,
6. Enforcement and discipline, and
7. Response and prevention.

For healthcare providers and suppliers, these seven principles have been expanded to eight areas with a little more specificity:

a. Established compliance standards and procedures,
b. A senior-level compliance officer with sufficient resources and authority,
c. Due care to limit discretionary authority to wrongdoers,
d. Training and communications,
e. A reporting system for employees as well as monitoring and auditing systems,
f. Consistent enforcement, including employee discipline,
g. Reasonable responses to detected misconduct, including program modifications to prevent further similar offenses, and
h. Periodic reassessment of the compliance program.

---

[1] See Dr. Abbey's book, "***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", CRC Press, 2008.

If you don't already have a compliance program and/or your program is an informal set of coding, billing policies and procedures, then the time has arrived to get serious about a written program that functions appropriately.

Editor's Note: In future issues of this Newsletter, the various elements of coding, billing and reimbursement programs will be discussed.

Proposed APC Changes for CY2011

The August 3rd *Federal Register* is a large document with rather wide-ranging discussions. APCs are now established so that there are routine policies that must be updated each year. There are also new issues that must be addressed. Here is a synopsis of issues with brief commentary as appropriate.

- Rebasing and Recalibration – All of the APCs weights along with the conversion factor are being recalculated.
- Integrating New Codes – New CPT and HCPCS codes will be integrated into the APC weights.
- Hospital Outpatient Quality Data Reporting Program – Data collection and submission processes are established. There is a payment reduction for not participating.
- Packaging – For CY2008 CMS started to increase the number of items and services that are packaged either through Status Indicator "N" or now through the SI "Q" indicators.
- Payment Adjustments for Rural SCHs
- Cost Outlier Formula Adjustments – CY2010 uses a dual threshold of 1.75 times the APC payment and $2,175.00. CMS is proposing to keep the 1.75 multiplier but moving the fixed threshold to $2,025.00.
- Device Dependent APCs – There are 38 APCs that are classified as device dependent (i.e., the cost of the associated device is a major portion of the APC payment).
- Drugs, Biologicals, Radiopharmaceuticals, Brachytherapy Sources, and Drug Administration Services – There is an extensive discussion of pricing and APC payments in these areas.
- Inpatient-Only Procedures – Several deletions from the list are proposed.
- Hospital Outpatient Visits – CMS is not proposing any national coding guidelines for the E/M (Evaluation and Management) code sets. Thus, hospitals are still on their own for developing and using their internal mappings.
- CAH (Critical Access Hospital) Physician Supervision – CMS is proposing to create a new set of services that require a physician or qualified practitioner to initiate the service, but physician supervision is not necessary for ongoing services (e.g., observation, infusions, injections). See separate article in this Newsletter.
- "-CA" Modifier Payment – APC 0375 is a catchall category for patients that have emergency surgery that was on the inpatient-only list but the patient was not admitted to the hospital. This occurs when the patient is rushed to the operating room and expires. Payment for this APC has been steadily increasing for the last several years.
- Preventative Care Services - §§4103 and 4104 of the PPACA extends coverage to more preventative care services.
- MedPAC (Medicare Payment Advisory Commission) Recommendations
- Proposed Updates to Ambulatory Surgical Center (ASC) Payments
- Proposed Changes to Use of CCRs (Cost-to-Charge Ratios) – The CCR issue affects both APCs and MS-DRGs. There are also special areas such as Blood and Blood Products that are affected. The implementation and use of the CMS-2552-10 cost report form will not be fully effective until 2013.

While you can certainly comment to any and all of these proposed changes and updates to APCs, here are issues worth developing comments.

1. Observation Packaging – If observation services are provided along with any Status Indicator "T" services (i.e., surgeries), the payment for the observation is packaged into the payment for the surgical procedure. This is to assure that post-surgical observation is not separately paid. However, the process is illogical for minor surgical procedures such as those performed in the ER (Emergency Room) in conjunction with observation. CMS should only package observation when there is a major surgical procedure and not package when there are only minor surgical procedures. Note that the concept of *minor* and *major* surgeries is fully delineated in the MPFS.
2. Inpatient-Only Procedures – The inpatient-only procedure list should be discontinued. A new modifier should be developed for use when there is a surgical procedure provided on an outpatient basis, but there is no APC mapping. This should be done on the same basis as the use of the "-CA" modifier. This process would allow for some payment of these surgical procedures that do not have APC mappings but yet can be performed on an outpatient basis at the surgeon's discretion and liability.

3. National E/M Coding Guidelines – If CMS does not develop and implement national guidelines for facility component E/M levels, then CMS should exempt hospitals from any monetary penalties that arise from assertions that hospital internally developed mappings caused upcoding.

Physician Supervision for CAHs

As noted in the July issue of this Newsletter, CMS is proposing some additional guidance for physician supervision, particularly at CAHs. Among the changes in physician supervision requirements that CMS made effective January 1, 2010 was a requirement that whenever therapeutic services are provided a physician or qualified practitioner must be on the campus and immediately available to take over the service.

Observation is considered therapeutic, and typically various services are provided for observation patients so that such services are not completely diagnostic. For observation at Critical Access Hospitals (CAHs), this supervision requirement is distinctly different from the CoPs (Conditions of Participation) that require only a nurse be at the hospital with a physician or qualified practitioner on call (i.e., no more than 30 minutes away).[2]

Consider the following case study.

> **Case Study 1** – ***Observation Patient at a CAH*** – The Apex Medical Center is a CAH located in a rural area. This evening there are two inpatients and one observation patient staying overnight. A registered nurse is on-duty for both the patients and the ED. A physician is on-call and can be at the hospital in about 15 minutes.

In this case Apex is not meeting the new physician supervision interpretation[3] because there is no physician or qualified practitioner on the campus of the hospital.

In order to address this situation, CMS has taken two steps. First, CMS issued an alert dated March 15, 2010 indicating that they, CMS, would not enforce the supervision requirements for outpatient therapeutic services in CAHs for CY2010.

Second, in the August 3, 2010 *Federal Register* that updates the HOPPS (Hospital Outpatient Prospective Payment System), CMS has proposed some changes. CMS's proposed fix to this situation, which appears to apply to all hospitals, is to define a series of services that are nonsurgical but of extended duration. See Table 37 in the August 3, 2010 *Federal Register*. This list includes services such as infusions, observation and injections. The list ***does not include chemotherapy and blood transfusions***. The basic idea is that there should be direct physician supervision with the initiation of these listed services, but once the patient is stable, then general supervision should be the norm (as opposed to direct supervision).

Notes:

- The concept of 'stable' is borrowed from EMTALA (Emergency Medical Treatment and Labor Act), and
- The concept of 'general supervision' is borrowed from the diagnostic supervision levels as delineated in the MPFS (Medical Physician Fee Schedule).

Note also that this guidance has been developed primarily because of a disconnect between the CAH CoPs and the supervisory requirements. However, in the proposed rule changes, this appears to apply to all hospitals.

The concept of 'incident-to' is heavily referenced in these discussions. There is the general sense that services are not only provided incident-to those of a physician but that there is a physician actively involved. Certainly, the incident-to payment requirement is used as a justification for requiring physician supervision. Note also that CMS has hinted that perhaps it is the ordering physician that should be providing the supervision.

Another concern raised in these discussions is that it is fairly clear that the burden of proof is on hospitals to document that proper physician supervision is being provided. CMS uses phraseology such as 'on the premises/campus' and 'immediately available'. However these specific concepts are not formally defined. From a compliance perspective, including possible future RAC audits, ***this is a major challenge***. The basic contention is that unless you can establish proper supervisory levels, as continuously refined by CMS, then the Medicare program should not reimburse you for services. RAC auditors would certainly contend significant overpayments.

As you study the convolutions within the physician supervision requirements, you will realize that there is yet another significant challenge. This is the challenge of documenting exactly who was providing the required physician or practitioner supervision.

---

[2] See for instance 42 CFR §485.631(a)(5).

[3] Note that CMS continues to maintain that the physician supervision rules are not new, recent discussion represent only a clarification and restatement of rules that have been in place for many years.

Case Study 2 – ***On-Campus Infusion Center*** – The Apex Medical Center has a very nice infusion center in a separate building on-campus. Chemotherapy, infusions, injections, blood transfusions and the like are all provided. There is a second floor in the building where several physicians including oncologists have offices and see patients.

Certainly the oncologists could be immediately available, and they certainly have the qualifications to take over care and even change procedures. However, can you be certain that there is at least one oncologist in the building at any given time?

The only way in which you can address this type of situation is to document exactly who (i.e., which physician or practitioner) is meeting the supervision requirement. This is a major change in documentation procedures and will require some careful analysis.

First, you will need to determine exactly where and when there are therapeutic services being provided by non-physician or non-practitioner personnel. For instance, you may have a wound care operation in which services are provided by nursing and/or physical therapy staff. Second, you will need to document exactly who provided the necessary supervision (i.e., immediately available and competent to take over care).

Who and how you develop this type of documentation could prove a challenge. Note that this type of process is already common in freestanding physician clinics for which incident-to billing takes place. The nursing services must be billed under a physician who is actually at the clinic and, theoretically, supervising the nursing services. (Remember, immediately available and able to take over care.)

Editor's Note: The whole area of physician supervision requirements is taking on a life of its own. Be certain to follow developments with great care.

Medicare Odds & Ends – CMS-855 Forms

We are receiving many questions concerning the filing of and the response to filings of the various CMS-855 forms. The greatest areas of concern appear with physicians obtaining their billing privileges with the Medicare program.

Keep in mind that CMS is now starting the revalidation process for the various CMS-855 forms. The CMS Medicare Administrative Contractors (MACs) are using regular mail for the revalidation requests. For many healthcare providers, particularly physicians, their CMS-855 information may be out of date including their mailing address.

Thus, the requests for revalidation of billing privileges may never make it to the healthcare provider. When the response deadline is reached, the MAC will terminate the billing privileges, and then a very difficult process ensues in order to re-establish billing privileges.

N.B. – Healthcare providers are fully responsible for making certain that all of the information provided in connection with the various CMS-855 forms is fully up-to-date.

The bottom-line in this area is that every healthcare provider who has or wishes to have billing privileges with the Medicare program fastidiously must assure that all of the proper CMS-855 forms are properly filed and are kept completely up-to-date. For hospitals, even of modest size, there may be dozens of different CMS-855 forms that must be maintained. This is particularly true if the hospital employs physicians or practitioners.

Make certain that you have properly educated and competent personnel addressing the CMS-855 situation.

Note: There are five different forms, and, depending upon your specific circumstances, you may have multiples of any and/or all of these forms.

- CMS-855-A – Hospitals – Part A
- CMS-855-B – Clinics – Part B
- CMS-855-I – Individuals
- CMS-855-R – Reassignment
- CMS-855-S – DMEPOS

Also, the various CMS-855 forms must correlate with the way in which the NPIs (National Provider Identifiers) and the TINs (Tax Identification Numbers) have been established.

Questions from Our Readers

Question: Given the following documentation, should we be coding an E/M level in addition to the injection procedure?

Patient is here for follow-up of her right wrist pain. We obtained an MRI and it does show quite a bit of inflammation of the 1st dorsal compartment with the edema going all the way along the thumb extensor and abductor. The scapholunate interval looks okay. The triangular fibrocartilage complex looks intact.
IMPRESSION: Right de Quervain's.
PLAN: I went ahead and injected her 1st dorsal compartment today with a Kenalog and lidocaine solution and will see her back in 4-6 weeks for follow-up.

PROCEDURE: After sterile prep of the right wrist, injected a solution of 1 cc Kenalog 40 mg and 2 cc lidocaine into the 1st dorsal compartment without difficulty. The patient tolerated the procedure well.

We frequently receive questions of this type with many different variations. The documentation appears to indicate that this is a follow-up visit with the main evaluation visit having been previously provided. There is no documentation indicating any assessment other than the right wrist pain.

The coding for the injection is CPT 20605-RT. This is a minor surgical procedure. According to the NCCI (National Correct Coding Initiative) coding policy guidelines, the evaluation and management relative to a minor surgical procedure is considered part of the procedure itself. In this case the E/M level would not be coded unless there were some significant indication of other services being provided. Of course, the Kenalog should be billed and coded.

Now what if this were a provider-based clinic in which the injection were provided? The circumstances may or may not be different from our previous discussion. If the patient did have a previous encounter and the only E/M services provided was with the provision of the injection, then the E/M level would not be appropriate.

Note: To some extent we are side-stepping the question as to whether or not the NCCI coding guidelines apply on the hospital side as well. According to the NCCI coding guidelines all the directives do apply to hospitals with a very few exceptions. Thus, hospitals are suddenly faced with applying certain concepts that are in the domain of the Medicare Physician Fee Schedule. In this case, the concept of minor surgical procedures versus major surgical procedures.

However, what if a primary care physician saw the patient, ordered the MRI, and then sent the patient to a hospital-based pain management clinic? With the assumption that an anesthesiologist provides the injection; would the anesthesiologist perform a more general workup? Typically, the answer is that the anesthesiologist would perform a consultation and then decide to provide the injection.

Presuming that this is a Medicare beneficiary, we would need to map the consultation code for both the physician and the hospital into appropriate office visit codes. The "-25" modifier would be required. However, in this type of circumstance the use of E/M levels for both the physician and hospital is appropriate. Of course, we are assuming that appropriate documentation is in place!

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 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 September 28th is "***CMS 855-A Form for Hospitals***" 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 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.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
http://www.HIPAAMaster.com

Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

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.

INSIDE THIS ISSUE

APC/APG Update
Compliance Plans Mandated by PPACA
Physician Supervision – Again!
CMS-855 Forms – Problems & Challenges
Questions from Our Readers

FOR UPCOMING ISSUES

More on RAC Audits and Issues
Chargemaster Pricing Issues
More on Coding, Billing Compliance
More on Payment System Interfaces

© 2010 Abbey & Abbey, Consultants, Inc. Abbey & Abbey, Consultants, Inc., publishes this newsletter twelve times per year. Electronic subscription is available at no cost. Subscription inquiries should be sent to Abbey & Abbey, Consultants, Inc., Administrative Services, P.O. Box 2330, Ames, IA 50010-2330. The sources for information for this Newsletter are considered to be reliable. Abbey & Abbey, Consultants, Inc., assumes no legal responsibility for the use or misuse of the information contained in this Newsletter. CPT® Codes © 2010-2009 by American Medical Association.

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

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.