# 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 are now in the time period in which we can comment to the proposed changes for APCs for CY2013. September 4, 2012 is the deadline for submitting comments relative to the proposed changes.

While there are the usual evolutionary changes, there are two areas of special consideration:

1. Changing from using the median to using the geometric mean for calculating the APC weights, and
2. Establishing separately payable pharmaceutical items at average sales price (ASP) plus 6%.

The first of these areas is discussed in this issue of the Medical Reimbursement Newsletter.

## Clinical Documentation versus Payment Documentation – Part 1

Through the RAC audit program CMS is going to great lengths to deny short inpatient stays as being medically unnecessary. Currently this is occurring mainly on a post-payment basis. However, CMS is definitely gearing up for more pre-payment audits in a number of different areas.

Let us consider a simple example from the cardiovascular area.

> **Case Study 1** – ***Coronary Stent Placement*** – An elderly patient presents in the evening to the ED with chest pain and symptoms consistent with cardiovascular problems. The attending physician is familiar with the patient and notes that the patient is in distress. The patient is admitted as an inpatient, and a coronary catheterization is planned for the next morning. The catheterization shows blockage in one of the coronary arteries, and a drug-eluting stent is placed. The patient recovers quite quickly and is discharged late in the afternoon.

This case appears fairly routine except for the fact that the inpatient stay was less than 24 hours. In this case the patient who appeared quite ill upon presentation did recover remarkably quickly. Now what would RAC auditors conclude about this case?

Without much doubt a RAC auditor would claim that the inpatient admission was not medically necessary particularly when viewing the entire case (i.e., the quick discharge). At issue here is the following:

- The physician, and ostensibly the hospital, must make a decision prospectively relative to admitting to the hospital or possibly placing the patient in observation, and
- The RAC auditor retrospectively makes a decision based on the overall case.[1]

In theory the RAC auditor should only look at the documentation leading up to the decision to admit as an inpatient or placing the patient in observation. However, the RAC auditor will look at the entire case when making a medical necessity judgment.

> **Note**: Financially there is a significant difference in payment between:
>
> a. Hospital admission with stent placement, and
> b. Observation care with stent placement.
>
> In the first case payment is made under MS-DRGs 247 with a national payment of $11,165.00. Under APCs the national payment will be approximately $7,398.00. The observation services will be subsumed into the APC payment for the stent placement. This is a significant payment difference.

This type of decision making on the part of RAC auditors will increase in the coming months and years. What steps can be taken to mitigate this trend?

[1] We have not even considered the medical justification for using the drug-eluting stent versus a bare metal stent.

What must happen is that physicians and hospitals must go to great lengths to extend clinical documentation into what is termed *payment documentation*. Developing payment documentation involves writing additional documentation that is specifically for the auditors, that is, the physician must convince the auditors that the decision to admit as an inpatient is appropriate.

The general attributes of documentation include the following, so-called, three C's:

- Clear,
- Concise, and
- ***Convincing***.

For our discussion, in developing documentation, the question then becomes how can we convince the RAC auditors, or any other auditors for that matter, that the choice for the site of service is appropriate? While there is no simple answer to this question, one technique is to have physician use the word ***because*** more frequently in developing a narrative of why a particular decision is being made.

*Editor's Note: This discussion will continue in the September issue of this Newsletter.*

## APCs and the Geometric Mean

As generally anticipated, CMS has proposed to make a major change in the way in which the APC weights are calculated from cost data. CMS is moving from using the *median* to using the *geometric mean* to calculate the weights. Both the median and geometric mean are measures of central tendency for a given set of data. Virtually everybody is familiar with the *arithmetic mean* often referred to as the *average*.

At first glance this change may be perceived as a technical change for which there will be little impact. However, statistically, this is a major change and there can be some significant payment impacts. Financial and reimbursement analysts at hospitals will want to examine the impact of this change with great care.

We will use a very oversimplified example to illustrate what is taking place inside the statistical calculations. This will help you understand why there is a major potential impact on redistributing payments for APCs.

First, let us tackle the terminology.

1. Median – For a given set of n data points, the median is the middle value or, if n is even, then we take the two middle points and calculate the arithmetic mean.
2. Arithmetic Mean – For n data points, we add the values of the n data points and then divide by n.
3. Geometric Mean – For n data points, we multiply the values of the n data points and then take the $n^{th}$ root.

If you examine the process for calculating the arithmetic and geometric means, you will see that the process is essentially the same except for the geometric mean we have raised the order of arithmetic operation by one. That is, instead of adding we multiply and instead of dividing we take the $n^{th}$ root.

The good news is that you can use an electronic spreadsheet like Microsoft's Excel to make these calculations.

AVERAGE (data range)
GEOMEAN (data range)
MEDIAN (data range)[2]

Why use the geometric mean? Statistically, the geometric mean is a much better measure of central tendency when there are excessive amounts of outlier data, that is, data that is much smaller or larger than the main body of data. For APCs, we are addressing cost data within the given APC groupings and there is much outlier data present in these data sets.

Now we will examine how the change from using the median to using the geometric mean can portend significant changes in reimbursement under APCs. Consider two very simple data sets:

- Data Set #1: 1 2 3 6 7 8 15
- Data Set #2: 1 1 2 4 6 9 11 18 21

With a quick look you can see that there are certainly outlier data particularly for the higher valued data points. The median, arithmetic mean and geometric mean are shown in Table 1. The median is the same for both data sets. Assume that the first data set is for Year 1 and the second data set is for Year 2 and that these data points represent costs for a given APC. Because the medians are the same, in moving from Year 1 to Year 2 there will be no major change in the calculation of the APC weight.

Note that the arithmetic mean is heavily influenced by the extra outlier data in Data Set #2. However, the geometric means changes are modes.. This is the whole reason for using geometric means when there is significant outlier data.

[2] If you are going to use MS Excel for these statistical calculations, be certain that you understand the exact formulas and the way that data is considered by Excel for making the calculations.

| | Median | Arithmetic Mean | Geometric Mean |
|---|---|---|---|
| Data Set #1 | 6.0000 | 6.0000 | 4.3660 |
| Data Set #2 | 6.0000 | 8.1111 | 4.9537 |

Table 1 – Statistics for Two Data Sets

The change that CMS is proposing means that the calculation of the APC weights will move from the median to the geometric mean. If we take the median from Year 1 and compare it to the geometric mean from Year 2, there is a relatively large change. In this case we move from 6.0000 to 4.9537 there is a 17.44% decrease. Thus, implementing the change of moving from the median to the geometric mean for our little example would generate a fairly significant decrease in the relative weight for the given APC, and thus the payment level would also be dramatically affected.

Presuming that CMS does make this change, which is highly likely, then hospitals will want to develop some models or mix of cases to see what potential impact may occur. For instance, the Emergency Department (ED) represents a fairly tractable area in which to develop a simple model of E/M levels along with various types of lacerations repairs, fracture care, burn care and other emergency conditions. By using the projected APC payment amounts, as provided by CMS, an estimate of the potential impact can be made.

## The 3-Day Payment Window Additional Guidance

On June 14, 2012, CMS issued an FQQ document with 43 questions and answers relative to the 3-Day Payment Window and, more specifically, CR 7502. This document does provide some specific answers and thus delineates guidance even though at an informal level.

The 3-Day Payment Window was previously referred to as the 3-Day Preadmission Window. Basically when a Medicare beneficiary is admitted to a hospital, the hospital is required to bundle certain outpatient services into the inpatient billing. There are actually two parts to the window: the first part includes any services on the date of admission preceding the actual time of admission. The second part consists of the three dates of service preceding the date of admission.

Also, for the three dates of service that occur before the date of admission, all diagnostic services must be bundled, but for therapeutic services, only those that are related to the inpatient admission are bundled. This window applies to any entities that are wholly owned or wholly operated by the admitting hospital.

The operational application of the 3-Day Payment Window changed in 2011 with legislation that liberalized the definition of 'clinically related' to an open definition from the previous diagnosis code matching of the inpatient and outpatient services.

If you are involved in any way with the application of the 3-Day Payment Window, you should definitely download this document and read through it with care.

One of the areas of concern surrounds Critical Access Hospitals (CAHs). Q&A #5 addresses this issue.

> *Q.5. Are Critical Access Hospitals (CAHs) subject to the payment window?*
>
> **A.5. If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) hospital and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.**

Clearly, the 3-Day Payment Window does not apply, per se, to CAHs. The remainder of the answer is more complex. If a CAH is owned or operated by another hospital, then the ***outpatient CAH services*** are covered under the window whether it be the 3-day or 1-day window depending upon who owns or operates the CAH. This bundling raises two immediate issues.

First, what if the CAH owns and operates a freestanding, physician clinic? While the CAH itself is not subject to the window, will these services in the freestanding clinic be subject to the window for the owning hospital? CMS's answer *seems to indicate* that the answer is 'no'. The above answer indicates that outpatient CAH services are covered which would not include the services at a wholly owned or wholly operated freestanding clinic.

> ***Note***: The above interpretation is somewhat disconcerting because the 3-Day Payment Window actually views the professional services in a freestanding clinic as if they were hospital outpatient services.

Second, if there are services that are carved out from the CAH and applied to the owning hospital's inpatient billing, there must be some way to move the charges and also allocate the costs. Because CAHs code and bill outpatient services following the typical PPS hospital requirements, moving the charges out is not that difficult.

However, addressing the allocation of costs may prove more difficult. Because CAHs are paid on a cost basis, eliminating the costs associated with services that are bundled into the inpatient billing at the other hospital will require care.

Q&A #32 indicates that RHCs (Rural Health Clinics) and FQHCs (Federally Qualified Health Centers) are not subject to the window. As CMS indicates, breaking out any services from an RHC for inclusion on the hospital claim would be extremely difficult.

There is an extensive discussion of the use and nonuse of modifier "-PD". This modifier is used only in the case of professional services in a freestanding situation. The "-PD" modifier invokes the MPFS (Medical Physician Fee Schedule) site of service differential. There is an interesting Q&A related to ASCs (Ambulatory Surgical Centers).

*Q.28. Should the modifier PD be used for a patient in an Ambulatory Surgical Center?*

**A.28. Yes, a wholly owned or wholly operated Ambulatory Surgical Center (ASC) would use the modifier PD to identify outpatient physician or practitioner services subject to the 3-day (or 1-day) payment window.**

By implication, wholly owned or wholly operated ASCs are subject to the payment window. Thus, when a physician provides services, such as an ASC surgical procedure, the physician would attach the "-PD" modifier if the services are subject to bundling. ASCs are already classified as *facilities* for the MPFS site-of-service reduction. What impact the "-PD" modifier would have, if any, in these circumstances is an interesting question.

See related articles in previous issues of this Newsletter:

- The 3-Day Payment Window – Part 1 – November 2011, pages 63-64.
- The 3-Day Payment Window – Part 2 – December 2011, pages 69-70.

## IPPS Update for FY2013

The update for MS-DRGs (Medicare Severity Diagnosis Related Groups) will start on October 1, 2012 (i.e., the beginning of the Federal Fiscal Year). On August 1st the examination copy of the final rule was issued by CMS.

The update for FY2013 is unusual in that there are only a few changes to either the ICD-9 code set or the MS-DRG groupings. The reason for this is that ICD-9 is basically being frozen in anticipation of converting to ICD-10.

While there is little activity on the coding and grouping front, there is significant activity on new initiatives for the ***pay-for-performance*** concept. The terminology in this area is a little misleading. Typically, extra payments would be made for increased performance, whatever measures are being used relative to measuring performance. The CMS approach is to lower payment for all hospitals and then to allow better performing hospitals to gain back the loss or even possibly gain back more than what was lost.

The two big areas for pay-for-performance are:

1. Hospital Readmissions, and
2. Value Based Purchasing (VBP).

There is a continuing emphasis on quality reporting in general. Quality reporting has been in development for several years. Anticipate continuing increases in the number and type of reporting requirements.

VBP is the newest process that CMS is implementing. For FY2013 all hospitals will receive a 1.0% decrease in payments. This decrease will be 2.0% by FY2017. The decrease in payments will then generate a fund that hospital can make back if certain performance goals are met.

To start with, the five conditions that will be included are:

- Acute myocardial infarction (AMI),
- Heart failure (HF),
- Pneumonia (PN),
- Surgical care, and
- Healthcare-Associated Infections (HAIs).

Through a rather complex algorithm, CMS will calculate the Total Performance Score (TPS) for each hospital. Based on the TPS, a hospital may or may not be allocated funds from the pool that was generated by reducing overall payments to all hospitals.

***Bottom-Line***: Hospitals should note that they will need to track this whole process with great care. Exactly how the bureaucracy will develop all of the formulas and processes is a significant question.

*Editor's Note: The process will be discussed in future issues of this Newsletter.*

## 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 with care for compliance issues.*

**Question: For treadmill services can we meet the CMS supervisory requirements by using a nurse practitioner (NP) or clinical nurse specialist (CNS)? Or must we use a physician to meet the supervisory requirements?**

This question is typical for a number of tests that are performed in both clinics and hospital settings. Treadmill tests (CPT 93015-93018) are diagnostic in nature so that the supervision rules come from the diagnostic indicators found in the Medicare Physician Fee Schedule (MPFS). For treadmills the indicator is 02, that is, direct physician supervision is required.

> **Note**: The concept of direct physician supervision for diagnostic tests is almost the same for physician clinics as it is for hospitals. The slight variation occurs with what direct physician supervision means. On the hospital side, for both diagnostic and therapeutic, the physician must be immediately available, but there is no location requirement. On the physician side, the supervising physician must be readily available and in the office suite.

If you go to §20.4.4 of the Medicare Coverage Manual, Publication 100-02, you will find language indicating that for diagnostic tests, non-physician practitioners may be able to perform the test, but they are not allowed to supervise others to conduct the given diagnostic test.

Further, if you go to the Code of Federal Regulations, namely, 42 CFR §410.32(b)(2), you will find the exceptions for supervision of diagnostic tests. Interestingly, at 42 CFR §410.32(b)(2)(v) we have:

> "Diagnostic tests performed by a nurse practitioner of clinical nurse specialist authorized to perform the tests under applicable State law."

What this appears to state is that when an NP or CNS performs a diagnostic test for which they are authorized under state scope of practice, no additional supervision is required. This would be just as if a physician performed the diagnostic test, that is, there is no further supervisory requirement.

The trick in considering all of this is that if the NP or CNS actually performed the treadmill test, then no additional supervision is required. However, if the NP or CNS is supervising nurses or technicians to perform the treadmill test, then a physician would be required to meet the formal supervisory requirements.

***Bottom-Line***: If you find yourself in a situation where you need to make the fine distinction discussed above, then obtain several opinions and also speak with you Medicare Administrative Contractor (MAC).

## 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*

On-site, teleconferences and Webinars are being scheduled for 2012. Contact Dr. Abbey at 515-232-6420 or e-mail at 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. The webinar scheduled for September 18th ***"MS-DRG Update for FY2013"*** 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***", 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 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.

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## ****** 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 Jane Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.**

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