Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

December 2008 – Volume 20, Number 12

ISSN: 1061-0936

Season's Greetings!!

The consultants and staff at Abbey & Abbey, Consultants, Inc., along with our extended family of consultants wish to take this opportunity to extend our warmest wishes for a happy holiday season and a productive and fruitful new year.

APC/APG Update

You should be receiving your new APC grouper for January 1, 2009. The grouping logic for APCs is becoming much more complicated as CMS moves towards even greater packaging and bundling of services. Much of this packaging is driven by the Status Indicator codes, particularly the new "Q1", "Q2" and "Q3" codes that replace the old "Q" Status Indicator. Determining the overall impact of increased packaging is difficult, but one area that will be affected the most is cardiovascular interventional radiology. This is occurring because CMS appears to be moving toward bundling any diagnostic radiology that is performed as part of an interventional radiology therapeutic service.

Editor's Note: In a future issue of this Newsletter we will look at some simple models of the financial impact for cardiovascular interventional radiology.

APCs for CY2009 – Increased Packaging

As discussed in the October issue of this Newsletter, CMS has changed directions significantly and is now moving toward significantly increased packaging for APCs. Based upon comments made by CMS, the degree of packaging will increase even more in the coming years.

> ***"We use the term "dependent service" to refer to the HCPCS codes that represent services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality. We use the term "independent service" to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we package payment for the dependent service. We note that, in future years as we consider the development of larger payment groups that more broadly reflect services provided in an encounter or episode-of-care, it is possible that we might propose to bundle payment for a service that we now refer to as "independent."*** **(**73 FR 68570)

Last year, CMS started using terminology involving 'dependent' and 'independent' services. This language was not explained although CMS started bundling based upon these concepts. As the quotation above indicates, CMS is now giving us some definitions.

Dependent services are those services that are typically ancillary and supportive to a primary diagnostic or therapeutic service. While we can all appreciate this concept, just how will CMS determine what services are *typically ancillary and supportive*? Will we have the opportunity to comment to CMS's interpretations of this concept?

Note: This new direction is very reminiscent of the concept of 'significant procedure consolidation' used in many APG (Ambulatory Patient Group) type payment systems. The basic idea behind significant procedure consolidation is that the most significant procedure within a grouping of similar procedures is the only procedure to be paid. For instance, if a patient presents to the ED with both moderate and minor lacerations, only one of the moderate laceration repair codes will be paid. The other, non-significant procedures are bundled into the payment for the significant procedure.

There is even more in this single quote. First is the comment, "…*as we consider the development of larger payment groups*." Clearly CMS is anticipating developing larger groupings that encompass more services within a single grouping. How CMS will do this without further violating the disparity between expensive and inexpensive cases that might fall within the same classification is a very interesting question.

Second is the comment "…*provided in an encounter or episode of care*…" At first reading this may not seem to be of importance. However, APCs are an encounter driven system, and the definition of exactly what constitutes and encounter is critical. The use of the phrase *episode-of-care* seems to be an indicator that CMS may move to a much broader definition of an encounter.

For instance, when APCs were implemented back in 2000, in a somewhat surprising move CMS (then HCFA) decided that multiple visits to a hospital's ED were separate encounters even if the visits were for the same reason or some related reasons. Most APG-type payment systems would bundle these services into the same encounter given that the services were part of the same *episode-of-care*.

Also, a sequence of services over several days may all relate to the same episode-of-care. For instance, for APCs, CMS has never defined a global surgical package. Thus, a patient may be seen a day or two before surgery for services, and then have a surgical procedure with another visit several days after the surgery. Currently, all three of these services are considered separate encounters. However, if an episode-of-care approach were taken, then these three services would all be considered part of the same encounter and be grouped together. This would basically comprise a global surgical package that CMS claims is unnecessary.

The concept of the encounter drives the whole APC grouping process and thus the degree of packaging or bundling that takes place. This language appears to indicate that CMS is considering making a very fundamental change in what is considered as an encounter.

Note: As discussed above with the independent and dependent procedures, APCs appears to be moving back to the basic features of APGs. This also appears to be the case with the way in which encounters are to be treated in the future.

Bottom-Line: We should expect that CMS will be making major changes to APCs by significantly increasing the amount of bundling that will be present in the APC grouping process. These changes will probably occur over a period of five years or more. Thus, being able to accurately predict reimbursement streams for specific service areas in the hospital will be difficult at best. Anticipate that certain service areas will be affected more than others. For instance, the current round of changes appears to affect cardiovascular interventional radiology the most.

APCs for CY2009 – Blood and Blood Products

One of the most interesting and confusing comments from CMS is in the discussion concerning payment for blood and blood products. During the early years of APC implementation, blood and blood products were significantly underpaid. CMS did conduct a study and determined that this underpayment was the fault of the hospitals for not properly preparing the cost reports with the correct level of detail.

In lieu of making required changes to the cost reporting process, CMS implemented a temporary fix so that payment for blood and blood products would be adjusted upward. However, this is not a complete solution. Hospitals still claim that blood and blood products are underpaid although not by as much as in previous years.

As reported in the November 19, 2008 *Federal Register*, an outside entity conducted a rather extensive survey on one of the more common blood products. The survey decisively indicated that CMS is systematically underpaying for the specific blood product.[1]

CMS's response to this external data is very interesting.

> **"*We continue to believe that using blood-specific CCRs applied to hospital claims data results in payments that appropriately reflect hospitals' relative costs of providing blood and blood products as reported to us by hospitals. We do not believe it is necessary or appropriate to incorporate external survey data into our rate setting process for blood and blood products because, in a relative weight system, it is the relativity of the costs to one another, rather than absolute cost, that is most important for setting payment rates.*"** (73 FR 68541)

CMS does not seem to contest the external data that indicates underpayments are occurring. The explanation appears to be that it is the relatively of the costs not the actual costs themselves. We leave it to our readers to see if anyone can make logical sense of the last part of this statement.

The bottom-line is that hospitals probably will continue to be underpaid for blood and blood products until all hospitals report blood and blood products in appropriate detail so that proper cost-to-charge ratios are developed for all hospitals. This process may take many years so plan to be patient.

[1] This should be no surprise to hospital financial personnel who are well aware of the underpayments in this area.

APCs for CY2009 – Cost Report & CCRs

When CMS introduced the new MS-DRGs, an additional change was to move the calculation of the MS-DRG weights from charge based to cost based. This change has generated significant discussion concerning the cost reporting process and the appropriateness of hospital cost-to-charge ratios (CCRs). RTI International was contracted to perform rather extensive studies and make recommendations relative to the whole process of *charge compression*.

With all of these discussions surrounding this issue for MS-DRGs, many seem to have overlooked the fact that the issue of charge compression has **always** been present for APCs! When APCs were started, the statistical calculations were made based on costs that were converted from the charges using the hospital specific CCRs. Thus, all the of the discussions of the cost report, CCRs and charge compression have always been a problem for APCs. For instance, see the discussion of blood and blood products above.

CMS is indicating that changes will be made in the cost reporting process to help address the charge compressions issue. However, to implement these changes will take several years because the whole cost reporting cycle (i.e., submission, approval, etc.) can take three to four years.

APCs for CY2009 – Imaging Families

For CY2009 there are five new imaging family composite APCs.

- 8004 – Ultrasound Composite → $192.69
- 8005 – CT and CTA without Contrast Composite → $415.76
- 8006 – CT and CTA with Contrast Composite → $635.10
- 8007 – MRI and MRA without Contrast Composite → $711.05
- 8008 – MRI and MRA with Contrast Composite → $990.32

These five new composite APCs result from three families of imaging services with the CT and MRI further divided between *with* and *without* contrast.

This change should not come as a great surprise. Other healthcare providers were subjected to the multiple imagining discounting process starting several years ago for payment made under RBRVS.

However, there will certainly be a financial impact, in this case a decrease in reimbursement. Hospitals providing such services should carefully analyze the decreases and then also ensure that proper coding and charging is taking place for these services. As with other APCs, payment for these composite APCs will be driven by proper coding and appropriate charges. If your hospital is providing multiple services that go into a composite, it is crucial that you code and charge appropriately for all the services even if there is no separate payment.

Interestingly, the difference between the *with* and the *without* contrast is in the $200.00 range. For instance the difference between APC 8005 and 8006 is $219.34. A careful analysis of the difference in resource utilization would be necessary to see if CMS's methodology in determining the payment difference is any place close to being correct.

APCs for CY2009 – Negative Pressure Wound Therapy

CMS has decided to map the following codes into APC 0013, which pays $54.70.

- CPT=97605 – Negative pressure wound therapy, including topical application(s), wound assessment, and instruction(s) for ongoing car, per session; total wound(s) surface area less than 50 sq cm
- CPT=97606 - ; total wound(s) surface area greater than 50 sq cm

This should be a useful APC payment for wound care centers that are provider-based.

APCs for CY2009 – Odds & Ends

The **inpatient-only surgical list** continues to be modified. While CMS admits that virtually all commenters over the last several years have recommended that this list be dropped, CMS is adamant that the list be maintained. While CMS uses quality concerns as the reason, the actual reason is probably more practical in that APC mapping would have to be developed for any and all surgical procedures that could possibly be performed on an outpatient basis.

A simple solution to the issue of performing inpatient-only surgical procedures on an outpatient basis would be to use the same approach that is used with the "-CA" modifier. The "-CA" modifier is used when a patient comes to the ED and is rushed to surgery, an inpatient-only procedure is performed and the patient expires.

The "-CA" generates a blanket payment through APC 0375, which has been increasing. Here are the payments and the percentage increases.

CY2006	CY2007	CY2008	CY2009
$2,719.74	$3,569.94	$5,006.13	$5,672.92
+31%	+40%	+13%	

Ostensibly, this increase is occurring because hospitals are more frequently using the "-CA" modifier and reporting appropriate costs associated with these procedures.

At least, the use of this approach for any inpatient-only procedure that is inadvertently performed on an outpatient basis would provide for some payment on the averaged basis.

Cost outliers are still out there, but they seem to be harder to generate each year. The dollar threshold component is being raised to $1,800.00. Note that CMS does not seem to make any real attempt to pay out the full percentage of cost outliers that are available for the program as a whole.

Brachytherapy sources are supposed to be paid on a pass-through basis. However, CMS has gone to great lengths to develop a mini-APC system just for these sources.

Payment for **hyperbaric oxygen therapy** (HBOT) is not increasing to any great extent. There has been some controversy in this area relative to payment rates and proper coding, but CMS does not appear to be making any changes.

Commenters have questioned the significant **variation in payment levels** for the same APC categories from year to year. Some APCs can go up or down as much as 50% to 60% from year to year. If APCs represented a stable system, then the variation in payments for a given APC, assuming no other changes, would more typically be in the 5% range. While CMS recognizes this situation, their response is basically, that is just the way it turns out.

The **2-times rule** is a statistical indicator of variation within a given APC. If the cost data going into the given APC is such that the highest costs are more than twice the lowest costs, then the 2-times rule has been violated, and the given APC category should be split into two or more APCs. The number of APCs on the 2-times rule list has been declining over the past several years so that CMS is making some progress in this area.

CMS is putting a cap on **Partial Hospitalization Program** payments through a new composite APC 0034 that pays $204.78. The basic idea is that if you are providing psychological or social services that typically fall into the PHP category, then your payment for such services on a daily basis will not exceed the PHP payment for APC 0034.

CMS continues to be concerned about **drug overhead costs**. While there hve been discussions about creating special HCPCS codes to capture drug overhead costs (e.g., C-Codes with expensive devices), CMS is not planning to implement this process. The drug overhead issue ties back into the whole cost reporting and CCR discussions. What CMS will do in this area is unclear at this point. Most likely, pharmacy items will be paid at ASP (Average Sales Prices) plus a percentage. For many hospitals, particularly chemotherapy programs, the percentage increase over ASP is very sensitive in that significant amounts of reimbursement are at stake.

Questions from Our Readers

Question: We are having difficulty with billing critical care (CPT 99291) and also billing for chest x-rays. According to CPT the interpretations of these chest x-rays are a part of critical care services. However, this guidance appears to be directed to the professional component, that is, physician and practitioner billing. Does this CPT guidance relative to bundling chest x-rays also apply on the technical component side for billing purposes?

CMS appears to be taking a second look at a number of issues involving CPT guidance. Keep in mind that the CPT book is generally written for professional component coding and billing. Only recently has CPT started to differentiate between professional and technical component guidance. For instance, see the new guidance in the injections and infusion code section of CPT.

Also, CMS has recently addressed the issue of when a patient is 'new' versus being 'established' and the use of the 3-year rule. In the case of the 'new' patient interpretation, the 3-year rule has been modified to being registered at the hospital within three years. In a somewhat similar vein, CMS has issued clarifying guidance that to code and bill for critical care, the 30-minute rule applies, Although early in the implementation of APCs it appeared that there was no such requirement. Critical care could be billed regardless of the amount of time incurred in providing critical care.

We appear to have the same situation with chest x-rays provided as part of critical care and whether or not the technical component x-ray services are really a part of the critical care payment.

At this point, the real determiner is the NCCI edits, more specifically, the hospital NCCI edits. The hospital edits are slightly different from the physician NCCI edits. One of the main differences has been the very issue of the technical component x-ray codes not being bundled into the critical care services. If CMS is making a change in this area, then this should clearly appear in the APC grouping logic that uses the hospital NCCI edits.

Another approach to gain clarity is to invoke Section 921 of MMA 2003. One of the provisions in this section of the legislation is:

> **"*Response to Written Inquiries – Each Medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitle to benefits under part A or enrolled under part B, or both, concerning the program under this tile within 45 business days of the date of receipt of such inquiries."***

This provision in MMA should allow a provider to carefully formulate a question, send the question in writing,[2] and then receive an official written response that is 'clear, concise and accurate'. Given the fact that CMS appears to be going back to a number of issues that seemed to be pretty well settled through the early years of APC implementation means that providers will need to be very careful to follow any revised guidance from CMS. Be prepared for CMS to state that the revised guidance is not new, just clarifying guidance.

The reason for CMS claiming that the guidance is not new goes back to another provision in MMA 2003, namely Section 903, where we have:

> **"*A substantive change in regulations, manual instructions, interpretative rules, statement of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines ...*"**

Thus, if CMS issues a substantive change in their interpretation of rules and regulations, then such a change in interpretation cannot be applied retroactively. But if the guidance is just clarifying what was already considered the interpretation, then such an interpretation can be applied retroactively. Of course, the key word is 'substantive'. Note that the issue of clarifying versus substantive changes becomes a RAC audit issue.

[2] Register, return receipt, of course!

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/JantoDecember2009EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2009Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information. Workshop planning information can be obtained from our password protected website.

A variety of Webinars and Teleconferences are being sponsored by different organizations. Georgia Hospital Associaiton, Ohio Hospital Association, Florida Hospital Assocaition, Instruct-Online, Accuro Health, Progressive Business, and the Eli Research Group are all sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2009.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2008. Contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for January 13th,"***Keeping Up With IPPS: Important Topics***". The presentation will run from 9:30 a.m. to 11:00 a.m. EST.

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

Also, Dr. Abbey has completed his ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro.

Contact Chris Smith concerning Dr. Abbey's books:

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

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

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

INSIDE THIS ISSUE

FOR UPCOMING ISSUES

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

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

Worried about the RAC Audits? Special audits and studies are being provided to assist hospitals 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.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about maintaining coding billing and reimbursement compliance? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.