// Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

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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

The final Federal Registers for both APCs and the MPFS were officially issued in late November. The APC FR entry is dated November 20, 2009, and the MPFS entry is dated November 25, 2009. As usual, there were some significant changes some of which really go beyond the payment systems themselves. Selected topics are discussed in this Newsletter, and the discussions will continue for the next several months.

CMS Drops the Physician Use of Consultations

In 2009 CMS dropped the use of the consultation codes on the hospital outpatient side for APCs. While this was a significant change, adjusting to this change was relatively straightforward. Because there is only one set of five outpatient consultation codes for physicians, the primary process is for hospitals to translate the five consultation levels into either the new patient or established patient visits, each of which also have five levels. Thus, the mapping process is fairly straight forward on the hospital outpatient side for provider-based clinics.

For physicians, losing the consultation codes for Medicare is a much larger issue. There are both outpatient consultations (CPT codes 99241-99245) and inpatient consultations (CPT codes 99251-99255). The inpatient consultations apply to hospitals, nursing facilities or partial hospital settings. Here is guidance from the November 25, 2009 *Federal Register* entry.

> ***Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported.*** (74 FR 61775)

While the use of the phrase *patient's admission* is disconcerting, it appears that CMS is stating that specialty physicians can use the initial hospital care codes for the first visit and then the subsequent hospital care codes for additional visits. Why CMS used the phrase *patient's admission* is not known, but it seems to imply that the specialty physicians should be providing their services, previously consultations, at the time of admission. However, specialty physicians may be called in to assist well after the actual admission to either the hospital or nursing facility.

In addition to this rather fundamental concern, there are several challenges for physicians and physician coding staff.

First, there are five levels of initial or subsequent inpatient consultation codes. However, there are only three levels of initial/subsequent hospital care or initial/subsequent nursing facility care. Thus, the whole coding process will need to be revised, at least for Medicare.

Second, CMS has created a new modifier:

"-AI" – Principal Physician of Record.

This modifier is used by the admitting or attending physician. The specialty or consulting physician(s) would not use this modifier. ***In theory***, the use of this modifier along with adjustments to the adjudication process should allow for separate payments to the various physicians. However, there will probably be some significant challenges including the possible need for the attending and specialty physicians to use different

diagnoses to separate their services. Only time will tell, but be prepared for problems.

Third, the consultation codes generally will be available for other third-party payers unless they officially follow the new CMS policy in this area. Thus physicians will use the consultation codes in some cases, and in other cases the initial or subsequent hospital or nursing facility codes. The ability to possibly translate, (i.e., crosswalk) the consultation codes into the initial and subsequent service codes will not be straightforward.

Third, there is a major issue with secondary payer coding and billing. If Medicare is primary and the initial/subsequent care codes are used and then the secondary payer requires[1] the use of the consultation codes, then the payment process will become complicated.

Likewise, what if Medicare is secondary? Possibly the primary care payer may require the use of consultation codes, which will then be passed over to Medicare. What will happen then?

CMS offers the following comment to this case:

> ***"In those cases where Medicare is the secondary payer, physicians and billing personnel will first need to determine whether the primary payer continues to recognize the consultation codes. If the primary payer does continue to recognize those codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes."*** (74 FR 61773)

In other words, ***we have a real mess coming down the line***. The immediate question is whether or not other third-party payers will be willing to change their acceptance and adjudication of claims to conform to CMS's change. We must all be on standby for possible adjudication glitches that may involve thousands of claims.[2]

Luckily, on the outpatient or clinic side, dropping the consultation codes is much the same as for provider-based clinics. The previous outpatient consultations must be mapped into either the new patient or established patient visits. This is a relatively straightforward process.

Note that the AMA, through the new 2010 CPT manual, has just issued new language on 'Concurrent Care and Transfer of Care'. Unfortunately, CMS decided to discontinue the consultation codes before there was any opportunity to determine if the new guidance from CPT would resolve the long-standing issues surrounding consultation services and the associated coding and billing.

For those specialty physicians providing consultations, continue to follow the same documentation guidelines, that is, there should be a request. Then advice or opinion should be rendered, and there should be a written report back to the requesting physician. Over the next several years, CMS will probably create guidelines for specialty physicians who are providing consultations but do not have the consultation codes available to report their services.

From a payment perspective under the MPFS, CMS is readjusting the various RVUs to incorporate an increase in payment for outpatient and inpatient E/M codes. While this process is on a budget neutral basis, there will be a shift in payment from the specialty physicians toward increased payment for primary care physicians.

Bottom-Line: Anticipate coding, documentation and claims adjudication issues surrounding the deletion of consultation codes on the part of the Medicare program. While almost all comments to CMS were opposed to this change, without further study CMS is proceeding with no delay.

CPT Addresses 'Concurrent Care' and 'Transfer of Care'

Just as CMS is discontinuing recognition of the consultation codes, the AMA through CPT has now addressed:

- Concurrent Care, and
- Transfer of Care.

This guidance is found under the E/M Service Guidelines section in CPT.

CPT states:

> ***"Concurrent care is the provision of similar services (e.g., hospital visits) to the same***

[1] The secondary payer may have their adjudication systems set so that only one initial/subsequent inpatient code is payable per day per patient. Thus, the attending physician will be paid, but without the consultation codes, the specialty physician is not taking over care will not be paid.

[2] There is also a question of whether or not CMS will be able to alter their adjudication processes to accommodate more than one initial hospital visit on the same date of service.

patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required."

This is fairly brief, but the second sentence really says it all! When concurrent care is provided, there is no need to provide additional information, separate diagnosis codes and/or other special reporting.

"Transfer of care is the process whereby a physician who is providing management for some or all of the patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services."

The keyword in this statement is 'explicitly'. Transfer of care is a formal process that should be accomplished in writing. Both physicians should be fully aware proper billing procedures. Additionally, patients should be informed of these arrangements.

Often times, physicians will provide coverage for colleagues in which there is not formal transfer of care. The covering physician or group of physicians may provide services, but the physician for whom coverage is being provided will still code and bill for the services. This can create some interesting situations in which a physician may be billing for services provided by a colleague, and the billing physician may actually be away or even out of the country.

The remainder of the guidance from CPT involves differentiating when a consulting physician can charge for a consultation and then, after completing the consultation, can officially take over care.

Mandatory Reporting for MSP

The Medicare Secondary Payer (MSP) provisions have long been an issue for all healthcare providers filing claims with the Medicare program. CMS has even established a special MSP RAC (Recovery Audit Contractor) to address overpayments by Medicare.

For healthcare providers, one of the major stumbling blocks has been to determine if, for a given encounter, Medicare is secondary. In some cases this determination is straightforward. For instance, if a Medicare beneficiary was in an automobile accident as a passenger in a friend's car, then some simple questioning will determine that Medicare is secondary. The primary payer will be the automobile insurer through medical payments (no-fault) or the liability portion of the insurance coverage.

In other instances, the Medicare beneficiary may be covered under a group health plan (GHP) although determining this fact may be difficult. In some cases, even questioning Medicare beneficiaries may not yield the information necessary to know that the patient is under a GHP.

Note: NGHP stands for Non-Group Health Plan and includes settlements, judgments, awards or other payment from liability insurance entities that includes self-insurance.

The basic result of this type of confusion is that the Medicare program incorrectly pays hospitals and physicians with Medicare being primary versus being correctly identified as secondary.

Congress, through Section 111 of MMSEA, Medicare, Medicaid and SCHIP Extension Act of 2007, has instituted a special reporting program to address some of the overpayment concerns with MSP. Unfortunately, this reporting process is being done in a highly bureaucratic fashion. There are significant fines associated with failure to report in the amount of $1,000.00 per day per claim. Thus, for a single instance of failure to report, over the period of a year, can amount to $365,000.00.

For hospitals, clinics and other healthcare providers, the question is whether or not these reporting requirements apply. Fundamentally, the question is whether or not a hospital or clinic is a RRE or Responsible Reporting Entity. This determination has become a quagmire due to interpretation.

RREs generally falls into two categories mentioned above:

1. GHP, and
2. NGHP.

GHPs are almost always insurance companies. However, the NGHP concept covers a broad set of circumstances. For instance, a hospital may be partially self-insured. While we await clarification from CMS, one of the main questions involves whether hospitals and/or clinics become RRE if they write-off charges. For instance, when a hospital writes-off part of bill, the hospital has become a payer for services to some extent. Let us consider a simple example:

Case Study – ***Sprained Wrist in the ED*** – Sarah has presented to the Apex Medical Center's ED with a laceration on the left arm. During her care she attempts to get off the gurney and slightly sprains her right wrist. A splint is applied to the sprained wrist. Because this injury occurred while Sarah was receiving

care, the hospital decides to write-off the charges relating to the sprained wrist.

In this instance, the hospital is the primary care payer for the services involving the sprained wrist and, in theory, Medicare will be secondary. Thus, the question becomes, 'has the hospital become a RRE relative to this sprained wrist incident?' If so, the hospital must report this situation.

While we await final clarification from CMS on this type of situation, in order to report, the hospital must register. There are four main steps for compliance with Section 111:

a. Identification – The RRE must be identified as being legally obligated to report and will be subject to fines for not reporting.
b. Registration – The RRE must register, with the Coordination of Benefits Contractor (COBC).
c. Testing – After registration, the RRE must successfully be able to submit files.
d. Reporting – After successful testing, the RRE can begin reporting. There is a query function to determine Medicare beneficiary status.

The critical date is April 1, 2010. By this date, if a hospital, clinic or other healthcare provider is an RRE (or might become an RRE), then everything must be in place. There are some rather complex timing issues for periods in which the RRE can report along with all the concerns about what should be reported.

To illustrate some of the complexities that can be encountered, let us take our simple case study and extend what might happen. Assume that ten days after Sarah had her laceration repair, she is returning to have the suture out. She also indicates that her wrist is still bothering her. An x-ray of the wrist reveals a barely visible, hairline fracture. The ER physician re-splints the right wrist and instructs her to see her primary care physician.

Alright, in this circumstance who is supposed to do what? Will the hospital also write-off this service? What will the primary care physician do relative to this wrist injury? Whatever the case, Medicare will be secondary and, depending upon CMS interpretations, this should all be reported.

Bottom-Line: Be certain to follow developments in this area with great care. See the CMS website:

www.cms.hhs.gov/mandatoryinsrep

Be certain to download the public forums for additional discussions.

Questions from Our Readers

Question: When a physician, other than the surgeon, performs a pre-surgery H&P the day before the surgery, does Medicare bundle the payment for the other physician into the surgeon's payment through the global surgical package?

The simple answer to this question is 'no'. The other physician is paid separately outside the global surgical package (GSP). Actually, the use of the word *surgical* in the GSP is a bit of misnomer. It should really be global *surgeon* package because the focus of this concept is with the surgeon or physician performing the surgery.

If the surgeon performs services within the pre-operative and post-operative periods, then the surgeon's payment under the GSP includes these services. Let us take a closer look.

On the pre-operative side, the day before the surgery and activities on the day of surgery up to the point of performing the surgery constitute the pre-operative period. If the surgeon performs any services related to the surgery, then payment is bundled into the GSP payment. However, if any other physician or practitioner performs services, including related services, in this pre-operative period, they will still be paid.

For instance, surgeons have long since learned to have a primary care physician or other practitioner perform the pre-surgery H&P so that there is no danger in the surgeon's performing such a service within the pre-operative period. There is an exception to the pre-operative window, namely the "-57" modifier that indicates the surgeon was called to assess the patient, and a decision was made to perform surgery. This typically happens through the ED. Even within the pre-operative period, this service will be separately paid outside the GSP payment.

On the post-operative side, the MPFS provides for three different post-operative periods:

0-days,
10-days, and
90-days.

For each surgical CPT code, you can find the post-operative period in the MPFS itself. 0-day post-operative period generally occurs with endoscopic procedures, and the GSP ends when the procedure is finished and, ostensibly, continues until the patient leaves the hospital.

The 10-day postoperative period is for minor surgical procedures, and the surgeon is responsible for any post-operative services during this period. While the surgeon

is responsible for the services, other physicians may often provide these services. Because there is rarely any formal transfer of care, the other physicians bill out these services using E/M levels.[3]

The 90-day post-operative period is for major surgeries, and the patient may remain in the hospital for several days after the surgery. Here we have to separate the post-operative care into:

- In the hospital postoperative care, and
- Out of the hospital post operative care.

If the surgeon provides the in-hospital post-operative care, then the surgeon's payment is bundled into the GSP payment. However, if some other physician or practitioner provides these services, then they are paid separately. Once again, the GSP includes the in-hospital post-operative care only if the surgeon performs the service.

After the patient is discharged from the hospital, the 90-day period commences, and the surgeon is responsible for the post-operative care during this period with payment included in the GSP.

If the surgeon decides to transfer care to another physician, for all or a portion of the post-operative period, then the billing and payment process become quite complicated.

In the MPFS the percentages of pre-operative, intra-operative and post-operative are given for each surgery. While CMS does not recognize the pre-operative percentage, the pre-operative percentage is added into the intra-operative percentage. The post-operative percentage is the amount that is paid out for the post-operative care. If the surgeon takes care of the first 30 days and then a second physician handles the next 60 days, we need to have some way to break out the post-operative payment. This is accomplished through the use of the "-55", 'Postoperative Management Only', and then pro-rating occurs on the number of days of postoperative responsibility. Also, the surgical code must be used.

While a complete discussion of how this is done is beyond the scope of this answer, those of you who code and bill for physicians should become completely conversant with this process. This situation is also complicated by the fact that the surgeon may not officially transfer the care but simply ask that a colleague cover for them.

[3] While technically this may not be appropriate it is often the common practice. The OIG is currently investigating the use of the "-54" and "-55" modifiers in this area.

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 2010. Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information.

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

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2009. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for December 8th "***Medicare Conditions for Payment***" that 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's ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro. His tenth book, "***Introduction to Healthcare Payment Systems***" is available from Taylor & Francis.

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 available from Francis & Taylor.

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

E-Mail us at Duane@aaciweb.com.

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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.

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