# Abbey & Abbey, Consultants, Inc.

# Medical Reimbursement Newsletter

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

December 2010– Volume 22 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

The main APC update issues were discussed in the October and November Newsletter. There are still a number of on-going issues that we will discuss in coming Newsletters. One of those issues involves drugs and pricing along with the proper use of Revenue Codes. This will take us into the area of Revenue Code 0636 versus Revenue Code 0250 and the use and/or misuse of the J-Codes. Also, there will be changes that must be made through ACA (Affordable Care Act) and other legislation that has been passed.

## The 3-Day Pre-Admission Window – Yet Again!

On June 25, 2010 the world of the 3-Day DRG Pre-Admission Window changed. However, hospitals are still trying to determine just how it changed. CMS is not being at all helpful in providing specific guidance. Thus, hospitals are left in a very unenviable position trying to code, bill and be reimbursed correctly only with very general guidance at best.

In the past, the 3-Day Pre-Admission Window has been specifically designed with fairly tight definitions from CMS. Here are the basic tenets for this window, some of which are still in place.

1. The trigger to apply the 3-Day Pre-Admission Window is that the outpatient services must be provided at a 'wholly owned or wholly operated' facility of the hospital. This trigger is broader that just provider-based operations, this trigger can also apply to freestanding clinics that are simply owned and/or operated by a hospital.
2. All diagnostic services provided by the hospital on an outpatient basis and/or those diagnostic services covered through the above trigger are bundled into the inpatient billing. This includes the diagnosis codes as well as the charges.
3. Non-diagnostic services that are related to the inpatient admission are also bundled into the inpatient billing including diagnosis and procedure codes for services so bundled. The key issue is what constitutes 'related' or 'clinically related'.
4. There are two distinct windows: A 3-day window for IPPS hospitals and a 1-day window for non-IPPS hospitals. Critical Access Hospitals (CAHs) are not subject to either window.

Up to June 25, 2010, the concept of relatedness was defined to mean that there was an exact match of the principal diagnosis occasioning the inpatient admission with the primary diagnosis of the outpatient[1] services. Depending upon the specific diagnosis code, this could be a 3-digit match, 4-digit match or 5-digit match.

While this test is specific, operationally, there are some definite challenges. Consider the following two case studies.

**Case Study 1** – ***Apex Medical Center Owned and Operated Freestanding Clinics*** – Apex owns two freestanding clinics that file claims only on the CMS-1500. Both clinics have a laboratory and limited radiology services. The billing system for the clinics is completely separate from the hospital billing system.

The only way that Apex can be assured of identifying diagnostic and possible therapeutic services is by manually reviewing any services provided at either clinic when a patient is admitted to the hospital. Even this approach has not worked smoothly because concerns have been raised about mid-level practitioners having

[1] The word 'outpatient' is used in a more general sense going beyond 'hospital outpatient' into any service falling under the trigger for the pre-admission window.

their services billed on an incident-to basis by a physician at the given clinic.

**Case Study 2** – ***Apex Medical Center Difficulty Properly Billing*** – For several years Apex has been trying to program the billing system so that the 3-Day Pre-Admission Window services will automatically cross over to the inpatient claim. However, this type of programming doesn't appear feasible. As a result, the billing system is designed to roll any and all diagnostic or therapeutic services provided on an outpatient basis within the window.

Apex recognizes that this is not the correct way to bundle the services. The QIO has raised objections in certain cases where an unrelated therapeutic service has actually increased the DRG payment through the inclusion of the associated diagnosis and, particularly, procedure codes.

Basically, prior to June 25, 2010 this rule was precise although significant operational problems existed for hospitals. As a result at least some, if not many, hospitals bundled more services into the inpatient billing than were really required.

Here is the timeline for the most recent changes.

- June 25, 2010, Section 102 of Public Law 111-192 is signed into law. This changes Section 1886(a)(4) of the Social Security Act by elevating the bundling of related services into the inpatient billing at the SSA level.
- August 9, 2010 – CMS issues an informal memorandum providing limited guidance based on language that was to appear in the IPPS update Federal Register for FY2011. The phrase 'clinically associated' is repeatedly used but there is no definitive definition or formula.
- August 16, 2010 – The IPPS update Federal Register is published. There is really nothing substantive in this FR entry not included in the August 9th memorandum.
- October 29, 2010 – Transmittal 796 is issued. This is basically a 1-page Transmittal that does introduce the "51" condition code that allows hospitals to attest to the fact that certain outpatient services are being billed separately.

The one glaring omission from these documents, and thus the guidance, is that ***there is no definition of the phrase 'clinically related'***. We have gone from a very specific definition to a situation for which there is no definition.

Note: This change is particularly egregious because the burden of proof for justifying separate billing of therapeutic services that are not related has been moved entirely to the hospital. We no longer have a formula that indicates when a therapeutic service is unrelated. This means that everything is subjective and auditors, including eventually RAC auditors, can question the determination of unrelated.

In Transmittal 796 CMS does provide a mechanism so that the separate billing of unrelated therapeutic services can be reported on the UB-04 using Condition Code "51". The Definition of Condition Code "51" is: Attestation of Unrelated Outpatient Non-diagnostic Services. This Condition Code will not be available until April 1, 2011.

While having Condition Code "51" certainly helps, this is not a complete answer. Consider the following case study,

**Case Study 3** – ***Freestanding Clinics Using Only the CMS-1500*** - The Apex Medical Center owns and operates two freestanding clinics, that is, claims are filed only on the CMS-1500. While Apex understands the use of the "51" Condition Code on the UB-04 for filing for unrelated therapeutic services provided on a hospital outpatient basis, the billing personnel do not know what to do about CMS-1500 claims that involve unrelated therapeutic services that must be considered for inclusion on the inpatient billing.

Keep in mind that the trigger for application of the 3-Day Pre-Admission Window is "wholly owned or wholly operated", and this includes freestanding clinics that file claims only on the CMS-1500. CMS seems to make no provisions for these billings. Ostensibly any possible improper overlap would be identified only by comparing the CMS-1500 with the UB-04. However, with the development of the regional MACs (Medicare Administrative Contractors), comparison of CMS-1500 and UB-04 billing for the same patient on related dates of service is now readily available.

***Bottom-Line*** – With CMS failing to provide specific guidance on what is 'clinically related', hospitals are placed in an almost impossible circumstance. In order to apply the bundling process correctly, hospitals must establish policies as to what constitutes relatedness. Even the development of a policy can be, and probably will be, challenged by federal auditors eventually including the RACs. Thus, hospitals must really review each case manually and then make a judgment as to relatedness. Most likely many services will be bundled that are not fully related, but taking a conservative stance will satisfy the main compliance issue.

Note that we have moved from a very specific formula for determining relatedness to an open-ended concept with no specific definition. Additionally, the whole burden of proof now rests with the hospitals to attest that

the services are unrelated and then be able to defend their decisions without benefit of precise definitions.

On December 9, 2010 HFMA issued a letter to CMS. Here is a key paragraph from this letter:

> ***"Further, we strongly believe the regulated healthcare community needs a crystal clear understanding of the standards to which it is held. That understanding has not been in place since Congress passed PACMBPR on June 25, 2010. Prior to enactment, non-diagnostic services provided within three days of an inpatient admission were separately billable unless there was an exact, five-digit match between the primary/principal diagnosis code on the outpatient service claim and on the inpatient claim. We believe that for the new definition to be useful for hospitals and meet statutory requirements, it must provide the same clarity as existed prior to PACMBPR. To that end, we propose CMS define "clinically associated" services as those provided when there is a three digit match between the primary ICD-9 diagnosis code. This definition has the added benefit of improving operational efficiency for providers. Under the existing guidance, providers are forced to manually review inpatient and outpatient claims documentation a second time in an attempt to identify services that might be "clinically associated." The definition proposed above would allow providers to automate this process, reducing administrative costs."***

This suggestion is quite appropriate and would increase the bundling of services and at the same time provide a specific, measurable way to determine relatedness. Perhaps hospitals would even be able to tell whether or not they are in compliance!

## Red Flag Rule – A Reprieve – Maybe!

We now have the 'Red Flag Program Clarification Act of 2010' that was signed into law on December 20, 2010. This law narrows the key definition of 'creditor' so that fewer organizations fall under the requirements of the Red Flag Rule.

*Editor's Note: It is strange that a full-fledged, separate bill is necessary to address this issue. Why this revision could not have been handled as a technical correction and included is some other legislation is an interesting question.*

For physicians, clinics, hospitals and other healthcare providers, the Red Flag Rule has seemed inappropriate because the original legislation was aimed at financial institutions, and healthcare providers were included because of the broad definition of a creditor. The basic idea is that healthcare organizations do extend credit, in some sense, by allowing patients to defer payments over a period of time.

The changed language includes:

> **"`(4) DEFINITIONS- As used in this subsection, the term `creditor'--**
> **`(A) means a creditor, as defined in section 702 of the Equal Credit Opportunity Act (15 U.S.C. 1691a), that regularly and in the ordinary course of business--**
> **`(i) obtains or uses consumer reports, directly or indirectly, in connection with a credit transaction;**
> **`(ii) furnishes information to consumer reporting agencies, as described in section 623, in connection with a credit transaction; or**
> **`(iii) advances funds to or on behalf of a person, based on an obligation of the person to repay the funds or repayable from specific property pledged by or on behalf of the person;"**

As usual, we must be very careful to read the actual language and then also wait for regulatory language that more fully explains what the law really means.

On the surface, the requirement of regularly and ordinarily obtaining and using consumer reports is of the greatest interest. Healthcare providers do not ordinarily obtain credit reports when services are provided and there is the possibility of some sort of extended payments whether by design or by happenstance.

Some healthcare providers do provide information to consumer reporting agencies. However this process for healthcare providers may not be particularly useful relative to collecting on accounts. The third requirement from this legislative language involves advancing funds. Healthcare providers do not ordinarily advance funds for future repayments. How this language will eventually be interpreted may prove interesting, but as stated, healthcare providers do not generally meet this criterion.

Thus, at first analysis this legislation appears to eliminate most healthcare providers from the Red Flag Rule and thus excludes them from a formal program relative to identity theft. ***Exempting healthcare providers from the Red Flag Rule does not mean that medical identity theft is not still a very real issue that must be addressed.***

While a formal program including identification of triggers generating the need for further investigation may not be necessary, identity theft still must be addressed. For physicians and clinics, identify theft may be a relatively small issue because most patients are well-known to the physicians and/or clinics. Other healthcare providers, such as hospitals, face greater challenges, particularly in providing emergency services. Post hospital healthcare providers such as SNFs (Skilled Nursing Facilities) or HHAs (Home Health Agencies) benefit from a more informal environment because they will tend to rely on the hospital for establishing the proper identity of the patient.

***Bottom-Line*** – Physician, clinics, hospitals and other healthcare providers can relax for the moment on the Red Flag Rule. However, be careful to read the legislative language to make certain you are comfortable relative to your healthcare provider's being excluded from the medical identity theft requirements. In time, there should be specific regulatory language issued, and such language should also be carefully studied.

**Note**: with the fact that medical identity theft is a potential issue and that healthcare providers must address this as a compliance issue, conforming to and meeting the requirements of the Red Flag Rule really are not all that onerous. In many instances you will operationally address this issue by doing, to some extent, what is required under the Red Flag Rule.

## CMS Guidance – A Disturbing Trend

Four coding, billing and reimbursement (CBR) compliance issues have recently become significant:

- Supervision Requirements Under the Provider-Based Rule (PBR),
- Bundling Requirements Under the 3-Day Pre-Admission Window,
- Technical Component E/M (Evaluation and Management) Coding/Billing, and
- Proper Use of the "-25" Modifier on Technical Component E/M Codes.

All four of these issues have been discussed in various articles in this Newsletter and our numerous workshops. Thus, these are long-term issues that are well known.

The disturbing trend on the part of CMS is that instead of specific guidance by which compliance conformance can readily be judged, CMS seems to want only general guidance and then hold the hospitals accountable for compliance standards that CMS can develope after the fact and, possibly, as internal audit guidelines.

This CMS environment could lead easily to claims of overpayment and associated recoupment efforts even when good faith efforts are made to maintain compliance. In many cases the compliance issues are addressed years after the fact.

Probably the most egregious example is with the technical component E/M coding guidelines and then the associated guidelines for using, or not using, the "-25" modifier. The only guidance on the "-25" modifier utilization comes from brief program memorandums issued in 2000 and 2001. No further guidance has been issued ostensibly because general national guidelines were in development, and the use of the "-25" modifier would be integrated into these guidelines.

Hospitals and other healthcare providers will now have to watch carefully as CMS develops regulatory guidance under ACA and other recent legislation. If this guidance is not specific on exactly what hospitals must do in order to achieve compliance within the new legal requirements, we could easily see compliance issues litigated and/or appealed for many years to come.

## Questions from Our Readers

**Question: Our hospital owns two freestanding clinics that are located nearby but off-campus. The physicians and several practitioners are employed by the hospital. We want to convert these clinics into provider-based clinics. What do we need to do?**

A precise answer to this question requires a great deal more specific information. There are two general concerns:

a. Meeting the requirement of the Provider-Based Rule (PBR) found at 42 CFR §413.65, and
b. Completing and filing the various CMS-855 forms to obtain billing privileges (see 42 CFR §424).

For this particular question, the clinics are already in operation and owned by the hospital. Thus, many of the PBR requirements will not be difficult to achieve. For instance, the clinics are probably already operationally integrated into the hospital. However, care must be taken to consider issues such as integrated medical records and common accreditation.

The two clinics are off-campus so there will be special obligations, such as:

1. Notice of two co-payments,
2. EMTALA policy, and
3. Direct physician supervision.

The notice of two-copayments is not difficult, but a form must be developed and personnel trained to provide the notice and, as appropriate, explain what is happening to the Medicare beneficiaries. The EMTALA policy results from the fact that these two clinics now will be part of the hospital. Thus, when an individual comes to the clinic, that person is entering hospital property, and EMTALA applies in case they have a possible emergency medical condition (i.e., and EMC under EMTALA). Presuming that the clinics are not deemed as Dedicated Emergency Departments (DEDs) under EMTALA, the policy, when an individual so presents, is simply to call for the EMTs (Emergency Medical Technicians) generally via ambulance. Note that this policy should be approved at the hospital board level.

The physician supervision requirement has expanded into a major discussion over the last several years as CMS has extended the direct physician supervision requirements to provider-based operations on campus and, apparently, to in-hospital situations as well. How these changes affect off-campus provider-based clinics has not been discussed thoroughly by CMS. With the latest requirements simply requiring immediate availability and ability to take over the care but without specific geographic location, the question of whether the physician or practitioner supervisor must be at the clinic is an open question.

The various CMS-855 forms can also become quite complicated. The hospital's CMS-855-A will have to be updated listing the two clinics as hospital service locations. Updating the CMS-855-B form or forms will depend upon current circumstances. The two clinics may have a single CMS-855-B for both clinics or there may be separate CMS-855-B forms. Whichever case applies, the CMS-855-B form will need updating to indicate that the clinic or clinics are now part of the hospital outpatient department.

The CMS 855-I and 855-R forms will also need checking to see if any changes must be made. Note that Physician Assistants do no use the CMS-855-R form because PAs must be employed, and their employer receives the Medicare payments for professional billings. The physicians and other practitioners (e.g., Nurse Practitioners) do use the CMS-855-R form for reassigning their Medicare payments, in this case, to the hospital.

Note that this very brief discussion has not included any sort of changes in the TIN or Tax Identification Number and/or any possible changes in the various NPIs (National Provider Identifiers).

Converting freestanding clinics to provider-based clinics is not a straightforward process!

## 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/JantoDecember2011EdCal.htm*

On-site, teleconferences and Webinars are being scheduled for 2011. 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 CY2010 and planned workshops for CY2011.

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 January 25th is "***Understanding the 3-Day Pre-Admission Window"*** 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 book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

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 Mary J. 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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