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

You should now have your new APC grouper for CY2009. This is a time for experimentation to see exactly what changes CMS really made to the APC payment system. Be particularly fastidious in monitoring the way APC claims are being adjudicated. Programming logic changes can be embedded without notice.

Be certain to review Transmittal 1664, dated January 9, 2009. This transmittal updates the Medicare Claims Processing Manual, Publication 100-04. Now that CMS has integrated the OCE (Outpatient Code Editor), both PPS hospitals and non-PPS hospital are included. This means that Critical Access Hospitals (CAHs) are now using the I/OCE.

Workshop participants from CAHs have reported that there are definite changes in moving to the I/OCE from the old non-OPPS OCE. Apparently, additional edits are now being applied to CAH claims.

Editor's Note: CAH readers, if you have questions and/or have notice changes please e-mail Dr. Abbey at:

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Physician Supervision – Yet Again!

On January 16, 2009 CMS issued Transmittal 101 to CMS Publication 100-02, Medicare Benefit Policy Manual. This transmittal further updates the portion of this manual dealing with coverage of diagnostic and therapeutic outpatient services. In particular the issue of physician supervisions is addressed. These same issues were addressed in the somewhat infamous Transmittal 82 last year.

Be extremely careful in reading this transmittal. CMS indicates the changes in which additions have been made, but there is no indication of what has been removed. We will examine some of the key changes, both additions ***and deletions***.

For Section 20.3, Encounter Defined, a new paragraph has been added. While this is a rather wordy paragraph, it basically states that the CoPs (Conditions of Participation) require a patient to be under the care of a physician or other qualified medical person.

There is now a fourth condition for coverage of outpatient diagnostic services, Section 20.4.4. Here is the new language.

> **Payment is allowed under the hospital outpatient prospective payment system for diagnostic services furnished at a facility that is designated as provider-based only when those services are furnished under the appropriate level of supervision specified in accordance with the definitions in 42 CFR 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii), and as described in Chapter 15 of this manual, Section 80 "Requirements for Diagnostic X-ray, Diagnostic Laboratory, and Other Diagnostic Tests," as though they are being furnished in a physician office or clinic setting. *With respect to individual diagnostic tests, the supervision levels listed in the quarterly updated Medicare Physician Fee Schedule (MPFS) Relative Value File apply. For diagnostic services not listed in the MPFS, Medicare contractors, in consultation with their medical directors, define appropriate supervision levels in order to determine whether claims for these services are reasonable and necessary.***

The general idea behind this statement appears to be straightforward. Hospital outpatient diagnostic services are held to the same standard of supervision as physician offices or clinics. The levels of supervision are delineated in the MPFS (Medicare Physician Fee Schedule) by CPT code.

Note: If you have never downloaded and carefully reviewed the MPFS, be certain to do so. This is a very large MS Excel spreadsheet that has an enormous amount of information including the diagnostic testing supervisory levels. This file is updated quarterly to accommodate changes in HCPCS.

There is another key phrase, namely:

> "… ***furnished at a facility that is designated as provider-based*** …"

The question is what is considered *provider-based*? Ostensibly this includes the entire hospital itself because provider-based status extents to both inpatient and outpatient services. Possibly, CMS intends this language to apply only to out-of-hospital provider-based situations, The way this is written makes it appear that diagnostic services in the hospital, which is certainly provider-based, are subject to these same supervisory rules. (See also 42 CFR §410.27.)

Now Section 20.5.1 addresses coverage of outpatient therapeutic services. The third paragraph now includes the following sentence:

> **The services and supplies must be furnished *under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law, furnished* by hospital personnel and under *the direct supervision of a physician or clinical psychologist as defined in 42 CFR 410.32(b)(3)(ii) and 482.12.***

Thus, we have the requirement that a qualified medical person must order the services and supplies and supervise the services.

The fourth paragraph in Section 20.5.1 is where the major change is taking place.

Here is the ***old paragraph***:

> **The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises. The hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished at a department of the hospital which has provider-based status in relation to the hospital under 42 CFR 413.65 of the Code of Federal Regulations, the services must be rendered under the direct supervision of a physician who is treating the patient. "Direct supervision" means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.**

Here is the ***new paragraph***:

> **The hospital medical staff that supervises the services need not be in the same department as the ordering physician. *For* services furnished at a department of the hospital which has provider-based status in relation to the hospital under 42 CFR 413.65, "*d*irect supervision" means the physician must be present and on the premises of the location *(the provider-based department of the hospital)* and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.**

Note that the first sentence in the old paragraph is missing! This is:

> **The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.**

This is a major change. The deletion of this sentence appears to be consistent with CMS's change in policy in this area. Namely, on-campus, but out of hospital operations are presumably on the hospital premises and, thus, the physician supervision requirement was assumed to be met. With the removal of this sentence CMS appears to be reinforcing the stance that for on-campus, out of hospital operations, direct physician supervision is required.[1] Note that CMS has clearly stated that off-campus provider-based operations have always required direct physician supervision.[2]

Note also that the language referring to the 'treating physician' as being the supervising physician has also been dropped. Given that the definition of a 'treating physician' has been unclear, this deletion appears to be appropriate.

Bottom-Line: CMS appears to be reinforcing their recent change in policy interpretation whereby on-campus, out of hospital provider-based operations are

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[1] See the November 18, 2008 page 68702 and July 18, 2008 page 41518 *Federal Registers*. (73FR68702 and 73FR41518)
[2] See April 7, 2000 *Federal Register*. Page 18524 (65FR18524)

required to have direct supervision by a physician or qualified medical personnel.

However, the changes in language now create a significant new question, that is, do these direct supervisory requirements extend to the hospital itself? For instance, consider a radiology department located in the hospital itself. Is this a provider-based department? If so, then this department is subject to the diagnostic testing supervisory rules delineated under the MPFS (Section 20.4.4) and also subject to the therapeutic services supervisory rules under Section 20.5.1.

Now the question as to whether a radiology department has provider-based status appears to be answered in the August 1, 2002 Federal Register on page 50080.

> **By contrast, Medicare or Medicaid payment (or both) to hospital departments that provide diagnostic or therapeutic radiology services to outpatients, or primary care, ophthalmology, or other specialty services to outpatients are affected by provider-based status, as would beneficiary liability for Medicare coinsurance amounts. Therefore, we would make provider-based determination for these departments.**

For hospital compliance officers, these changes create a real challenge in terms of what should or should not be done for in-hospital operations. A conservative compliance stance would be to meet the more stringent supervisory requirements for in-hospital situations. The changes in guidance for on-campus but out of the hospital appear to be reasonably clear and are apparently the same as for off-campus provider-based operations.

Note: Critical Access Hospitals (CAHs) fall under the Provider-Based Rule (PBR). However, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) fall under a set of special rules. While these supervisory interpretations may not apply to RHCs and FQHCs, care should be taken to watch for possible applicability. Terminology is this area can become quite confusing. For instance, there are both freestanding RHCs and provider-based RHCs depending upon the organizational structure and relationship to a hospital.

RACs and the Extrapolation Process - Part 1

Editor's Note: This is the first article in a series of article concerning the extrapolation process for determining recoupment amounts.

On November 12th and 13th last year CMS provided two Special Open Door Forums for the RAC program. Ostensibly the first day was for Part A and the second day for Part B. However, there appeared to be significant overlap relative to questions that were answered.

Note: The transcripts of these two forums are available at the CMS RAC web site. If you are involved with the RAC program in any capacity, please download these two transcripts. Read them! It is well worth the read to pick up details of this program that do not seem to appear elsewhere.

One of the questions asked involved whether the RACs would be allowed to use the extrapolation process that has been used by CMS, OIG and DOJ auditors. The answer was surprising. From page 20 of the transcript for the Special Open Door Forum held on November 13, 2008 we have:

> *"(Lisa Johnson): And then during the time when the RAC is reviewing the facility and they review hypothetically 10 patient charts, will they then be extrapolating and estimating based on total amount of Medicare patients seen by that facility? Or is it per case per charts that they review?*
> *Melanie Combs-Dyer: This is Melanie again. The Recovery Audit Contractors both in the demonstration program and in the permanent program have the ability to perform extrapolation. However, during the demonstration program, none of our demonstration RACs chose to follow the extrapolation process. We don't know yet whether any of our permanent RACs will choose to do extrapolation. But if they do, they will have to follow all of the same instructions that our regular carriers and FIs and (MACs) have to follow about choosing a statistically valid random sample using a statistician and all the other requirements for using extrapolation."*

Based on the RAC success in the pilot program, there was probably no reason to use the extrapolation process; significant recoupment resulted from the automated and detailed approaches used by the three RACs. However, when the RACs move to all of the states, most likely there will be some impetus to use this technique.

The basic idea is to use the following process:

1. Identify the universe of cases involving the given audit issue,
2. Determine a statistically valid sample to be taken from the universe,
3. Audit the sample,
4. Extend the findings from the sample to the entire universe, that is, extrapolate the findings to the entire universe.

Alright, let us take care of some terminology. In statistics there are two important words:

a. Interpolate, and
b. Extrapolate.

Interpolate simply means that you are estimating data points that are in between other data points in the statistical sampling. Extrapolate means that you are estimating data points that go beyond or outside the sampling.

Extrapolation is fraught with very real concerns, particularly in the healthcare field. Let us consider a simple example with E/M (Evaluation and Management) coding. This can occur with physician and clinics and, most likely, will also occur with hospitals.

Here are the basic facts.

- Over the period of a year, there have been 2,000 visits by Medicare beneficiaries involving established patient E/M levels.
- It is determined that a statistically valid sampling is 125 cases.
- After auditing the 125 cases, the auditors determine that in 41 of the cases, upcoding has occurred.
- The average overpayment for the 41 cases is $18.00.
- 41 divided by 125 is 32.80%.
- 32.80% times the universe (2,000) is 656 cases.
- Extrapolating to the entire universe, we have 656 cases times $18.00 or $11,808.00.

The proper coding of E/M levels depends upon coding guidelines. For physicians and clinics we have the 1995 guidelines and the 1997 guidelines. The 1995 guidelines are official although the 1997 guidelines can be used if beneficial to the physician or clinic.

What about E/M levels on the hospital or technical component side? There are no national guidelines! CMS has directed hospitals to develop their own mapping of resources utilized into the various E/M levels and then to use the mapping. Thus, for auditing in general, and particularly the RAC auditors, we have two issues:

a. Was the mapping accurately followed in selecting the E/M level, that is, does the documentation support the level, and
b. Does the mapping accurately convert resources into the levels (e.g., is a normal distribution over the levels achieved)?

Let us take an example. We will assume for our purposes that the RACs will be allowed to investigate technical component E/M levels. A RAC auditor may review your mapping process. This is generally a point system or narrative system of some sort. These mappings should be in place for the Emergency Department and also for provider-based clinics.

The RAC auditor may discover that a minor procedure is being separately coded and billed AND also in your E/M mapping. The auditor would then claim that the E/M levels associated with the separately billed procedure were all one level higher than justified.

Editor's Note: In the March issue of this Newsletter we will delve into some of the technical aspects of using extrapolation.

RAC Audit Tidbits

CMS has reported that the protest lodged by two unsuccessful bidders for the RAC contracts has been resolved. Apparently the unsuccessful bidders are going to subcontract with the companies that were chosen as the RACs. Whatever the case, CMS is back on track for implementing the program.

While we will be continuing the discussion of the RACs and associated audits in future issues of this Newsletter, here are two small examples of issues.

Blood Transfusions – CPT 36430 for blood transfusions is only paid once per day under the Medicare program. Guidance in this area has been less than clear. In some cases CMS claims that blood transfusions are on a per-encounter basis and then turns around and claims that there is only a single payment per day.

For instance, a patient may present in the morning for a blood transfusion and then return in the evening of the same day for a second blood transfusion. In theory, these are two separate visits or encounters and should be paid separately under APCs.

However, CMS wants only one 36430 paid per day. Now this issue goes back to the fundamental question of whether this is a billing issue or a payment issue. A quick analysis is that this is a payment issue and that CMS should have the APC grouper (i.e., the I/OCE) check the number of units associated with 36430 billing. There should only be one unit for CPT 36430. However if you check you will find that there is no unit edit on this code. Thus, if two or more units are indicated, they will be paid in error.

Thus, what should be a payment issue becomes a coding and billing issue. For Medicare, even if you have

more than one encounter, the 36430 should appear only once.

What does this mean for the RACs? The RACs in their automated reviews will look for claims in which the 36430 appears more than once and/or there are two or more units. What you must do is to look for any instances in which errors are being made in this area.

It is not hard to find this type of error. Nursing staff may check off more than one thinking that for each unit of blood transfused, there should be a transfusion charge. Some hospitals have actually implemented a policy that blood transfusions are never to be coded for fear of possibly being overpaid.

Cost Outliers – Several years ago cost outliers for both DRGs and APCs were an issue relative to outdated cost-to-charge ratios (CCRs) resulting from significant charge increases. While this particular issue has subsided, there are still instances in which cost-outliers can be an issue.

In preparation for the RACs, or really just as a good practice, you should review the frequency and type of outlier payments you are receiving. For our purposes we will consider outlier payments under APCs.

When you analyze your outlier payments you should see a somewhat random pattern of outlier payments for a variety of services. If you see outlier payments repeatedly occurring with certain services, then you should investigate. Obviously, what you are doing is what the RACs will do in their automated reviews.

For instance, you may have relatively simple cystoscopies for which high charges may be generated if there are several related cystoscopy procedures, there is MAC (Monitored Anesthesia Care), and there are several hours of recovery. These types of cases can drive relatively high charges for a procedure that may take only 15-20 minutes. The APC payment is not that high, so that a cost outlier may be invoked.

If this happens repeatedly and primarily for cystoscopies then the number of outlier payments for cystoscopies may become significant. An automated review by a RAC will quickly identify this as a potential overpayment issue.

These two examples show that even small issues can arise, and that you must be ever vigilant to study, analyze and/or think like a RAC auditor. Performing your own data mining on your Medicare claims database will probably yield a number of issues that you should resolve before the RACs come.

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 Association, Ohio Hospital Association, Florida Hospital Association, 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 March 10th, "**Observation Issues and Answers**". 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.

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http://www.aaciweb.com
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INSIDE THIS ISSUE

APC Update
Physician Supervision– Yet Again
RACs and Extrapolation
RAC Tidbits

FOR UPCOMING ISSUES

More on RAC Audits and Issues
National Drug Codes
More on Coding, Billing Compliance
More on Payment System Interfaces
More on the CY2009 APC Update

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****** 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 or 515-292-8650.

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 or 515-292-8650 for more information and scheduling.