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

CMS has issued two questions and answers at their FAQ[1] web site concerning observation services. Both of the issues discussed are of great importance. See the observation article below.

Also, be certain to follow carefully any further guidance concerning the physician supervision requirements under the provider-based rule (PBR). With the new guidance starting this year, there are numerous questions yet needing answers.

Medicare Secondary Payer – Part 2

The MSP program has long been a challenge for the Medicare program. In this second article we will discuss the conditional payment process used by the Medicare program along with some examples of how to determine what should be done with insurance payments after Medicare has made a payment.

While circumstances may fully indicate that Medicare is secondary, given the elongated legal processes for insurance companies to pay on claims, hospitals and physicians may wish to gain payment more quickly. This can be accomplished by filing a claim with Medicare. Medicare will pay the claim as if they were primary. If and when the insurance company pays the claim, then Medicare can assume its proper role as secondary.

This process is often used when payment may not be prompt, that is, paid within 120 days. Also, this process applies to liability and Workers' Compensation situations.

However, there are some significant conditions involved with this conditional payment. If a provider or supplier does file a claim with Medicare, then the provider or supplier accepts the Medicare payment as payment in full. If later the insurance company makes a payment, then the hospital or physician only can retain what Medicare pays for the services.

Case Study 1 – The Apex Medical Center has treated a Medicare beneficiary that was injured. The charges were $1,200.00 for the services. Medicare is billed. Assume all the services are covered by Medicare and that the deductible has been satisfied. The Medicare allowable is $900.00 with a copayment amount of $180.00. Apex receives $720.00 from Medicare and $180.00 from the beneficiary. Eventually, Apex also receives $1,200.00 from the liability insurance company. What should Apex do?

Because Apex pursued the conditional payment process, Apex must accept as payment that which Medicare would have or, in this case, what Medicare did pay. Thus, of the $1,200.00 received from the liability insurance company, Apex will:

i. Return $720.00 to Medicare, and
ii. $180.00 to the patient.

This leaves $1,200.00 - $900.00 = $300.00. This amount will also be paid to the patient. Medicare as secondary pays nothing, Apex receives the full amount of the Medicare payment, and the patient receives the excess $300.00 from the liability insurance payment.

This case study has been simplified by assuming no deductible and that all of the services and/or items provided are covered. Also, the case study gives us very little information about the accident or the liability coverage involved. Let us consider a slightly more complicated case.

Case Study 2 - A Medicare beneficiary has sustained injuries from an accident. Charges for services are $1,200.00. Medicare is billed. The allowable amount is $900.00. There is still a Medicare deductible of $50.00. The Medicare co-payment is $180.00. There are non-covered services for $100.00. The facility receives a payment of $720.00 - $50.00 = $670.00 from Medicare. No payment is received from the

[1] See https://questions.cms.hhs.gov/.

patient. Eventually, Apex receives $1,100.00 from a liability insurance company.

What does Apex do with the $1,100.00? First, Medicare will be refunded their $670.00 payment. The amount still owed by the patient, that is $50.00 + $180.00 = $230.00, will also be retained. This leaves $1,100.00 - $900.00 = $200.00. The hospital can retain $100.00 for the non-covered services and the remainder would go to the patient.

Let us consider another simple case study.

Case Study 3 - Sam, Sarah's cousin, was riding in a friend's car on the way to the hardware store when there was an accident. A tire on the car blew out and the car struck a utility pole. Luckily, there were no serious injuries, but Sam did go to the Apex Medical Center's ED to receive services including a laceration repair, and the total bill, for Sam, was $975.00.

Here we know more about the specific circumstances of the accident, and we can make some reasonable assumptions about the insurance coverage.

For this case study, the driver of the automobile involved in the accident will probably have Medical Payments as a part of their automobile coverage.[2] The coverage amount will probably be more than enough to cover the $975.00 charges from Apex. Also, this coverage is no-fault in nature so that payments will be made with very little hassle.

Thus, Apex will bill the automobile insurance company and, most likely, be paid the $975.00 without much question. Alright, are we done? There is really nothing to bill Medicare as secondary because full payment was received.

However, there is a general rule that when a provider or supplier provides covered services to a Medicare beneficiary, then a claim to Medicare is required. This rule results from OBRA (Omnibus Budget Reconciliation Act) of 1990.[3] The main thing that will be reported on the claim is that payment in full has been made. This is communicated through Condition Code 77 on the UB-04.

Case Study 4 - A Medicare patient has received services at the Apex Medical Center. The beneficiary does have a group health plan through their spouse's work. Thus Medicare is secondary. Chest X-Ray – Charge is $210.00. Lab – Charge is $32.00. Claim Total = $242.00. Primary pays $85.00, $107.00 Adjusted. There is a $25.00 deductible, $15.00 Co-Insurance and $10.00 Co-Pay (Total is $50.00).

In this case Medicare is certainly secondary by law. Apex will need to file a secondary claim with Medicare indicating the following:

1. The billed amount ← This is available from the claim itself,
2. Contractual adjustment amount → Value Code 44,
3. Primary payment amount → See Value Codes – 12-47.

For our purposes we will assume that Apex is contractually obligated to accept payment from the primary payer, that is, Apex must accept the $107.00 adjustment.

The amount not paid by the primary payer itself is the $50.00 from the deductible, co-insurance and co-payment. Medicare will consider this amount. While we need specific information about the Medicare payments for the radiology service (paid under APCs) and the laboratory service (paid under the clinical laboratory fee schedule), most likely as secondary Medicare will pay the $50.00 still owing.

Even these overly simple case studies show that this whole area can become quite complicated and care must be taken to process any liability insurance payments correctly and to file accurate claims.

In the next part of this series we will continue to study some specific examples and claims filing processes.

Observation – The Saga Continues

Observation services comprise an issue that continues to evolve over time. At the rate we are going, CMS may actually resolve the many coding, billing and reimbursement issues over a twenty year period.

In January, CMS issued two entries concerning observation at their FAQ web site. Both of these questions and the associated answers are important interpretations.

For Q&A #9973 the question is:

How should the hospital report observation services when the patient's status is changed from inpatient to outpatient using Condition Code 44? May the hospital report observation services from the beginning of the hospital outpatient encounter?

[2] Typically, Medical Payments or some equivalent form of coverage is found in automobile and homeowner's policies.
[3] See CMS FAQ #1396.

At issue is whether or not a hospital can bill the hours of observation going back to when the incorrect inpatient admission was ordered, that is, when the inpatient services are changed to outpatient services by using Condition Code 44. Here is the answer:

> ***The use of Condition Code 44 pertains to the entire patient encounter, the patient's status, and the hospital bill type submitted. Medicare does not recognize a separate patient status called "observation;" all hospital patients are either inpatients (if they are admitted as inpatients on the order of a physician) or outpatients (registered by the hospital as outpatients). When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. Reporting of individual HCPCS codes on an outpatient claim must be consistent with all applicable instructions and CMS guidance.***
> ***However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, the hospital cannot report hours of observation services using HCPCS code G0378 (Hospital observation service, per hour) for the time period during the hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician and the reporting requirements specific to observation services are discussed in detail in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, Section 290.2.2. The clock time begins at the time that observation services are initiated in accordance with a physician's order.***
> ***While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter.***

CMS's answer seems contrary to the whole point of using Condition Code 44. CMS is stating that the observation services cannot start until there is a physician's order. The hours prior to the observation order are simply reclassified from inpatient to outpatient, but not with observation status. Consider the following case study.

> **Case Study 5** – A physician admitted Sarah through the ED as an inpatient because of an electrolytic imbalance. Sarah is doing quite well, and it is now 28 hours into her stay. Utilization review has been checking the documentation and has asked to meet with the physician. A conference is held, and it is determined that Sarah should have been an outpatient observation patient. The physician writes an order for observation care, and Sarah is discharged 6 hours later.

According to this answer from CMS, no observation services can be charged for the first 28 hours because there was no physician order for observation services. The last 6 hours can be billed for observation, but the APC composite payment will be made only if there are at least 8 hours, that is, 8 units of G0378. Thus, the ED service will be paid and the hospital can charge for all the other services, but there will be no observation payment.

Question: Is it possible that hospitals, up to the point of this specific guidance,[4] have incorrectly billed and been paid for observation services? Could this type of situation become a RAC issue?

The second recent question, from Q&A #9974, is:

> ***May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?***

The fundamental question here is whether or not injections and infusions could or should be parts of observation. Obviously, only in certain situation are injections and infusion therapy provided. Also, CMS has also indicated that *therapeutic services* that interrupt the observation stay should not be counted as time toward the overall observations stay. Then CMS expanded this to include diagnostic services as well.[5]

While chemotherapy is specifically mentioned in the guidance, other types of injections and infusions are not explicitly indicated. Here is the answer.

> ***The Medicare Claims Processing Manual (Pub 100-4), Chapter 6, Section 290.2.2 states that***

[4] Addressing this as *specific guidance* is a little strong because this is simply an answer to a question, not a formal statement in the rules and regulations.
[5] See §290.2.2 of Publication 100-04, Medicare Claims Processing Manual.

"observation" services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy)." In situations where such a procedure interrupts observation services and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the lengths of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services under HCPCS Code G0378 (Hospital observation service, per hour).
The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.
If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

With this answer, hospitals will now need to determine when, and if, injections or infusions are provided that meet the test of active monitoring. Of course, this raises more questions! While there may be active monitoring, just how much active monitoring, that is, how long must the monitoring be maintained in order to count?

Case Study 6 – During her observation stay Sarah received a slow IV push. The push is provided over about 5 minutes. The nurse remains with Sarah for another 5 minutes to see if there is any adverse reaction.

Whether the facts in this simple case study would generate the need to remove time from the observation clock becomes problematic. Note that CMS takes a familiar stance indicating that the hospital's Medicare Administrative Contractor will provide more explicit information.

Questions from Our Readers

Question: Our hospital has several anesthesiologists and CRNAs. They are very fastidious about performing a pre-surgery assessment. This service is considered part of the anesthesia service, but what if the surgery is cancelled? Can the anesthesiologists or CRNAs charge for this service, and, if so, how? We have a number of surgeries being cancelled each month.

Let us consider this question from the perspective of the Medicare program. For Medicare there is an anesthesia global package. To find a discussion of this concept you must go to the "National Correct Coding Initiative Policy Manual for Medicare Services". This document is currently at Version 15.3. Chapter 2 addresses anesthesia services.

From page II-1 we have:

"***Anesthesia care is provided by an anesthesia practitioner who may be a physician, a certified registered nurse anesthetist (CRNA) with or without medical direction, or an anesthesia assistant (AA) with medical direction. The anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care."***

From pages II-3 and 4, we have:

"***It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit of the anesthesia code. The evaluation and examination are not reported in the anesthesia time. If surgery is canceled, subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E&M code (usually a consultation code) may be reported. (A non-medically directed CRNA may also report an E&M code under these circumstances if permitted by state law.)***"

While the reference to using consultation codes is no longer valid[6], the use of an E/M level is justified and the anesthesiologist or CRNA will follow the general professional guidelines as found in CPT itself along with additional guidelines from Medicare.

Thus, a 1500 claim form with the proper E/M code from either the 99201-99205 (new patient) or the 99211-99215 (established patient) should be filed. Obviously there could be a number of complicating factors. For instance, what if the surgery after being cancelled is performed a week later? Will the anesthesia pre-operative assessment be redone? Is it appropriate to bill the E/M level if later the surgery is performed and the assessment is not redone?

However, this is not the end of the discussion. Most likely the anesthesiologist or CRNA will have provided this service in the hospital setting, probably in an outpatient area. Some hospitals have dedicated provider-based clinics for providing these and associated pre-operative services.

Thus, when the anesthesiologist or CRNA reports the E/M level, the place of service (POS) will probably be 22 for hospital outpatient. The Medicare site-of-service (SOS) reduction will be applied through the MPFA payment.

Certainly, in cases of this type, the hospital should be billing a UB-04 with an E/M level as well. The actual E/M level must be determined through a mapping of the resources utilized. While there can be variations, usually something from the first three levels would be determined. The hospital will also need to distinguish between new and established patients. However, the hospital must use of three-year rule relative to whether the patient has been registered. In a case of this type the patient generally will be established.

Note: As an exercise, assess whether this anesthesia care package, as described in the NCCI Policy Manual, also applies on the hospital on technical component side. In theory, what is in the NCCI Policy Manual is supposed to apply to hospitals as well even though the language is directed to physicians and, in this case, to anesthesiologists or CRNAs. Hospitals resources are often consumed (i.e., examination room) when these pre-operative anesthesia assessments are performed. Is payment for this resource utilization included in the payment for the operative services?

[6] CMS has dropped the use of the consultation codes, inpatient or outpatient, by physicians starting in CY2010.

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/JantoDecember2010EdCal.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 CY2010. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for March 23rd "***Observation: Billing and Compliance Issues***" 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.

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FOR UPCOMING ISSUES

****** 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: Duane@aaciweb.com

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned 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. E-Mail: Duane@aaciweb.com.