Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

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Happy New Year!!

The consultants and staff at Abbey & Abbey, Consultants, Inc., along with our extended family of consultants wish to take this opportunity to wish you a wonderful and productive new year.

APC/APG Update

You should now have your new Version 11.0 Integrated Outpatient Code Editor (I/OCE). This should include the NCCI edits version 15.3. There are two Edit changes.

- Edit 24 (Date out of OCE range) – The grouper software should maintain 28 prior quarters, that is, 7 years.
- Edit 74 (Units greater than one for bilateral procedures with modifier 50) - This is a technical change relative to Type of Bill 85X for Critical Access Hospitals using Revenue Code Sequences 096X, 097X or 098X (i.e., Method II).

The full APC conversion factor is $67.406. It is interesting that hospitals rarely pay much attention to this conversion factor because the national payment amount is listed in Addendums A and B for APCs.

Be certain to download and study the following two transmittals:

1. Transmittal 1872 – December 11, 2009 – 'January 2010 Integrated Outpatient Code Editor I/OCE Specifications Version 11.0', and
2. Transmittal 1882 – December 21, 2009 – 'January 2010 Update of the Hospital Outpatient Prospective Payment System'.

CY2020 APC Update – Part 2

Episode of Care – The window of service used by APCs is generally a single date of service. Additionally, CMS does recognize multiple, but separate encounters on a given date of service. Within the *Federal Register*, the phrase *episode of care* is also being used. The concept of an episode of care could easily span more than a single date of service. Whether this additional language has any significance is problematic. However, starting with CY2008, CMS has been making significant structural changes to APCs. Keep your eyes open for this possible future issue.

Ambulatory Surgical Centers – ASCs are now paid through a hybrid payment system using both APCs and the MPFS (Medicare Physician Fee Schedule). ASCs need to watch carefully the lists of surgical procedures that can be performed only in the hospital setting versus those that can be performed in an ASC. Of course, we must also watch the list of surgical procedures than can be performed in physicians' offices. For CY2010 there are the typical evolutional changes in these lists.

Inpatient-Only Procedures – While virtually all commenters are opposed to continuing the inpatient-only list, CMS continues to be adamant that this list is necessary. While there were a number of changes, the following code has been removed from the list:

CPT=37215 – Intravascular Stent Placement – APC=0229 – SI="T"

This is the carotid stent placements. These can now be performed in the outpatient setting and paid by the Medicare program. Of course, physicians have been performing these on an outpatient basis for non-Medicare patients for some time.

Drug Packaging Threshold – CMS continues to package more drugs. The threshold has been increased to $65.00 from $60.00. Most likely this threshold will continue to increase in the coming years.

Packaging Indicators – Starting with CY2008 CMS has embarked on significantly increased packaging. The old 'Q' status indicator has been split into:

- Q1 – STVX Packaged
- Q2 – T Packaged
- Q3 – Composite

Watch for increased movement to the Q1 status. Services categorized with the Q1 status indicator are basically paid only if they are done on an isolated basis. For instance, Fluoroscopy, CPT 76000, groups to APC=0272 with a payment of $85.56. However, it is status indicator Q1 so that payment will be packaged if almost any other service is provided. How often is fluoroscopy provided all by itself?

Editor's Note: It is an interesting exercise to take Addendum B in MS Excel format and to sort it by status indicators Q1 and Q2 to see what CPT codes map into these packaging categories. For instance, CPT=76098 – Radiological Examination, Surgical Specimen is status indicator Q2 that is packaged if there is a surgical procedure performed. But how often would there be a radiological examination of a surgical specimen without a surgery be performed?

Cost Outliers – Hospitals will continue to see fewer cost outlier payments. There is a double threshold. The Fixed Threshold has been moved from $1,800.00 in CY2009 to $2,175.00 for CY2010.

2-Times Rule – When an APC category is statistically out of control, most likely it will hit the 2-Times Rule list. While this list has been decreasing over time, there are still several APC categories that exhibit too much statistical variation. Two fairly common APCs on this list are:

- APC=0604 Level 1 Hospital Clinic Visits
- APC=0141 Level I Upper GI Procedures

These are very common APC categories, and CMS should be working to split these categories into two or more parts. Alternatively, certain services could be remapped into other APCs to achieve statistical validity.

Blood and Blood Products – APC payment for blood and blood products continue to improve, albeit slowly. Be certain that you are working with your cost report personnel to properly report blood and blood products so that a correct cost-to-charge ratio is developed.

CA Modifier – This modifier is used when a patient is rushed through the Emergency Department, an inpatient-only surgery is performed, the patients dies and is never admitted as an inpatient. There is a single blanket payment made through APC 0375 in these situations and reimbursement has been improving over time.

- CY2010 → $5,965.94
- CY2009 → $5,672.92
- CY2008 → $5,006.13

Question: Why can't we do the same thing for IP-only surgeries inadvertently performed on an outpatient basis? If there were a single blanket payment, then the inpatient-only list could be discontinued.

Physician MPFS Conversion Factor

According to the CMS website for the physician fee schedule, the conversion factor for CY2010 is being set at $36.0846. The national anesthesia conversion factor is set at $21.114. Both of these conversion factors are significantly higher than the Sustainable Growth Rate conversion factors. Standby for *Federal Register* entries confirming this change.

Medicare Secondary Payer – Part 1

The MSP program has long been a challenge for the Medicare program. While the MSP was included in the RAC demonstration project, there was relatively little recovery, and the full RAC program does not appear to address MSP as such.

While there are varying estimates of how much the Medicare program overpays as primary when Medicare is actually secondary, there is little question that significant amounts are expended inappropriately.

So what is the problem? Let us consider a simple case study.

> **Case Study** - On a wintry day, Sarah visits a neighbor down the block. When leaving her friend's home, she slips on the icy steps and falls. There appears to be no injury. She uses her (speed) walker to go on home. An hour or two later she is in great pain, and the ambulance is called. Sarah is brought to the Apex Medical Center and is diagnosed with a fractured hip. The ambulance report indicates that Sarah fell on her own steps.

Now with the facts in the case study, the primary liability for this accident lies with the neighbor's homeowner's insurance. First, the no-fault part of the coverage, generally referred to as medical payments, would apply up to the policy limits, and then the liability portion of the coverage would kick into place. However, it is quite likely that Medicare will be considered as primary because of the belief that the accident occurred at Sarah's home.

The Apex Medical Center will probably complete an MSP questionnaire. Again whether the exact location of the accident and the resulting liability will be determined is problematic.

Less dramatic concerns arise with group health insurance plans. Workers' compensation adds another element to this whole MSP situation.

Thus, one of the main issues for hospitals, physicians and other healthcare providers is to determine if, for a Medicare beneficiary, there is some other form of primary coverage. In some cases it may even be difficult to determine if you are dealing with a Medicare patient so that Medicare can be billed as a secondary payer.

A second issue is how to bill Medicare as secondary and then how you should be paid. Let us take the general approach to MSP billing and associated reimbursement.

As secondary, Medicare will pay any amounts not paid by the primary payer up to the limit of what Medicare would pay as if they are primary. For instance,

Billed Amount - $1,000.00
Primary Payment - $600.00
Medicare As Primary Payment - $700.00
Thus Medicare pays $700.00 - $600.00 = $100.00

Obviously, this is a highly simplified example! With real world claims, there will probably be different Medicare payment systems involved. Thus, in order to know what you should be paid, you will have to understand how Medicare adjudicates the claim.

From Medicare's point of view, what information is needed in order to properly adjudicate a secondary payer claim?

a. The billed amount (this comes from the claim),
b. (If any) Adjustment or Contractual Amount.
c. The primary payment amount.
d. The difference between the amount paid and the contractual payment amount (which they can calculate).
e. Medicare will then consider the difference between what was paid and the contractual amount (or total billed if there is no contractual amount),
f. If there is not a positive difference between these two amounts, then the primary paid in full.

In subsequent articles, we will discuss how to bill for these services to Medicare as secondary.

RAC Update – More Issues

The number of approved issues for the RACs has just recently increased. Health Data Insights, for Region D, has recently issued a large number of MS-DRG issues. Surprisingly, almost all the MS-DRGs are include in one form or another. These issues generally are categorized under 'DRG Validations' and apparently include both underpayments and overpayments.

Here is an example of the language, in this case for amputations.

> *DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 239, 240, 241, 255, 256, 257, 474, 475, 476, 616, 617, 618, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs. (At this time, Medical Necessity excluded from review)*

This issue will require complex reviews. What is interesting is that there are 66 MS-DRG groupings that are listed. This appears as a very broad brush approach to MS-DRGs and probably indicates that the truly problematic MS-DGR categories are not yet identified.

There is also a rather general NCCI (National Correct Coding Initiative) issue. These edits apply to both physicians (generally Part B) and to hospitals (generally Part A). Basically, this issue boils down to the proper use of the "-59" modifier. The statement of the issue is quite general, so whether the examinations will be automated or complex review of medical records is not clear. Most likely the RACs will use a combination approach in this area.

DME in the hospice setting as well as in the SNF (Skilled Nursing Facility) and even the hospital setting is a relatively easy automated review issue.

There is also an issue that addresses ***anesthesia care and packaged E/M services***. §50 of Chapter 12 of CMS Publication 100-04, Medicare Claims Processing Manual is referenced along with NCCI edit coding guidance. The statement of this issue appears to be directed toward anesthesiologist and CRNAs (Certified Registered Nurse Anesthesiologists). However, both Part A and Part B are listed for applicability.

> *Under NCCI Edit rules, the anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care. … Physicians can indicate that E&M services rendered during the anesthesia period are unrelated to the anesthesia procedure by submitting modifiers 24, 25, 57 and/or 59, depending on claim specific circumstances, on the E&M service. Only critical care E&M services are payable during the anesthesia post-*

operative period. The post-operative period is defined as the day immediately following the anesthesia service and any subsequent days during the same inpatient hospital admission as for the anesthesia service.

Another generally stated issue involved inappropriate payments to physicians relative to services being provided in a ***facility setting***.

Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility and a nonfacility. The CMS furnishes both fees in the MPFSDB update. Professional fees, when the services are provided in a facility, are applicable to procedures furnished in the facilities.

Basically this issue involves the physician or practitioner accurately reporting the Place of Service (POS) on the professional claim. Hospitals should note that if you have provider-based clinics, even if the physicians are not employed, you, the hospital, are responsible for the correct POS reporting.[1]

The Red-Flag Rule

The Red Flag Rule is yet another regulatory burden placed on healthcare providers. As with the mandatory reporting for MSP, the Red Flag Rule was not primarily intended for healthcare providers. These requirements were designed for credit card companies and financial institutions in general. Nonetheless, healthcare providers generally fit the definition of *creditors*. This simply means that healthcare providers typically allow patients to pay on their accounts over time.

The Red Flag Rule involves identity theft or for healthcare providers medical identity theft. For hospital and clinic compliance personnel the Red Flag Rule is a significant exercise in establishing a specific compliance program. As is often the case, the federal guidance is somewhat general and allows healthcare provides to assess risks in this area followed by appropriate action steps.

The three main concerns are:

1. Detect Identity Theft,
2. Prevent Identity Theft, and
3. Mitigate Identity Theft

The Red Flag Rule is extensively discussed in the November 7, 2007 *Federal Register*. Healthcare providers are explicitly mentioned.

"When identifying Red Flags, financial institutions and creditors must consider the nature of their business and the type of identity theft to which they may be subject. For instance, creditors in the health care field may be at risk of medical identity theft (i.e., identity theft for the purpose of obtaining medical services) and, therefore, must identify Red Flags that reflect this risk." (72 FR 63727)

While healthcare providers are protesting the coverage in the medical and healthcare fields, most likely this rule will prevail for healthcare providers.

For healthcare providers we already have a systematic process in the form of the seven principles derived from the Federal Sentencing Guidelines.

- Compliance Standards & Procedures
- Oversight Responsibilities
- Delegation of Authority
- Employee Training
- Monitoring & Auditing
- Enforcement & Discipline
- Response & Prevention

All of these elements in modified form are discussed in the *Federal Register* from the Federal Trade Commission (FTC).

- Phase 1 - Risk Assessment and Prior Experiences
- Phase 2 – Review the Federal Register Appendix
- Phase 3 – Identify Triggers
- Phase 4 – Detecting the Triggers That Will Invoke Action
- Phase 5 - Response and Escalating Activities

In Phase 2 a review is to be made of the appendix in the November 7, 2007 *Federal Register*. This appendix is designed to give those falling under the Red Flag Rule some examples of triggers that should evoke action on the part of the organization relative to possible identity theft.

While some of these triggers don't apply to healthcare providers, here are some examples of situation that might cause concern.

- Address Differences – Insurance vs. Drivers License vs. Records
- Photo Identification – Mismatch Between Individual and Picture
- Post Office Box As Residence
  - Billing address may be P.O., but should have a residence address
  - Residence address should exist
- Telephone Number – Pager or Answering Service

[1] See 65 FR 18519 – April 7, 2000 *Federal Register*.

    - Pager of Answering Service May Be Secondary
    - Main telephone number (including cell phones) should exist
- Medical Record Inconsistencies
    - Patient reports care, history, symptoms different from record.
- Patient Who Has Insurance Number But No Card
    - Need to distinguish a one-time event from a consistent series of events.
- Complaints/Questions From Patients
    - A bill for services that were not provided to them.
    - A bill for product that the patient claims were not provided.
    - A bill from a healthcare provider unknown to the patient.
    - A notice of insurance payment for services or items never received by the patient.
    - Collection notice for a bill unknown to the patient
    - Insurance denial due to frequency limitations or caps that the patient maintains have never been attained.
    - Concern about credit report additions from healthcare providers for services that the patient has not received.
    - Concern about contacts from an insurance fraud investigator.
    - Assertions from the patient that they are the victim of identity theft.

For healthcare providers a number of other related question arise. For instance:

How do the Red Flag Rules relate to the various HIPAA Privacy concerns?

For hospitals, how do the Red Flag Rules relate to the Joint Commission requirements relative to the National Safety Goals (NPSGs) for patient safety?

Also, for post-acute care providers (i.e., SNFs and HHAs), can they rely on the hospital to have verified identity?

Presuming that you have identified triggers and the actions that will be taken, this must be written into policies and procedures and constitute a written plan. This plan must be approved by appropriate compliance authorities within the organization. The plan should be reviewed annually and updated based upon experience.

For healthcare organizations the Red Flag Rules are just part of larger compliance considerations.

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 CY2009. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for January 26th "***Mandatory Reporting for MSP***" 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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****** 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.

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: Chris@aaciweb.com.