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

The proposed APC update for CY2009 is out! The examination copy of the Federal Register appeared on July 3rd and the official FR entry is scheduled to be published on July 18th.

Please take the opportunity to send comments to CMS concerning a multitude of issues surrounding APCs and the proposed changes for CY2009.

Your comments can be sent by mail or submitted electronically. The deadline is September 2, 2008, no later than 5:00 p.m. EST. Note that for written comments, you must submit an original plus two copies.

For both the July and August Newsletters we will be discussing a number of topics relating to APCs and other concerns relative to CMS's discussions. In some cases we will provide suggestions for possible comments. You may use any of our suggestions at your discretion.

CY2009 APCs – E/M Coding Guidelines

Well, the technical component E/M coding guidelines are not yet ready, and, based on the tone of CMS's discussion, we may never have technical component guidelines. We are now about to enter the tenth year of APCs without E/M coding guidelines. This situation is almost beyond belief.

Note: The lack of national technical component E/M coding guidelines puts hospitals all across the country at significant compliance risk.

No matter what point system, narrative system and/or other mapping you are using, an outside auditor could always look at your system and conclude that you are upcoding and/or that there are other deficiencies in your mapping. There is little defense against such claims.

One of the criteria that an auditor would use is to graph the frequency distribution of E/M services for your Emergency Department and other provider-based clinics. If there is a normal distribution (i.e., a bell shaped curve), then, presumably, your mapping is appropriate.

This is the precise argument that CMS is making at the national level. What CMS has found is that if you take all the hospitals across the country and graph the frequency of E/M levels, a normal distribution results.

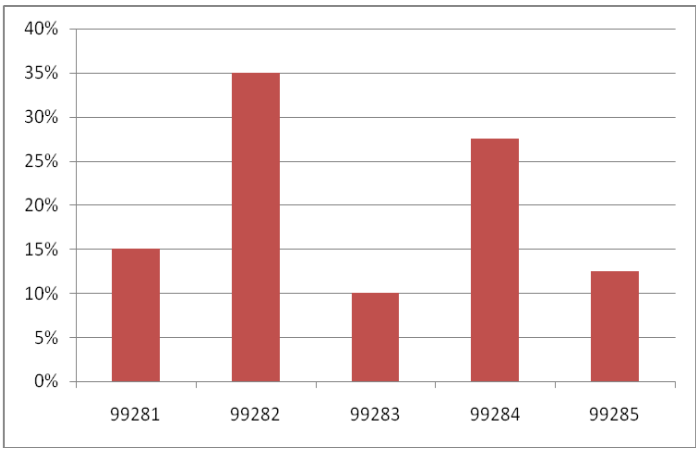
As described in section IX.A. of this proposed rule, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. As noted in detail in sections IX.C. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time. Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, As described in section IX.A. of this proposed rule, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. As noted in detail in sections IX.C. of the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on average, were

billing all five levels of visit codes with varying frequency, in a consistent pattern over time. Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for specific classes of hospitals. (73 FR 41510-41511)

The fact that the statistical averages at the national level show a normal distribution is of little comfort to individual hospitals. Let us take the fictitious Apex Medical Center as an example. The Apex Medical Center's ED encounters two types of patients:

1. Clinic level patients who really don't have emergencies but come to the ED for convenience or because they don't have a primary care physician, and
2. True emergency cases that are generally fairly significant such as accidents, falls, lacerations and fractures.

While all types of cases are seen in AMC's ED, below is a histogram of the percentage frequency distribution for ED cases.



For those of you into statistics this is a bimodal distribution. This type of distribution is being created by the types of patients presenting to AMC's ED. Now how do we ensure that AMC is compliant with the CMS directives concerning E/M levels?

The simple answer is that without national guidelines there is no really good way to gauge whether AMC is in compliance or not!

Recommended Comments:

1. CMS should immediately develop and, after proper review, implement national technical component E/M coding guidelines. This should occur no later than 2010.
2. For as long as there are no technical component guidelines, CMS should inform the OIG, Medicare Auditors and any other audit personnel (presumably eventually including RAC auditors) that technical component E/M levels are not to be audited until guidelines are available and fully implemented.

CY2009 APCs – Imaging Families

Ever since DRA 2005 we have been expecting bundling or some sort of discounting on the hospital side. This discounting was implemented for physicians and IDTFs in 2006. CMS is now proposing to implement reductions in payment relative to these 11 families.

- Ultrasound (Chest/Abdomen/ Pelvis-Non-Obstetrical)
- CT and CTA (Chest/Thorax/Abd/ Pelvis)
- CT and CTA (Head/Brain/Orbit/ Maxillofacial/Neck)
- MRI and MRA (Chest/Abd/Pelvis)
- MRI and MRA (Head/Brain/Neck)
- MRI and MRA (Spine)
- CT (Spine)
- MRI and MRA (Lower Extremities)
- CT and CTA (Lower Extremities)
- MR and MRI (Upper Extremities and Joints)
- CT and CTA (Upper Extremities)

These are the same families currently found in the special discounting under RBRVS.[1]

The logic being proposed uses five composite APCs: 8004-8008. No coding charges are required, everything will be programmed into the APC grouping logic. From page 41450, we have:

To implement this proposed policy, we would provide one composite APC payment each time a hospital bills more than one procedure described by the HCPCS codes in one OPPS imaging family displayed in Table 8 below on a single date of service. If the hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, then the hospital would receive payment for the "with contrast" composite APC. A single imaging procedure, or imaging procedures

[1] See the large Excel spreadsheet comprising MPFS as developed through RBRVS. This RBRVS spreadsheet is freely available from the CMS website and has a great deal of valuable information.

reported with HCPCS codes assigned to different OPPS imaging families, would be paid according to the standard OPPS methodology through the standard (sole service) imaging APCs to which they are proposed for assignment in CY 2009. We are proposing that hospitals would continue to use the same HCPCS codes to report imaging services, and that the I/OCE would determine when combinations of imaging procedures would qualify for composite APC payment or would map to standard APCs for payment. We would make a single payment for those imaging services that qualify for composite APC payment, as well as the packaged services furnished on the same date of service. The proposed composite APCs would have status indicators of "S," signifying that payment for the APC would not be reduced when appearing on the same claim with other significant procedures.

Recommended Comments:

While hospitals do like to see potential reductions in payments, we should really be happy that we had several years of extra payment (in some sense) before CMS formally addressed this issue. Thus, no comments are recommended as such.

CY2009 APCs – New versus Established Patients

Interestingly enough CMS discusses the issue of the proper definition of a 'new' versus 'established' patient on the hospital or technical component side of claims filing. In the April 7, 2000 Federal Register, CMS (then HCFA) stated in a brief parenthetical comment that an established patient is one who has a hospital medical record number.

Recently, CMS has been hinting that perhaps the hospital definition should be based on a 3-year rule as well. Basically, using a 3-year rule comes a little closer to the language used by physicians from CPT.

While there is an interesting discussion, from page 41507 we have:

... but [we] are instead proposing to modify the definitions of "new" and "established" patients as they apply to hospital outpatient visits. Specifically, the meanings of "new" and "established" would pertain to whether or not the patient was registered as an inpatient or outpatient of the hospital within the past 3 years. Under this proposal, hospitals would not need to determine the specific clinic where the patient was previously treated because the proposed approach would not rely upon when the medical record was initially created but rather, would depend upon whether the individual had been registered as a hospital inpatient or outpatient within the previous 3 years.

Recommended Comments:

The 3-year rule on the hospital side should be implemented as enunciated.

CY2009 APCs – Physician Supervision

In Section XII. OPPS Nonrecurring Technical and Policy Clarifications, A. Physician Supervision of HOPD Services (73 FR 41518-45519), CMS discusses a limited aspect of the physician supervision requirements. Many question have been raised because of the language in Transmittal 82 to Publication 100-02, Medicare Benefit Policy Manual. This Transmittal has been discussed in the March, April and May issues of this Newsletter.

The issue that CMS addresses is the ***assumption*** that the physician supervision for in-hospital and on-campus departments of the hospital is met because there is a physician close by in these areas. CMS has always insisted on direct physician supervision for off-campus provider-based clinics.

But first, back to the basics… The physician supervision requirements must be viewed in the context of:

- Diagnostic Services, and
- Therapeutic Services.

For diagnostic services CMS has generally reverted to the MPFS supervisory requirements (e.g., IDTF requirements). No new requirements for hospital outpatient departments have ever been issued.

We [CMS] have not subsequently issued new requirements for the physician supervision of diagnostic tests in provider-based departments of hospitals. Instead, we have continued to follow the supervision requirements for individual diagnostic tests as listed each year in the updates to the MPFS.

Alright, this gives us some guidance relative to diagnostic services. What about the therapeutic services?

This is among the topics discussed in Transmittal 82. In this FR entry, CMS is quite clear that the direct physician supervision requirement is for both off-campus and on-campus (including in-hospital) locations.

> ***It is our [CMS] expectation that hospital outpatient therapeutic services are provided under the direct supervision of physicians in the hospital and in all provider-based departments of the hospital, specifically both on-campus and off-campus departments of the hospital.***

While this is an important discussion, another very disturbing issue from Transmittal 82 involving physician supervisions is in the following statement:

> ***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.*** (Emphasis added.)

This issue that the supervising physician must be the treating physician is not addressed in this FR entry. In some respects, this treating physician issue is much more significant than the physician supervision for on-campus therapeutic services.

Note: Within all these discussion concerning physician supervision, there have been no changes made to the actual CFR language.

Recommended Comments:

Concerning the physician supervision requirements for hospital and provider-based clinics, CMS should issue revised guidance removing the 'treating physician' language so that the required direct supervision is simply by a physician or qualified practitioner.

CY2009 APCs – Inpatient-Only Procedures

Inpatient-only procedures are surgical procedures that will be paid only if they are performed on an inpatient basis. No payment is made if they are performed on an outpatient basis, and the Medicare beneficiary becomes liable for the payment.

Most hospitals do experience a few cases each year in which a planned outpatient procedure becomes more extensive than planned and turns into an inpatient-only procedure. Of course, clinical staff is not aware that an inpatient-only procedure or procedures have been performed. The patient is placed in observation, and the patient is never admitted as an inpatient.

The decisions as to whether a given procedure should be performed on an outpatient basis are really a clinical decision and should not be dependent on the way in which Medicare pays for services. However, we must all accept the fact that CMS does not want to establish APC mappings for all procedures that could possibly be performed on an outpatient basis.

What is needed in this type of situation is an equivalent to the "-CA" modifier that provides a blanket payment when an inpatient-only procedure is performed on a patient coming through the Emergency Department and the patient expires without being admitted. Such a blanket payment would provide some reimbursement even if the amount is not appropriately high.

Recommended Comments:

A new modifier should be developed so that when an inpatient-only procedures is inadvertently performed on an outpatient basis, there is a default blanket payment as is used with the "-CA" modifier.

CY2009 APCs – Drug Administration

Now that we finally have the infusion, injection and chemotherapy codes fully revised in CPT, CMS is at a point where they can refine the payments for these services. For CY2009 the proposal is to reduce the number of APCs. While this is a grouping change, the real question is whether there will be any significant financial impacts from these changes.

Let us take a few of the codes and check for payment differences.

CPT	CY2008 Pay	CY2009 Pay
90760	$114.64	$ 74.23
90761	$ 25.13	$ 25.03
90765	$114.64	$ 74.23
90766	$ 25.13	$ 25.03
90772	$ 25.13	$ 25.03
90775	$ 51.22	$ 36,66

Note: There is a discrepancy between the preamble grouping and the Addendum B grouping for 90765.

Even a moment of thought indicates that there will be significant reductions in payments.

Simple Example: A patient presents to the ED. An IV infusion of a medication is started and continues for a total of four hours.

CY2008 Payment - $114.64+3*$25.13 = $190.03
CY2009 Payment - $ 74.23+3*$25.03 = $149.32

This is 21% decrease in payment.

While much more thorough financial analyses must be performed, even at a rudimentary level, these grouping changes indicate a significant drop in payment for infusions and injections. Chemotherapy departments should also review any impact on changes relative to the chemotherapy administration codes.

Recommended Comments:

While the changes in grouping and the adjustments to the payment levels are difficult to contradict without extensive financial analyses, we can certainly comment to the fact that any such changes should not involve an overall reduction in payment of more than 5% or 10%.

Transmittals 87 and 82 – More Thoughts

On May 8, 2008 CMS released a very important transmittal addressing a topic that has created confusion for many years. This is Transmittal 87 to Publication 100-02, the Medicare Benefit Policy Manual. The topic addressed is ***incident-to services provided in a freestanding or physician owned and operated clinic***. **This Transmittal was withdrawn shortly after it was released because of opposition in the healthcare community.**

Even though this Transmittal has been withdrawn, we can still obtain some insight on what CMS is thinking in terms of clinics and different incident-to services.

The Provider-Based Rule (PBR) found at 42 CFR §413.65 divides clinics into:

- Provider-Based, and
- Freestanding.

There is also a special classification of clinics that are freestanding but are owned or operated by a hospital. The trigger for the DRG Pre-Admission Window to apply is "owned or operated". Thus a hospital may have freestanding clinics (i.e., not provider-based) and the services provided in these clinics can still be imputed to be hospital outpatient services if the services fall within the DRG Pre-Admission Window, that is three dates-of-service preceding the date of admission.

Watch carefully for future developments as CMS refines the incident-to billing rules.

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:
http://www.aaciweb.com/Sept2007June2008EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2008 Contact 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. Instruct-Online, AHC Media, LLC, Accuro Health and the Eli Research Group are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008. This calendar is updated frequently as presentations are scheduled. Note that most of these sponsors can also provide these sessions in CD/DVD format. Thus, if you are not able to participate at the scheduled time, you can still obtain the information and listen at your leisure.

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 next webinar is scheduled for August 12th, "**Chargemaster: Understanding Revenue Codes**". The presentation will run from 9:30 a.m. to 11:00 a.m. EDST.

Dr. Abbey has completed his eighth book, "***Compliance for Coding Billing & Reimbursement: a Systematic Approach to Developing a Comprehensive Program***" 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.

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**
- **Chargemaster Coordinator's Handbook** is currently in preparation.

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

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FOR UPCOMING ISSUES

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More Anticipated CY2009 APC Changes

****** 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.

Interventional Radiology, Catheterization Laboratory and Vascular Laboratory a Challenge? Special studies are being provided to assist hospitals in coding, billing and establishing the Charge master. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about preparing for the RAC audits? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.