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 changes* to APCs for 2011 are finally out! The display version appeared on July 2nd. The official version will not appear in the Federal Register until August 3rd. The deadline for submitting comments is August 30, 2010.

Now is definitely the time to carefully review this rather lengthy document and make comments as appropriate. In the August issue of this Newsletter we will discuss some of the more important proposed changes and suggest possible areas where comments might be useful.

The display copy of the Federal Register is at:

http://www.ofr.gov/OFRUpload/OFRData/2010-16448_PI.pdf.

DRG Pre-Admission Window – Congress Acts

Editor's Note: As indicated in the June, 2010 edition of this Newsletter, Congress has acted relative to revising the DRG Pre-Admission Window.

Congress has modified the Social Security Act through Section 102 of H.R.3962 - Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Section 102 is entitled, "CLARIFICATION OF 3-DAY PAYMENT WINDOW'.

Note: This legislation was signed into law on June 25, 2010. Thus, any changes made by the law are immediately effective as of that date.

Section 1886 of the SSA, paragraph (a)(4) addresses, among other payment issues, the 3-day and 1-day pre-admission windows in a very long sentence. The new additional language is:

`In applying the first sentence of this paragraph, the term `other services related to the admission' includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient--

(A) on the date of the patient's inpatient admission; or

(B) during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of such admission ***unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission****.';*

The key phrase is highlighted above. While we can discuss at some length what this statement really means, ***clearly the burden of proof is being moved to the hospital to justify unbundling non-diagnostic (i.e., therapeutic) services***.

Currently, that is pre-June 25th, we have specific guidance from CMS in the form of:

1. February 11, 1998 Federal Register (63 FR 6864),
2. PM-A03013, February 14, 2003,
3. Transmittal 1429 to Publication 100-04, Medicare Claims Processing Manual, February 1, 2008.

In this guidance all diagnostic tests are to be bundled into the inpatient billing and then all therapeutic services that are related are also bundled using a specific test. The test is that the primary diagnosis code for the outpatient service must *match exactly* to the principal diagnosis for the inpatient admission.

Let us consider a simple case study for services provided at a provider-based clinic:

Case 1 – ***Cold Treated at Provider-Based Clinic*** - Sam, an elderly resident of Anywhere, USA presented to the Acme Medical Clinic on Tuesday and complained of a cough and slight fever. He is

diagnosed with a cold, but an antibiotic injection is provided, just in case. Unfortunately, Sam presents to the ED of the Apex Medical Center on Thursday evening with exacerbated symptoms and he is admitted to the hospital with pneumonia.

In this case study Acme is a provider-based clinic relative to the Apex Medical Center. Note that the 'trigger' for applying the pre-admission window is simply wholly owned or operated which certainly includes provider-based clinics. Most likely, the primary diagnoses for the various therapeutic outpatient services will not be the same as the principal diagnosis for the inpatient admission so that they can be billed separately.

However, with the change in the language of the SSA, these outpatient services most likely will be considered as related to the inpatient admission. The Secretary will need to issue new rules in this area, which probably will involve the National Public Rule Making (NPRM) through the *Federal Register* process. How soon this will occur is problematic.

By putting the 'relatedness' language into the SSA itself, the whole issue of the DRG Pre-Admission Window comes into the limelight. With this change in the law, hospitals are left in the lurch until specific rules and regulations can be formulated. This may take a year or more in view of all of the other regulatory changes that are taking place.

A second feature of H.R. 3962 is that Congress decided that hospitals are not allowed to go back and correct claims already filed.

> *(c) No Reopening of Previously Bundled Claims-*
> *(1) IN GENERAL- The Secretary of Health and Human Services may not reopen a claim, adjust a claim, or make a payment pursuant to any request for payment under title XVIII of the Social Security Act, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital) for services described in paragraph (2) for purposes of treating, as unrelated to a patient's inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient's inpatient admission.*

The reason for this inclusion is not really clear because this delimits the normal claim filing and refilling time periods for Medicare in general. If a hospital discovers that outpatient therapeutic services have been incorrectly bundled into the inpatient billing, then there is no way to go back to correct this situation. While less likely, if therapeutic services have been incorrectly broken out, then an overpayment may have occurred. How this can be corrected with this new language will need consideration by legal experts.

> **Note**: There are occasions when bundling therapeutic services into inpatient billing actually can increase the MS-DRG payment due to the increased diagnoses that become available.

Bottom-Line: Billing in this area is now split into two parts:

1. Prior to June 25, 2010, and
2. On or after June 25, 2010.

For billing services with date of service prior to June 25th, the current billing practices should be followed. For situations on or after June 25th, hospital will need to consider increasing the bundling of therapeutic outpatient services into inpatient claims for cases in which the outpatient services possibly could be considered related to the inpatient admission.

In time CMS should issue new rules concerning the exact algorithms that hospitals should use to determine when outpatient therapeutic services are related to inpatient services.

While hospital's cope with this specific billing issue, the possible involvement of the RACs (Recovery Audit Contractors) also will need monitoring.

Mandatory MSP Reporting - Update

CMS has finally addressed the issue of mandatory reporting under MSEA Section 111 relative to write-offs and gratuities. As with much of the guidance from CMS, the burden of decision making is left with hospitals and other healthcare providers. This guidance is in the form of an alert issued May 26, 2010.[1]

> *As a risk management tool to lessen the probability of a liability claim against it and/or to facilitate/enhance customer good-will, entities may reduce the amount due for items and services (write-off) or provide something of value (e.g., cash, gift card, etc). If an entity takes such actions, it may or may not constitute a reporting obligation (as a TPOC) as explained below.*

The two different situations are write-offs and provide something of value. The critical decision is:

[1] See the CMS MMSEA Section 111 Alerts web site: www.cms.gov/MandatoryInsRep/

Is there evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk?

If the answer to this question is 'no', then healthcare providers only need consider Medicare as secondary and file a claim that includes the value of the write-off or gift so that Medicare is informed. No reporting as an RRE (Responsible Reporting Entity) is necessary. Here is the actual language from the Alert.

> *"In instances where a provider, physician or other supplier has reduced its charges or written off some portion of a charge to a Medicare beneficiary as such a risk management tool, the provider, physician or other supplier is expected to submit a claim to Medicare reflecting the unreduced permissible (e.g., limiting charge) charges and showing the amount of the reduction provided or write-off as a payment from liability insurance (including self-insurance). Medicare's interests with respect to this particular TPOC amount have been protected through this billing procedure; the provider, physician or other supplier shall not report the write-off or value of property provided as a TPOC."*

TPOC is an acronym standing for 'Total Payment Obligation to Claimant'. Let us consider a simple example of this type of case.

> **Case 2** – ***Gift Certificate for Delayed Service*** – Sarah has used her speed walker to go to the Apex Medical Center's Patient Financial Services office. She is upset because, earlier in the week, there was a delay in service at the ED. While she was cared for and has no clinical complaints, there was a delay. As a standard procedure the hospital offers her a twenty dollar gift certificate to address her complaint.

In this case there is no expectation of any further clinical services being sought. Thus, when the claim is filed, the twenty dollars will need to be reported as a primary payment with Medicare secondary.

> **Note**: Without a doubt the whole issue of the *value* of the item or gratuity will require careful definition. At this juncture, common sense dictates fully reporting any values involved in these situations.

> **Case 3** – ***Return to ED after Fall*** – Sarah is returning to the ED a week after she had a laceration repaired in the Apex Medical Center's ED. Unfortunately, when her laceration was repaired, she attempted to get up, partially fell and injured her wrist. X-ray showed no fracture and a splint was applied. The treatment for the wrist was written-off. She is now re-presenting with pain in the wrist.

The facts in Case 3 are distinctly different from Case 2. The write-off was used as a risk management tool. According to the CMS Alert, a proper secondary claim will have to be submitted, and this amount will also need to be reported by Apex as an RRE. Here is the specific language from the Alert.

> *In instances where a provider, physician, or other supplier has provided property of value to a Medicare beneficiary as such a risk management tool when there is evidence, or a reasonable expectation, that the individual has sought or may seek medical treatment as a consequence of the underlying incident giving rise to the risk, the entity shall report the write-off or value of the property provided as a TPOC from liability insurance (including self-insurance). If the value of the property provided is less than the TPOC reporting threshold, it need not be reported under Section 111.*

If the value involved does not meet the TPOC reporting threshold, then the reporting as an RRE can be omitted. However, the secondary claim process still will need to be pursued.

Another question has also been addressed relative to deductible payments under liability insurance. While not common, if a hospital makes a deductible payment to the injured party, then it is still the liability insurance company's responsibility to perform the necessary RRE reporting.

> ***Bottom-Line***: If physicians, hospitals and clinics don't provide write-offs relative to liability cases, then RRE reporting is not required. If there are instance in which discounts or gratuities are provided when there is no anticipation of the patient seeking medical treatment as a consequence of an incident, then the value of the gratuity must be reported as a primary payment with Medicare as secondary.

Transmittal 1875 – E/M Coding – Part 2

In the June issue of this Newsletter the following question was raised:

> How should the first two levels of the CPT inpatient consultation codes be mapped into the initial hospital care codes?

Note the levels of history, examination and medical decision making for 99251 and 99252 versus 99221.

- 99251 – Level 1 Inpatient Consultation
  - Problem-Focused History
  - Problem Focused Examination
  - Straightforward Medical Decision Making
- 99252 – Level 2 Inpatient Consultation
  - Expanded Problem Focused History
  - Expanded Problem Focused Examination
  - Straightforward Medical Decision Making

Here is 99221.

- 99221 – Level Initial Hospital Visit
  - Detailed/Comprehensive History
  - Detailed/Comprehensive Examination
  - Straightforward/Low Complexity Medical Decision Making

Based on the three main criteria for developing the E/M levels, 99251 and 99252 cannot even map into the first level of initial hospital visits, that is, 99221. So what are we to do?

Before we address a possible solution, note that 99253, 99254 and 99255 do map almost perfectly into the 99221, 99222 and 99223 sequence of codes.

One solution to this dilemma is to map the first two levels of the inpatient consultations into the subsequent hospital visits, that is 99231 and 99232. This is certainly not a perfect solution, but this approach is fairly conservative from a compliance perspective. Thus, we have the following for the inpatient consultation codes:

99251 → 99231
99252 → 99232
99253 → 99221
99254 → 99222
99255 → 99223

Similarly for skilled nursing facility visits we have:

99251 → 99307
99252 → 99308
99253 → 99304
99254 → 99305
99255 → 99306

On the outpatient side, the mappings are somewhat more straightforward. If you are mapping the consultations codes into new patient visits, then:

99241 → 99201
99242 → 99202
99243 → 99203
99244 → 99204
99245 → 99205

Mapping the outpatient consultations to the established visits encounters a problem with CPT 99211. 99211 is used by nursing or subordinate staff in the freestanding form of clinics. Using the history, examination and medical decision making criteria, here is a possible mapping.

99241 → 99212
99242 → 99213
99243 → 99214
99244 → 99215
99245 → 99215

Note that the mapping into the established visit codes is further complicated by the fact that only two out of three of the key components (history, examination, medical decision making) are required. By the nature of outpatient consultations, at least for an initial consultation even for an established patient, both the history and examination will be performed at a fairly significant level. Thus, initial consultation will generally map into 99214 or 99215.

Now the above discussion addresses physician coding involving the mapping of the consultation codes into the hospital initial care and outpatient clinic visits. Hospitals with provider-based clinics also need to translate the outpatient consultations into new and established patient clinic visits. There is no need to address inpatient consultations because these are not billed through provider-based clinics on the outpatient side.

There are two circumstances that make this process somewhat easier.

1. Hospitals use a mapping of resources utilized, and
2. There are five levels of consultations codes being mapped into five levels of clinic visit codes.

Note that on the hospital side CPT 99211 is fully available because it is just the Level I placeholder for the first level of resource utilization regardless of whether a nurse is involved or not. Thus, in theory, the five levels of consultation codes map directly based on resource utilization.

99241 → 99201 or 99211
99242 → 99202 or 99212
99243 → 99203 or 99213
99244 → 99204 or 99214
99245 → 99205 or 99215

There may still be a challenge. If your hospital has specialty provider-based clinics (e.g., orthopedics, cardiology, etc.), then you may have developed a different resource mapping for the specialty clinics relative to primary care clinics. Thus, a consultation at a

specialty provider-based clinic may map into a clinic visit code differently from the mappings generally used in a primary care clinic.

CMS has never really addressed the facility E/M coding relative to primary care vs. specialty clinics. To what degree these types of mappings should correlate is unknown. However, if you are mapping consultation codes for provider-based specialty clinics into new and established clinic visits, then you should at least consider how the different mapping are or are not correlating.

Physician Supervision for CAHs

In a 'Web Notice'[2] dated March 15, 2010 CMS has relented on enforcing the relatively new supervision requirements for CAHs. This document can be found at:

https://www.cms.gov/HospitalOutpatientPPS/Downloads/WebNotice.pdf

A careful study of the significantly revised supervision rules (see the June issues of this Newsletter) indicates that there are some conflicts with CAH's Conditions of Participation (CoPs). For instance, consider the following case.

> **Case Study** 4 – ***Inpatient Admission Converted to*** Outpatient – Sam, an elderly resident of Anywhere, USA has been admitted as an inpatient at the local CAH. After a day and a half, Utilization Review in connection with the admitting physician determines that this stay should be observation. Condition Code 44 is used.

On the surface, this case raises no concerns. However, the CoPs for CAHs allows for a nurse to be present for inpatients with a physician or practitioner on call. Because this case was converted to outpatient, the supervision rule under the Provider-Based Rule (PBR)[3] requires that a physician or qualified practitioner be on-site and immediately available. In this case the CAH may not (assuming only a nurse was present) have met the supervision rule requirements.

CMS has indicated that this issue will be studied further with new guidance included in the APC update *Federal Register* for 2011. See the APC/APG Update section of this Newsletter. Standby!

[2] Web notices appears as another level of guidance from CMS. The formality of such guidance is questionable as it is with Questions & Answers from CMS. Be certain to download and save such guidance for compliance purposes.

[3] See 42 CFR §413.65.

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 sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2010.

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 August 24th "***Modifiers for APCs"*** 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 in the series addresses fee schedule payment systems and should be available shortly. The third book in the series is devoted to prospective payment systems and is currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
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http://www.APCNow.com
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Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

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