Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

July 2011– Volume 23 Number 7

ISSN: 1061-0936

APC/APG Update

Both the APC and MPFS update *Federal Registers* are out. For APCs the date is July 18, 2011, and comments must be submitted August 30th. The MPFS update is dated July 19, 2011, and the deadline for comments is also August 30th. These *Federal Register* entries are out almost a full month relative to previous years. See comments below. Be certain to comment if you think there are changes needed to either APCs or MPFS.

APC Proposed Update

Dozens of issues are discussed in the proposed changes for APCs in the July 18th *Federal Register*. We will select several that could involve the need to comment.

Composite APCs – There is movement to establish a new composites in the cardiac resynchronization therapy (CRT) area. APCs in this area are 0108, 0418, 0655, and 8009. This is a distinct growth area so check for these services at your hospital relative to overall costs and reimbursement.

Packaging – Increased bundling for APCs continues unabated. This trend likely will continue on into the future. At this point in time CMS is adding more packaging in diverse areas.

In-Patient Only Procedures – While virtually all commenters over the years have requested that this list be discontinued, CMS is adamant about maintaining this list. If CMS did not have this list, they would have to map many, infrequently performed surgeries into APCs.

A suggested recommendation is to develop a special modifier similar to the current "-CA" modifier for use when an inpatient only procedure is inadvertently performed on an outpatient basis. The new modifier would group all these cases to a single APC category that will provide a general blanket payment. At least this way, hospitals will receive some reimbursement and the Medicare beneficiary will not be held liable.

Observation and Status indicator "T" Procedures – In the last Federal Register cycle CMS did recognize the recommendation of not bundling observation into minor surgeries. Of course CMS was quick to indicate that there is no definition of minor surgery in APCs.

The suggested recommendation is to try again. Let CMS know that for observation services in which there is a minor surgery, as defined under the Medicare physician fee schedule, that the payment for observation should not be bundled into the minor surgery.

2-Times Rule – The APCs violating the 2-times rule are diminishing over time. The listing in the July 18th Federal Register is down to seventeen APCs. The three APCs that have been on the list for some time are:

- 0058 – Level I Strapping and Cast Application
- 0245 – Level I Cataract Procedures without IOL Insert
- 0604 – Level I Hospital Clinic Visits

Note that for the strapping and cast application APC, the Level I is redundant because this is the only one level now left.

Hospital Outpatient Visits – There appears no effort to establish national guidelines for the technical component E/M levels. CMS continues to assess overall statistics for all hospitals. The results on the global sampling are within

reasonable bounds, but even CMS is noticing a movement to the levels 4 and 5. While we can encourage CMS to develop and issue national guidelines, there appears to be little interest. Anticipate that this will become a major RAC audit issue using extrapolation. Assuring compliance in this area without any measurable guidelines is infeasible.

Physician Supervision – Part 1

In the July 18th *Federal Register* CMS again comments to the whole physician supervision issue that started the current revision cycle in 2008. Fortunately the whole situation is starting to calm down although we still have ambiguous guidance relative to the supervising physician or qualified practitioner being immediately available. Without a doubt, this whole area will be subjected to RAC scrutiny, and there will be claims of gross overpayment because there was not appropriate physician supervision.

The current discussion is found on pages 42277-42285. At the end of this article, all of the *Federal Register* entries pertaining to this topic are listed as reference.

CMS starts their discussion with the following on page 42277.

> "*In the CY 2000 OPPS final rule with comment period, CMS established the hospital OPPS and indicated that direct supervision is the standard for all hospital outpatient therapeutic services covered and paid by Medicare in hospitals and in provider-based departments (PBDs) of hospitals (65 FR 18524 through 18526). Currently, as discussed in the CY 2011 OPPS/ASC final rule with comment period (75 FR 72008), this standard requires the supervisory practitioner to be immediately available to furnish assistance and direction throughout the performance of a hospital outpatient therapeutic service or procedure*."

If you go back to the April 7th *Federal Register*, you will find that the discussions at that time were not nearly as precise as the above statement. CMS (then HCFA) was quite adamant that direct physician supervision was required only for off-campus clinics or other off-campus operations. The physician supervision for on-campus and inside the hospital was assumed on CMS's part because there would be a physician nearby.

Also the use of the phrase *provider-based department* or PBD is quite recent. In the provider-based rule (PBR) the terms used are *facility* or *organization*. The question of whether all these rules and requirement apply to operations inside the hospital as well as to operations on the campus, but outside the hospital, are finally being established. With this terminology, virtually everything falls under the PBR requirements including physician supervision.

With the recent changes starting in 2008, the concept of direct physician supervision for on-campus and in-hospital locations has also become more stringent. For the period 2000 through 2008 there was the presumption that some physician would be nearby in case there were any urgent or emergent situations that required the presence of a physician. This concept has now become more stringent in that not only must a physician be available, the physician, or qualified non-physician practitioner, must be able to take over the care and change the procedure if necessary.

The key issue throughout the past years is that the phrase *immediately available* has never been defined. Thus hospitals are forced to develop their own definitions within their policy and associated procedures.

On page 42279 we have an interesting paragraph.

> *As indicated above, in the CY 2011 OPPS/ASC final rule with comment period (75 FR 71998 through 72013), we further adjusted the direct supervision standard to increase flexibility for hospitals while maintaining an appropriate level of quality and safety and consistent with the incident to statutory provision. Specifically, we redefined direct supervision to remove all requirements that the supervisory practitioner remain present within a particular physical boundary, although we continued to require immediate availability. We also established a new category of services, "nonsurgical extended duration therapeutic services" (extended duration services), which have a substantial monitoring component. We specified that direct supervision is required for these services during an initiation period, but once the supervising physician or nonphysician practitioner has determined the patient is stable, the service can continue under general supervision."*

There are several important points in this paragraph. First CMS has changed the direct physician supervision requirement so that the physician or qualified non-physician practitioner is not required to be on the campus of the hospital. This almost appears as an oxymoron. How can a physician be immediately available and not on the campus? Also, direct supervision has always been stated to require that the physician to be *on the premises*. This change in removing the on-the-campus requirements appears in deference to Critical Access Hospitals (CAHs). The conditions of participation (CoPs) for CAHs allow for a physician to be on call and available within 30 minutes.

How hospitals should respond to the removal of the on-the-campus requirement is a very good question. Certainly if you are using a time metric this would suggest that a 5 to 10 minute response time is adequate, but is that immediate availability?

Also, CMS has developed the concept of *extended duration therapeutic services*. Services such as observation or infusion therapy fall into this category. The basic idea is that physician supervision is required for initiation. However, once the patient is stable, the direct supervision requirement does not apply. Interestingly, the word *stable* is not defined. Are we to take the definition of stable from EMTALA (Emergency Medical And Labor Act)? Also, once the patient is stable, then only *general supervision* is required. Has general supervision been defined on the therapeutic side? The concept of general supervision and personal supervision come from the rules on the diagnostic side.

Given all the ambiguity and questions that have been raised, CMS is utilizing one of the standard bureaucratic techniques when decisions have to be made. CMS is forming a committee to study various types and levels of services relative to supervisory requirements. CMS appears to lean toward having the APC Advisory Panel perform this function.

Here is a brief quotation, from page 42281, that will give you some insight.

> "*With respect to an initial agenda of services for the review entity, commenters recommended that CMS begin evaluating services with work Relative Value Units (RVUs) < 1.0 (approximately 160 services), which they believe would include many extended duration services. They also requested that CMS evaluate surgical procedures (especially minor surgical procedures) and portions of the surgical recovery period for general supervision. We continue to support direct supervision as the default supervision level for all hospital outpatient therapeutic services."*

As you should note in this excerpt, concepts from the MPFS are now being used. The RVUs mentioned are directly from the physician fee schedule. Also the reference to minor procedures is a concept from MPFS (procedures with a 0-day or 10-day postoperative period). For APCs there is no definition of minor surgical procedures even as questioned by CMS.[1]

Bottom-Line: Hospitals must develop their policies and implementing procedures for meeting the requirements for physician supervision. This will require developing such policies and procedures under ambiguous guidance. At this time a conservative stance is generally recommended including documenting on a day-by-day basis as to which physician or practitioner provided the required supervision.

Editor's Note: This discussion will be continued in the September Newsletter. See July 18, 2011 (76 FR 42277), November 24, 2010 (75 FR 71998), August 3, 2010 (75 FR 46306), November 20, 2009 (74 FR 60564), July 20, 2009 (74 FR 35358), November 18, 2008 (73 FR 48702), and July 18, 2008 (73 FR 41518) *Federal Registers*.

3-Day Pre-Admission Window
The Saga Continues

The CMS 3-Day Pre-Admission Window or what CMS is calling the 3-Day Payment Window was addressed in both the IPPS update *Federal Register* (May 5, 2011) and the MPFS update *Federal Register* (July 19, 2011).

The key directive in this 3-day window is that *related therapeutic services* are bundled into the inpatient billing if such services are provided within the window at an outpatient facility that is wholly owned or wholly operated by the admitting hospital. This changed on June 25, 2010 with the passage of P.L. 111-192. The requirement for bundling related services into the inpatient billing was moved to the Social Security Act.

Unfortunately, the definition of related services is no longer precise. Prior to June 25, 2010 we did have a precise definition through diagnosis code matching.[2] While CMS's failure to provide a precise definition represents ambiguous guidance, hospitals must still develop policies and implementing procedures to address this requirement.

The newly recognized issue, on the part of CMS, is not really new at all. The issue has always been there, CMS simply has not addressed it over the years. As we will see, the issue is more complex than appears at first sight.

We will provide two little case studies to illustrate what is transpiring in this area. For these case studies, the Acme Medical Clinic is a freestanding clinic that is owned and operated by the Apex Medical Center. Acme, as freestanding, files only the 1500 professional claim and is paid the full MPFS payment amount. Acme has a physician office laboratory and basic radiology.

[1] See 75 FR 71854.

[2] See February 11, 1998 *Federal Register*, pages 6864-6868 (63 FR 6864).

Note: We will use *freestanding* to identify clinics that file only on the 1500 claim form. This term is defined in the provider-based rule (PBR) found at 42 CFR §413.65. CMS uses the phrase *physician practice.* This seems confusing because the phrase physician practice seems to imply physician ownership.

Case Study 1 – On Tuesday morning, Sarah is presenting to the Acme clinic with cough, congestion and a slight fever. One of the physicians does a thorough workup including laboratory and radiology. A definitive diagnosis cannot be made. Sarah is given an antibiotic injection and placed on an antibiotic regimen. She is sent home to rest. On Thursday evening Sarah is brought by neighbors to the Apex Medical Center and is admitted with a diagnosis of pneumonia.

Because Acme is owned and operated by Apex, the 3-Day Payment Window applies. Certainly the laboratory and radiology tests should be bundled into the inpatient billing. In addition, as CMS has indicated, the physician really should not be paid the full professional fee. In essence because Sarah was admitted, the physician should be paid for this service as if it were provided in a facility setting. This means that the site-of-service differential should be applied.

Here is CMS's comment from page 42915.

"In circumstances where the 3-day payment window applies to nondiagnostic services related to an inpatient admission furnished in a wholly owned or wholly operated physician practice, we propose that Medicare would make payment under the physician fee schedule for the physicians' services that are subject to the 3-day payment window at the facility rate."

Typically the site-of-service differential application is triggered by the place of service (POS) being something like '22' for hospital, outpatient. Because this is a professional claim from a freestanding clinic, the POS will most likely by '11' for physician office. For the window something different is needed. Again from page 42915 we have:

"Specifically, we would establish a new Medicare HCPCS modifier that will signal claims processing systems to provide payment at the facility rate."

CMS continues this discussion indicating that for those CPT codes that actually break apart the technical component from the professional component and then also list the total component, the process will be to bundle the technical component.

Note: Be careful with CMS's notation. They are using PC as the acronym for professional component and TC as the acronym for technical component. ***These are not modifiers!*** There is a "-PC" modifier that is totally unrelated. The professional component modifier is the "-26" modifier.

Now a logical question is how will Acme, the clinic, know when to use the new modifier to incur the reduction in payment? Here is what CMS proposes, from pages 42915-49216:

"The hospital would be responsible for notifying the practice of related inpatient admissions for a patient who received services in a wholly owned or wholly operated physician practice within the 3-day (or when appropriate 1-day) payment window prior to the inpatient stay. We would make the new modifier effective for claims with dates of service on or after January 1, 2012, and wholly owned or wholly operated physician practices would receive payment at the facility rate for related nondiagnostic services and receive payment for only the professional component for diagnostic services effective for services furnished on or after January 1, 2012."

Now exactly how you are going to establish this communication link is a great question. CMS also goes on to discuss possible interfaces with the global surgical package (GSP) under the MPFS. A physician at one of these owned and operated clinics might perform a surgical service that involves a post-operative period that will overlap with the 3-Day Payment Window. From page 42916 we have:

"*Under the 3-day payment window policy, the practice expense portion of the initial surgery and any pre- and postoperative visits associated with the surgery (both those subject to the global surgery rules and separate diagnostic procedures) should be included on the hospital's Part A claim for the inpatient admission. The wholly owned or wholly operated physician practice would bill for the surgery performed for the inpatient as well as for the initial surgical procedure performed in the physician practice that started the global period. The wholly owned or wholly operated physician practice would apply the HCPCS modifier that CMS would pursue to implement the 3-day payment window to each of these services HCPCS code. Medicare would pay the physician practice for the initial surgical procedure and the related procedure following inpatient admission at the facility rate."*

Also the enrollment process, that is the wonderful CMS Form 855, will also need updating at least for the clinic and most like for the hospital as well.
There is yet another aspect of this whole situation that CMS does not address. In order to set the stage, there

are both physicians and non-physician practitioners at the Acme Medical Clinic. Because this is a freestanding clinic, when there is a physician and an NP providing services, the physician files the claim for the services of the NP. This incident-to billing is allowed for freestanding clinics. This way, there is a 100% payment under the MPFS instead of an 85% payment if the NP actually files the claim.

Case Study 2 – Sarah presents to the Acme clinic on Monday morning with cough, congestion and slight fever. She is an established patient and the NP examines her and performs a workup. An injection is provided and a course of antibiotics is prescribed. The NP does consult with the physician, but the physician does not see Sarah. Sarah is sent home. On Thursday evening Sarah is brought by concerned neighbors to the Apex Medical Center where she is admitted with an eventual diagnosis of pneumonia.

While the logical analysis of this situation is a bit convoluted, keep in mind that if the services in Case Study 2 are analyzed as being provided in a facility setting (i.e., apply the 3-Day Payment Window), then the only services that the physician can bill are those that the physician personally performed. Any services incident-to those of the physician, but not performed by the physician, are paid on the facility side.

Note: We are using the same basic phrase for two very different concepts.

i. Incident-To Billing, and
ii. Incident-To Services.

Incident-to billing can only occur in freestanding clinics where the physician is supervising the services of subordinate staff. Incident-to services appears in the SSA[3] in the section where hospital payment is addressed. Hospitals are paid for all services that are incident-to those of a physician.

It appears that the NP services, the full professional services, should be bundled into the hospital inpatient billing. Thus, not only would the site-of-service differential apply, the whole payment for the NP services, that are incident-to those of a physician, will be obviated in lieu of bundling into the inpatient billing and the subsequent inpatient payment.

Note that if the NP were billing for the services, then the normal site-of-service differential would apply. Also, if the E/M services are provided jointly (i.e. physician sees patient), then the physician can bill for the service even if they are incident-to.

[3] See the following sections of the SSA: §1861(s)(2)(B) and §1861(s)(2)(A)

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/JantoDecember2011EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2011. Contact Dr. Abbey at 515-232-6420 or e-mail at DrAbbey@aaciweb.com for information.

A variety of Webinars and Teleconferences are being sponsored by different organizations including the Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, Colorado Hospital Association, Hospital Association of Pennsylvania, and the Eli Research Group. Please visit our main website listed above for the calendar of presentations for CY2010 and planned workshops for CY2011.

The Georgia Hospital Association is sponsoring a series of Webinars each month. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for August 23rd "***Coding and Billing for Non-Emergency Care in the ED"*** 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 book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
http://www.HIPAAMaster.com

Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

INSIDE THIS ISSUE

FOR UPCOMING ISSUES

Affordable Care Act Issues
More on RAC Audits and Issues
Chargemaster Pricing Issues
More on Coding, Billing Compliance
More on Payment System Interfaces

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