Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

June, 2008 – Volume 20, Number 6

ISSN: 1061-0936

APC/APG Update

The *Federal Register* entry for proposed changes to APCs for CY2009 should be issued shortly. Because of increased activities with issuance of new and/or modified guidance on a number of fundamental issues, this FR entry will probably be as large, if not larger, than last year's entry. We should anticipate increased bundling, and we may even see some more guidance on surgical packaging.

The National Public Rulemaking process is very important for hospitals to make their concerns known relative to a variety of issues. With the sudden increase in guidance for APCs and also the significant change in direction to make APCs look more like APGs, this will be your opportunity to comment to CMS.

RAC Program Issues – Part 4 - CAHs

Editor's Note: This article continues a series of articles discussing the issues being addressed through the CMS RAC audits.

In this article we will divert from the many PPS hospital issues and discuss how the RAC audits will affect Critical Access Hospitals (CAHs). While some issues remain the same, others change dramatically.

The payment process under the Medicare program for CAHs is cost based. In theory the only true RAC audit concern should be the cost report itself, specifically, does the cost report truly represent allowable costs, and has the cost report been correctly developed? In practice, the main issue will continue to be medical necessity, which, as discussed in previous articles, is subjective.

Let us start with observation services. As with any other hospital, CAHs provide observation care and face the same challenges as other hospitals, that is, documentation, medical necessity, counting hours, and so forth. However, the payment process for observation is different from PPS hospitals. We will discuss the following observation situations:

- Short Stay Observation
- Pre-Inpatient Observation
- Post-Outpatient Surgery Observation

Short Stay Observation - For PPS hospitals using APCs, observation stays that are less than eight hours are not considered for payment purposes. However, at a CAH these short stay observation cases are paid on an interim basis just as is any other outpatient service. These types of short stay observations typically occur through the Emergency Department. Having patients being held for up to six hours is not unusual.

For PPS hospitals, this short stay would be considered just a part of the ED visit. For CAHs, these services, if billed as observation, will be separately payable. However, the RAC auditors would probably consider these services medically unnecessary as observation in that they should be considered just part of the ED visit.

Pre-Inpatient Observation – For PPS hospitals, the Pre-Admission DRG Window basically bundles most observation services into the inpatient stay that is eventually paid through DRGs. For CAHs, these pre-admission observation services are paid separately as for any other service. This should not be a significant RAC audit issue although it probably will be included in assessing the propriety of the overall stay at the hospital.

Post-Outpatient Surgery Observation – Post OP surgery is very much a different issue. For PPS hospitals, when there is an OP surgery (typically Status Indicator "T"), there is no payment for observation services. However, for CAHs there is the normal payment process that includes post-operative observation. Thus, this could be a very real issue. The basic idea is that the movement of the patient from recovery to observation status is not really medically necessary so that the observation services are not covered. Once again, this is the subjective medical necessity issue.

Another area of concern for CAHs is extending the length of stay for inpatients. While the various rules concerning the average length of stay and beds can be a concern, a CAH could increase cash flow by simply keeping a patient a day or two longer. In PPS hospitals, the incentive is the other way around. Because payment is fixed in advance through the DRG system, hospitals want to discharge their patients as quickly as possible.

While we will need time to tell, RAC auditors could question the unnecessary stays. The contention on the part of the auditors would be that the charges and associated costs were not necessary, and, thus, monies should be returned.

Some of the issues faced by PPS hospitals and CAHs are exactly the same. For instance, the question about the 3-day qualifying inpatient stay prior to skilled nursing services is exactly the same for all hospitals.

Basically, CAHs face the need to analyze the RAC audit issues in a slightly different perspective from PPS hospitals. The issues are still there, and some of them are exactly the same. While it would be nice to conclude that CAHs are not as much at risk as PPS hospitals, such a conclusion does not appear to be correct.

Transmittal 87 – Now You See It, Now You Don't

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***. The last twenty years have seen extensive discussion and even legal cases surrounding services that are provided incident to those of a physician in a freestanding setting.

> **Note**: The phrase ***incident-to*** is also used on the hospital or provider-based side. However, the use of this phrase is in a very different context. Under the Social Security Act (SSA), hospitals can be paid only for services provided incident-to those of a physician. The double use of this phrase can be quite confusing!

Within a matter of a few weeks, CMS withdrew this Transmittal under considerable pressure from the affected healthcare community. There appears to be no announced timetable to revise and reissue this guidance.

Anyone involved in physician billing and/or related compliance issues should study this transmittal very carefully.[1] This includes hospital personnel involved with provider-based clinics as well. Even though this has been withdrawn, the language and concepts presented provide a window into the way CMS is thinking about these issues.

Let us take one small piece out of this twenty-seven page transmittal. Among the definitions is that of 'clinic', which CMS defines as:

> ***CLINIC means a physician owned and operated clinic and is not a hospital or other facility based clinic. A group refers to a group practice as defined in 42CFR411.352.***

Now exactly how is this to be interpreted? Basically, CMS seems to be saying that the various incident-to billing rules apply to physician owned and operated clinics. This is not quite the same concept as a ***freestanding clinic*** as defined and discussed in the provider-based rule (42 CFR 413.65).

The gap in the definitions is illustrated the following situation.

> Case 1 – The Apex Medical Center has several provider-based clinics. These clinics meet all the requirements in the provider-based rule. For Medicare beneficiaries, both a UB-04 and 1500 claim form are filed. Apex also has several freestanding clinics that are owned and operated by the hospital with the physicians as employees. Only a 1500 claim form is filed, that is the clinics are not provider-based.

The freestanding clinics that are owned and operated by Apex do not appear to meet the definition of clinic as provided above in the withdrawn transmittal. That is, the term clinic as defined must be physician owned and operated. Thus, we have a giant gap in the definitions. In order for the definition of clinic to be consistent, the definition should be the same as the concept of a freestanding clinic (i.e., not provider-based) as is found in the provider-based rule.

Otherwise, all of the incident-to billing rules for physicians and practitioners would not apply to these freestanding clinics that are not organized (or qualified) to be provider-based.

Another issue is the ongoing definition of ***direct supervision***. In Transmittal 82 to the Medicare Benefit Policy Manual, for provider-based clinics the standard definition of direct physician supervision was given, but there was additional language that the supervising physician must also be the treating physician. In the

[1] If you have any trouble obtaining this Transmittal, contact Dr. Abbey at DrAbbey@aaciweb.com.

rescinded Transmittal 87, physician supervision appears to be available from the ordering physician or anyone in the same group practice (i.e., same NPI and reassignment using the CMS-855R form).

These are just two, small example of questions that are raised in this transmittal. Be watchful for further developments in this area.

Cardiac Rehabilitations Changes for CY2008

Cardiac rehabilitation services have long been a target for CMS. Several years ago the OIG, apparently at CMS's urging, studied the need for a physician to be physically present during the cardiac rehabilitation services. The OIG did study this issue and concluded that physicians are generally in close proximity to the cardiac rehabilitation service areas.

Now in Transmittal 1445, CMS has a new paragraph that has some interesting language, particularly relative to the concept of the *half-time unit rule*.

The National Coverage Determination for cardiac rehabilitation programs requires that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. See the National Coverage Determination (NCD) Manual, Pub. 100-03, section 20.10, for more information. A cardiac rehabilitation session may include more than one aspect of the comprehensive program. For CY 2008, hospitals will continue to use CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services. ***However, effective for dates of service on or after January 1, 2008, hospitals may report more than one unit of HCPCS code 93797 or 97398 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day****. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the cardiac rehabilitation services provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.*

While the coding has not changed, the billing process has changed. Most interestingly, ***for cardiac rehabilitation the typical half-time unit rule is not used!*** For cardiac rehabilitation you must perform the full 60-minutes in order to count the last subsequent unit. Exactly why CMS decided not to use their long-established approach is not known, but this probably indicates CMS's long-standing concerns about paying for cardiac rehabilitation programs.

Nuclear Medicine Edits

A brief paragraph in Transmittal 1445, February 8, 2008 to Publication 100-04 indicates that nuclear medicine services using radiopharmaceuticals will be edited for appropriate HCPCS codes.

Effective January 1, 2008, the I/OCE will begin editing for the presence of a diagnostic radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Hospitals should begin including diagnostic radiopharmaceutical HCPCS codes on the same claim as a nuclear medicine procedure beginning on January 1, 2008. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service.

While this type of edit is logical, the timing for implementing this edit is interesting. Starting in CY2008, the radiopharmaceuticals are now packaged. These are generally in the A9500 range of HCPCS codes. Previously, these codes were separately payable on a pass-through basis.

Why didn't CMS edit for the radiopharmaceutical codes in previous years? While you can draw your own conclusions, the answer would seem to be that in previous years CMS was not concerned whether you coded the A9500 codes. If you did not code them, then you lost direct payment. Now that these radiopharmaceuticals are packaged, it is vital that you code and charge appropriately so that the APC weights for the nuclear medicine services are correctly calculated.

Observation Services – Part 2

In the first part of this series of articles we discussed the all-important ***start*** and ***stop*** times for observation services. As discussed there, we continue to have difficulties with the start time relative to being a ***status*** versus being a ***bed***. Two recent transmittals (Transmittal 82 and Transmittal 1445) used as the basis for this series of articles must now be expanded to include Transmittal 34 to CMS Publication 100-07, State

Operation Provider Certification Manual. This additional transmittal addresses Critical Access Hospitals and provides additional information of both a general nature and then specifically for CAHs.

In December, 2002, Dr. Richard Baer the Medical Director of AdminaStar Federal, Inc. issued a two page document discussing observation services. This document has proved to be highly influential over the past several years as CMS has developed additional guidance surrounding observation services.[2]

Here is what Dr. Baer indicates does NOT constitute observation services:

- As a substitute for an inpatient admission;
- For continuous monitoring.
- For medically stable patients who need diagnostic testing or outpatient procedures.
- For patients who need therapeutic procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting.
- For patients waiting nursing home placement.
- To be used as a convenience to the patient, his or her family, the hospital, or the attending physician.
- For routine prep or recovery prior to or following diagnostic or surgical services.
- As a routine "stop" between the emergency department and an inpatient admission.

If you read through this list carefully, you will start to envisage situations to which this list applies. Let us take a simple one. Inpatients may be at a point in their stay by which they can be discharged to a skilled nursing bed. However, there are no SNF beds available. In some cases hospitals have moved these patients to observation status until beds become available. However, in 42 CFR 424 (the Conditions for Payments section of the CFR), CMS clearly states that the patient is to remain an inpatient until a bed becomes available. That is, the payment for these services, even if they appear not to be medically necessary is through the DRG payment.

Another issue with observation is whether or not the services are being provided as a 'convenience' to the patient, the patient's family and/or the physician. In other words, are the observation services medically necessary. Let us consider a simple case study.

> Case Study – An elderly Medicare beneficiary comes to the ED on a cold, snow night and complains of a fever, cough and congestion. The ER staff performs a complete workup and determines that the patient has a cold with some sinus congestion. Prescriptions are provided, but it is now 11:00 p.m. at night and the patient has no transportation home. Also the patient lives alone. The ED physician orders observation stating the reason as 'nobody at home to care for this patient'.

This type of situation is not at all uncommon although there are many different variations on the same theme. The observation services in this case are highly questionable. Unless there are some significant medical conditions cited by the physician, the observation services are not medically necessary. The hospital should really issue an ABN (Advance Beneficiary Notice).

Of course, this type of situation raises a whole new series of challenges. For example, who is going to recognize the need for an ABN? Who is going to generate an ABN? Who is going to explain and get the ABN signed? Unless a hospital has utilization review staff present twenty-four hours a day, someone else will need to be educated on the whole ABN process.

Thus the dividing line between medically necessary versus simply being a convenience can be a very fine line. In smaller communities there is no public transportation including taxi cab service. So what is a hospital supposed to do? Have security take the patient home? Use the ambulance to take the patient home?

Alright, let us consider another one of these bullets. Observation is not for continuous monitoring. Does this apply to telemetry for chest pain and/or cardiac patients? More likely the point being made is that observation is not for patients that should really be in an intensive care status where the patient would receive continuous monitoring.

Editor's Note: We will continue this discussion in Part 3 of this series in the July issue of this Newsletter.

Questions from Our Readers

Question: We are a Critical Access Hospital. Under EMTALA, can we qualify an ER nurse (RN) to perform the Medical Screening Examination for cases in which there appears to be no emergency?

For acute care hospitals, 42 CFR 482.55 does not specify the type of personnel who must be available to

[2] If you would like a copy, e-mail DrAbbey@aaciweb.com .

provide emergency services and who would, therefore, perform assessments and screenings. The regulation states only that the services must be organized and supervised under the direction of a qualified member of the medical staff and that there must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. Therefore, an acute care hospital may, if it chooses, have protocols that permit a registered nurse to conduct specific emergency medical screenings if the nature of the individual's request for examination and treatment is within the scope of practice of a registered nurse.

Now CAHs are under a slightly different set of Conditions of Participation (CoPs). At 42 CFR 485.618(d), states that a physician, a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be on call and available onsite at a CAH within a specified timeframe. Therefore, under this CAH CoP, these are the only CAH personnel who are permitted to conduct an appropriate medical screening to determine that an individual who presents in the manner described above does not have an emergency medical condition

However, CMS did address this issue in the November 24, 2006 *Federal Register* and basically leveled the playing field between CAHs and acute care hospitals. A CAH, if applicable, has the flexibility of utilizing a registered nurse, with training and experience in emergency care, to conduct specific medical screening examinations only if the registered nurse is on site and immediately available at the CAH when a patient requests medical care and if the nature of the individual's request is within the registered nurse's scope of practice and consistent with applicable State laws and the CAH's bylaws or rules and regulations.

There is a nice discussion of this issue in the November 24, 2006 *Federal Register* (71 FR 68159). Part of the motivation for making this change is that this change would effectively eliminate the need for a doctor or nonphysician practitioner to report to the emergency department to attend to a non-emergent request for medical care if a registered nurse is on site at the CAH and has made a determination that the care needed is of a non-emergent nature.

In some cases the EDs at CAHs experience significant rates of patient presenting with minor or urgent conditions that should really be addressed at the clinic level. This change in the CMS regulations allows CAHs to more effectively address these patients by providing the level of care that they really need without meeting the onus of an unnecessary regulation.

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 webinar scheduled for July 15th, "***Financial Implications of MS-DRGs***". 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.

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

More on Coding, Billing Compliance
More on Payment System Interfaces
More on Observation Services
Anticipated CY2009 APC Update

****** 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.