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

On February 8, 2008 CMS issued ***an extremely important transmittal***. Transmittal 82, February 8, 2008, to Publication 100-02, Medicare Benefit Policy Manual, addresses some fundamental definitions and concepts relative to the Medicare OPPS. All coding, billing, reimbursement and compliance personnel should download this transmittal and read it very carefully. A separate article is provided in this Newsletter. You can download this transmittal at:

www.**cms**.hhs.gov/**transmittal**s/downloads/R**82**BP.pdf.

RAC Program Issues – Part 1

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

The stated mission for the RAC audits is:

- Reduce Improper Payments
- Detect and Collect Overpayments
- Identify Underpayments
- Implement Systems to Prevent Future Improper Payments

While we will be discussing specific compliance issues, there are four general issues from which the specific issues arise.

- Medical Necessity – Non-Covered Services
- Incorrectly Coded Services
- Incorrect Payment Amount
- Duplicate Services

The RACs will work with the FIs, Carriers and/or the new MACs relative to:

- Coverage Determinations
- Coding Determinations, and
- Other Determination

One of the issues that has arisen with the demonstration program in New York, Florida and California is that of consistent policies and procedures on the part of the Medicare Administrative Contractors. In addition to the normal sources (NCDs, LCDs, CMS Manuals, CMS Memorandums) ***Coding Articles in the Jurisdiction*** can be used.

As we discuss these issues,keep two points in mind:

1. The RACs can only go back to October 1, 2007, and
2. There are really no new issues.

Virtually all of the issues being addressed by the RACs have long been identified by the OIG, DOJ and the Medicare program itself. Because of the delimitation on the look-back period, hospitals, clinics, physicians and other healthcare providers have time to get ready.

The ability of the RACs to use coding articles within the jurisdiction to attach coding and medical necessity issues is very interesting. Time will tell if this will be a legitimate source for judging claim accuracy.

The first issue we will discuss is ***short hospital stays***. These are hospital inpatient admissions that are very short, fr instance, same day admits and discharges along with admissions on one day and then discharge on the next day. These short hospital stays have been off and on the OIG Work Plan over the years.

The basic issue is that of medical necessity. The contention of the RAC is that these stays should have been observation stays. There can be a very significant payment difference. Consider the following simple example.

> Case – An elderly patient presents in the morning through the ED with an electrolytic imbalance. The patient was started on a diuretic but refused to take prescribed supplemental potassium. The physician admitted the patient as an inpatient. The patient is hydrated and given potassium. By the afternoon the

patient is more than ready to go home. The physician discharges the patient.

We can all easily look at this case and judge, after the fact, that this really should have been an observation stay. Utilization review should have addressed this case before the patient was discharged. However, can UR react that quickly to these admissions at your hospital?

Also, we might be concerned about meeting inpatient admission criteria. While we don't have all the specifics for this case, an electrolytic imbalance can be life threatening. Thus, by criteria, the admission may have been legitimate.

However, most likely the RAC auditors will claim that this should have been observation services and that there has been an overpayment of several thousand dollars.

Editor's Note: We will continue the discussion of these issues and the necessary preparation for the RAC audits in future Newsletters.

The New ABN is Out!

From the CMS ABN website we have:

"Beginning Monday, March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and NEMB (Form CMS-20007). CMS will allow a 6-month transition period from the date of implementation for use of the revised form and instructions. Thus, all providers and suppliers must begin using the revised ABN (CMS-R-131) no later than September 1, 2008."

See: http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp

CMS has supplied a FAQ with the new ABN. While most of the questions are fairly routine, the first question and answer deserves discussion.

Q1. What changes have been made to the current ABN?

A1. Some key features of the revised ABN are that it:

- *Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;*
- *Replaces both the existing ABN-G and ABN-L;*
- *May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);*
- *Has a mandatory field for cost estimates of the items/services at issue; and*
- *Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.*

First, the ABN is now '**Advance Beneficiary Notice of Noncoverage'**. Logically this title makes more sense. However, it blurs the line between a service/item being excluded (i.e., never covered) versus a service/item not being covered because it is not medically necessary. With the title change and the amalgamation of the three forms, CMS seems to be telling us that we should be issuing ABNs in cases in which the Medicare beneficiary should have known that the service/item was not a covered benefit.

Second, note the last change in which a Medicare beneficiary can elect to pay for the services directly instead of having a claim submitted to Medicare. Operationally, this is wonderful and will ease this whole process. ***However, there is a potential downside in that this could become a compliance issue***. The future issue will be that the hospital told the patient the service would not be covered. The patient paid directly, but in actuality, if a claim had been filed, Medicare would have paid.

Editor's Note: Apparently, we will now have to change the acronym from ABN to ABNN.

CPT/HCPCS Update
ESA Modifiers

Transmittal 1412 to Publication 100-04, Medicare Claims Processing Manual, dated January 11, 2008 provides instructions on using three new HCPCS modifiers.

- EA – ESA, Anemia, Chemo-Induced
- EB – ESA, Anemia, Radio-Induced
- EC – ESA, Anemia, Non-Chemo/Radio

ESA is Erythropoiesis Stimulating Agents. Congress, through TRHCA 2006 including a reporting requirement for the use of this drug. The most recent hematocrit or hemoglobin level must be reported.

While we can all appreciate the clinical concerns in this area and the need for such reporting, hospitals have procedural difficulty in determining the need for the modifiers and then the way to get the modifiers onto the proper J-codes on the claim.

J-codes are typically driven by charge entry through the chargemaster. While each hospital must assess the best way to meet these reporting requirements, the pharmacy may be in the best position to track the need. Health information management personnel will also need to be involved to some extent.

CMS Secret MUE Edits

During a recent teleconference on injections and infusions, a question was raised about being paid for additional units for:

- 90761 – Additional Hours of Hydration
- 90765 – Additional Hours of Infusion
- 90772 – IM/SQ Injection

It appears that there are some secret (i.e., black-box) edits[1] that CMS is using relative to these services. These are called, 'Medically Unlikely Edits' or MUEs for short. In this case, the edits involve delimiting the number of units that can be used with these codes. These particular edits appear to have been implemented on January 1, 2008.

From the hospital side, such edits are ridiculous. These types of extended services may be given during an observation stay that can span three dates-of-service. Thus, the number of units can become rather significant.

From CMS's point-of-view, having large numbers of units significantly increases payment for these services. Keep in mind that before the adoption of the new codes, the Q-Codes simply made a single payment regardless of the number of units.

The good news is that CMS appears to have relented. These specific MUE edits are being removed and providers are being instructed to re-file the affected claims from the first quarter. Check with you FI or MAC to confirm this information as appropriate.

Editor's Note: The consultants at Abbey & Abbey, Consultants, Inc. have noted in several audits that claims generation software and/or back-end software may be allowing only "1" as the number of units for these codes. Be sure to review claims for injections and infusions to make certain the units are properly on the claims.

OPPS Update – Key Definitions – Part 1

As noted in the APC/APG update section, CMS has issued a transmittal that addresses some very fundamental and important definitions and concept used in Medicare Outpatient Payment Prospective Payment System, that is, generally APCs. Generally, we all follow the APC update in the Medicare Claims Processing Manual, So this transmittal may not be quite as evident.

However, the topics discussed and the guidance provided are fundamental to APCs. Great care should be taken to read through this transmittal to understand the fundamental definitions that drive the other rules and regulations.

Most of the information in this transmittal is new! Thus, we have about ten pages of new information. The main topics addressed are:

- Limitation of Coverage to Hospital Outpatients
- Outpatient Defined
- Encounter Defined
- Outpatient Diagnostic Services
- Outpatient Therapeutic Services
- Outpatient Observation Services

Let us start our discussions with the concept of an 'outpatient'.

> ***A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or CAH. Where a tissue sample, blood sample, or specimen is taken by personnel that are neither employed nor arranged for by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. See section 70.5 for coverage of laboratory services furnished to nonhospital patients by a hospital laboratory unless the patient is also a registered hospital outpatient receiving outpatient services from the hospital on the same day and the hospital is not a CAH or Maryland waiver hospital. Similarly, supplies provided by a hospital supply room for use by physicians in the treatment of private patients are not covered as an outpatient service since the patients receiving the supplies are not outpatients of the hospital.***

Be certain to carefully parse this information. The concept of an 'outpatient' is reasonably straightforward. However, we do get into issues when a specimen is sent to the hospital laboratory. This guidance confirms the nonhospital patient status. Also, there is a further statement that this laboratory circumstance is different if

[1] These 'secret' edits have been a source of long-term frustration for hospitals and physicians. All we can do is to be watchful for strange payments and returned claims.

the patient is also receiving other outpatient services on the same date of service. While this is not ordinarily an issue, care should be taken to identify situations in which this occurs. In theory, the specimen may have been collected elsewhere and sent to the hospital laboratory. Then the patient receives unrelated services on the same date of service.

Note also admonition concerning supply items furnished to the ***treatment of private patients***. This deserves a little deciphering. A physician may be using the hospital as an office, that is, the physician is paying rent for the use of the facilities. This is why you see the phrase, 'private patients'. Under these circumstances, the supply items are being provided to the physician for use on his/her patients. The rental agreement (at fair market value, of course!) should include the supply items.[2]

We also see the concept of a 'day patient'.

> ***Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is considered an outpatient.***

Now, let us turn to the definition of an 'encounter'. Keep in mind that APCs is very much an encounter-driven payment system. Thus, this definition is fundamental to the entire APC payment system.

> ***A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.***

This definition appears to be somewhat simplistic. Granted, the vast majority of outpatient encounters are quite delimited. The patient comes to the provider. Services are provided and then the patient leaves. This generally occurs over a time period that can be counted in minutes. But there are certainly exceptions to the rather simple concept.

- What about the patient that presents for outpatient surgery, goes to recovery, then to extended recovery and finally to observation? This could span more than one date of service.
- What about observation? Some observation stays span three dates of service, and services may be provided by multiple providers.

The definition of an 'encounter' is critically important. Here are two very brief examples.

Example – The coding and billing of injections and infusions is 'encounter' driven. We must know exactly when an encounter starts and stops in order to be able to code and bill properly in this area.

Example – When a patient presents to the ED the encounter starts. The hospital is responsible for all services until the end of the encounter. If the patient is taken elsewhere, say for a Cat Scan, and then brought back, then the hospital is responsible for having an arrangement with the facilities providing the Cat Scan.

There are other examples in which the fundamental concept of 'encounter' is important.

From this relatively simple definition, there are two other terms that are suddenly important:

- ✓ Diagnostic Services
- ✓ Therapeutic Services

Here is CMS's definition of diagnostic services.

> ***A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.***

This definition seems quite reasonable. The next issue for diagnostic services is that of coverage. Among the guidance this is a very interesting new paragraph.

> ***Covered diagnostic services to outpatients include the services of nurses, psychologists, technicians, drugs and biologicals necessary for diagnostic study, and the use of supplies and equipment. When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, Medicare covers the service as if the patient had received***

[2] Yes, this has been a compliance issue and there have been cases in which hospitals have had to repay CMS for inappropriately billing for supply items under these circumstances.

the service in the hospital outpatient department.

Note the little example provided here. CMS is telling us that a hospital can send out hospital personnel to perform services to sites other than the hospital and still bill this as having been provided in the hospital outpatient department. Presumably the services and associated resources used are still incident-to those of a physician (e.g., physician order tests).

Now we will switch gears and look at CMS's definition of ***outpatient therapeutic services***. Well, this definition is not in this transmittal for Chapter 6, §20.5. Instead there is a reference to 42 CFR §410.27 which was updated by the first APC *Federal Register*, April 7, 2000. However this section deals with ***coverage and payment***; there is no definition of therapeutic services, per se.

In terms of coverage, we have:

> ***Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency room services. Policies for hospital services incident to physicians' services rendered to outpatients differ in some respects from policies that pertain to "incident to" services furnished in office and physician-directed clinic settings. See the Medicare Policy Manual, Pub 100-02, Chapter 15,"Covered Medical and Other Heath Services", section 60.***

The basic statement is that for outpatient therapeutic services to be covered, these services must be incident-to those of a physician or qualified practitioner. The really interesting note is the reference to the two, very different ways in which the phrase 'incident-to' are used. This phrase comes directly from the Social Security Act. Hospitals are to be paid for all services and supplies that are provided incident-to those of a physician or practitioner.

On the physician side with freestanding clinics, physician can be paid for services provided by subordinate personnel, and the physician bills on an incident-to basis. Note the difference in location; in one case it is in a hospital, facility setting while in the other the location is in a physician's office or freestanding clinic.

Editor's Note: In the next issue of this Newsletter we will address two more extremely important concepts: ***services provided in the hospital and under a physician's supervision****.*

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 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. Two webinars are scheduled for April. "***Improving the Revenue Cycle and Gaining Better Reimbursement***" on April 8th and "***Recovery Audit Contractor Issues***" on April 15th. Both presentations run from 9:30 a.m. to 11:00 a.m. EDST..

Dr. Abbey has completed his seventh book, "***Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance.***" HCPro is the publisher. 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**
- **Compliance For Coding, Billing & Reimbursement: *A Systematic Approach To Developing a Comprehensive Program***

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

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FOR UPCOMING ISSUES

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****** 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.