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

Transmittal R2418CP represents the April 1, 2012 update to APCs or the HOPPS (Hospital Outpatient Prospective Payment System). This is a quarterly update. Typically the number of changes is modest. Here are some of the update items.

1. Updated Device Edits – Two types of edits must be passed: procedure-to-device edits and device-to-procedure edits. There was a CPT change to CPT code 33249 so that HCPCS code C1882 had to be removed from the procedure-to-device edit list.
2. C9733 maps to APC 0397, Vascular Imaging. C9733 is used to report fluorescent vascular angiography (non-ophthalmic).
3. Drugs and Biologicals – Payment for non-pass-through drugs is set at ASP+4% and ASP+6% for pass-through drugs. There are four new HCPCS for new pass-through drugs. Also there are four J-codes that have updated payment rates.
4. Skin Substitutes – Edits are being placed in the I/OCE to ensure that separate payment is made for skin substitutes only when they are billed with skin substitute applications procedures.
5. Coverage Determinations – CMS makes a note that simply because there is a HCPCS code and a payment rate does not mean that the item or service is covered.

As usual, when you update your APC grouper software, look for any aberrations when you track adjudication of claims and the associated reimbursement.

Physician Supervision: As the Dust Settles

CMS has gone through a major change cycle with the physician supervision requirements. The change cycle started in 2008 and has continued on into 2012. CMS maintains that these *changes* are only *clarifications*. Ostensibly, CMS's claim for clarifications is to allow for retrospective application of the clarifications. If changes were made, then CMS would not be allowed to apply them retroactively.

While the main changes appear to be in place, there is the expanded APC advisory panel that is (or will be) working on determining those therapeutic services that require only general supervision along with some that may require personal supervision. As an example of the types of services that must be considered, review the *Questions from Our Readers* section for the sleep laboratory.

Auditing and compliance personnel at hospitals must now carefully consider possible federal audits for the years 2009 on through 2011. Further changes are possible in 2012. CMS has indicated that generally they will not go back further than January 1, 2009.[1]

This means that each of the years, that is, 2009, 2010 and 2011 must be separately addressed because there were slightly different versions for physician supervision. Here is a brief synopsis.

- 2000-2008 Physician Supervision Requirements
  - Applied Only To Off-Campus Where Direct Physician[2] Supervision Required
  - On Campus or In Hospital, Physician Supervision Presumed
- 2009 Physician Supervision Requirements
  - Mid-Level Practitioners Could Not Meet the Supervisory Requirements
  - General Immediately Available Requirement
- 2010 Physician Supervision Requirements
  - Mid-Level Practitioners Can Meet Supervisory Requirements
  - Supervising Physician/Practitioner Immediately Available and On-Campus

[1] See page 60587, November 20, 2009 *Federal Register* (74 FR 60587).

[2] Presumably during this time period mid-level practitioners could not meet the requirements.

- 2011 – Physician Supervision Requirements
  - Mid-Level Practitioners Can Meet Supervisory Requirements
  - Supervising Physician/Practitioner Immediately Available But Not Required to be On-Campus

Thus, the requirements for each of these time periods are somewhat different. This brief synopsis does not include issues such as expanding supervisory requirement beyond incident-to services and special circumstances for critical access hospitals (CAHs) and small rural hospitals. For instance, CMS created the concept of 'nonsurgical extended duration' services in the August 3, 2010 and November 24, 2010 *Federal Registers*. These services require direct supervision for initiation, and then, when the patient is stable, only general supervision is required. This involves mainly infusions, injections and observation.

The challenge for hospitals is to take each of the three years, 2009, 2010 and 2011, and to analyze whether there are any supervisory compliance shortfalls along with making certain that documentation is in place to substantiate that proper supervision was maintained.

Let us consider a case study.

Case Study 1 – The Apex Medical Center has a nice wound care clinic in a separate building on the hospital campus. The main providers are a nurse practitioner, several specially certified registered nurses and a physical therapist along with necessary staff. There is a physician present on Monday and Thursday mornings to assess patient. Otherwise, the NP is in charge of the services provided.

In Case Study 1, there is a physician present on Monday and Thursday mornings. Also, presumably, there is a nurse practitioner in the clinic at all times services are being provided. Of course, the constant availability of the nurse practitioner would need verification and documentation.

Now let us consider the years 2009 to 2011. For 2009, only physicians can provide physician supervision. Thus there may be a problem in that the nurse practitioner cannot qualify for the physician supervision of other subordinate personnel. If this situation were audited, what would Apex do?

For 2010 and 2011, the supervisory concerns for the wound care center are significantly mitigated. Now the nurse practitioner can qualify to meet the physician supervision requirement. Everything is on-campus so the change from 2010 to 2011 concerning being on-campus is not an issue. Of course, care must be taken to address any time periods when the NP was not present at the clinic.

Added to these concerns is the fact that there are subtle changes made by CMS over the time period 2008 to 2011. In 2008 and 2009, when these discussion suddenly started, the main concentration concerned on-campus, but out of hospital therapeutic services. Over time CMS seems to have expanded their concern to in the hospital activities as well. CMS is now using the phrase provider-based departments (PBDs). This appears to apply to all outpatient departments, including those that are in the hospital.

Case Study 2 – The Apex Medical Center has a dedicated observation unit on the third floor of the hospital. The ER is on the ground floor on the opposite side of the building.

With the inclusion of in hospital provider based departments, physician supervision is a requirement although observation itself is a non-surgical extended duration service. Thus, physician supervision would be required only when certain services are initiated. Can the ER physicians provide the necessary physician supervision? Given the immediate availability requirement, there could be times when the ER physicians are not interruptible. Thus, some other physician or practitioner will need to provide the necessary supervision. Hospitals can react to this type of situation today going forward in time, but can hospitals document that supervision was in place in 2009, 2010 and 2011?

Also, CMS is broadening the scope of coverage for physician supervision beyond the typical incident-to physician services. Additional benefit categories are now being included such as radiation therapy.[3]

Bottom-Line: Hospital compliance personnel will need to address the physician supervision issue with great care because of all the changes (i.e., for CMS, clarifications) along with slightly different requirements for each year from 2009 to the present. 2012 should bring identification of additional services that require only general supervision. In some cases this will ease this regulatory burden, but such changes will not obviate compliance for 2009 through 2011.

Incident-To Billing for Physicians

The phrase *incident-to* is used in two very distinct and different ways. This phrase appears at the Social Security Act (SSA) level. The two sections are:

[3] See July 18, 2011 *Federal Register*, page 42284. (73 FR 42284)

- §1861(s)(2)(A) – Physician Billing
- §1861(s)(2)(B) – Hospital Payment

Incident-to billing for physicians allows a physician, or practitioner for that matter, to bill for services that are provided by subordinate personnel, that are under the direct supervision of the given physician. Thus nurses and other staff members can provide services, and the physician can bill for them as if the physician had actually performed the services.

Note: Incident-to billing by physicians is generally a Medicare issue. Many, if not most, private third-party payers require a physician or practitioner to be credentialed by the third-party payer before they can see and treat covered patients. Of course, this then becomes a contractual issue. The circumstance in which a physician is billing a private payer with whom the physician has no relationship is an open question.

Incident-to billing is allowed only in freestanding clinics, that is, clinics that are not provider-based. For provider-based clinics, presuming that a hospital is the main provider, the hospital is paid for all services that are incident-to (but not provided by) the physician.

Incident-to billing is often used in freestanding clinics in order to optimize reimbursement for services. For instance, if there are both physicians and mid-level practitioners in a clinic, having the physician bill for the services provided by the mid-level practitioners will generate more reimbursement at least under Medicare. Generally the mid-level practitioners are paid at 85% of the normal Medicare Physician Fee Schedule amount.

One question that sometimes arises is whether or not one physician can bill for the services of another physician on an incident-to basis. While the rules and regulations concerning incident-to billing in a freestanding clinic do not appear to prohibit this type of billing, there is a further concern. The concern is why one physician is billing for the services of another physician.

This situation would certainly lend itself to fraudulent billing for individuals intent on committing fraud. For instance, a physician may be excluded from the Medicare program. Another physician could bill for the services of the excluded physician, and this would never appear on the 1500 claim form. If there were any sort of an audit, this situation would become apparent. Also, if this type of activity were pursued for any length of time, the physician who is billing for the services would show a productivity level that would, statistically, really stand out. A high productivity level would probably be more likely to attract the interest of some sort of Medicare auditor.

One of the legitimate reasons why this issue sometimes arises is that a new physician may be coming to a clinic. The new physician is not yet enrolled with Medicare. Thus, while the new physician is being enrolled, the billing for the new physician can be made by an already established physician in the clinic.

However, even this type of situation has limited applicability. From the Conditions for Payment (CfPs), namely 42 CFR §424.520(d) we have:

"(d) Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

Thus, if a new physician came to a clinic, the application for Medicare enrollment on the part of the new physician would take place either before they physically arrived or shortly after they arrived. Typically, there would be little need to perform incident-to billing for the brief period of time that the new physician's enrollment application was made.

Of course, there would be the potential of a cash flow shortfall while the new physician was awaiting final approval of enrollment in Medicare. As CMS continues to refine PECOS (Provider Enrollment, Chain and Ownership System), the time that it takes to enroll physicians and practitioners should become short enough that cash flow will not be an issue.

Questions from our Readers

Editor's Note: Questions from our readers are encouraged. Those asking questions are kept anonymous. Also, suggested answers should be assessed with care because policy decisions are often involved.

Question: How should the following sequence of services be coded and billed?

1. **Patient present to the ED on Monday afternoon. A single IV site is established. Saline solution is provided KVO.**
2. **In the ED, through the IV site, Drug A is infused from 1930-2045 and Drug B from 2000-2045.**

3. **At 2045 the patient is admitted to observation with both drugs continuing to be administered IV. Drug A continues to be administered from 2045 until 0115 the next day. Drug B was infused from 2045 until 2230.**

While these questions can certainly be extended with IV pushes and other services of this type, there are several rather *fundamental* issues present in this question.

First, there has been a change in the guidance in the 2012 CPT Manual. The new guidance certainly seems to state that with a non-continuous service, by crossing a date of service, the logic for initial and subsequent starts over. From page 518 of the 2012 CPT Manual, Professional Edition, we have:

> *"However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, both administrations would be reported as an initial service (96374)."*

The fundamental question is whether or not for non-continuous injections/infusions provided on different dates of service causes the use of the initial/subsequent logic to start over? CMS has addressed this issue to a certain degree by disagreeing with CPT. In Transmittal 2376, December 29, 2011, CMS states:

> *"As noted in CR 7271, Transmittal 2141, in 2011 CMS revised Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 230.2, to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, CMS noted that beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services,* ***per encounter*** *for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. CMS has subsequently become aware of new CPT guidance regarding the reporting of initial drug administration services in the event of a disruption in service; however, Medicare contractors are to continue to follow the guidance given in this manual."* (Emphasis Added)

Now CMS seems to have missed an important point in that the CPT guidance not only included an interrupted service, the services were provided on *different dates of service*. Actually, it is a little hard to interpret two IV pushes of the same drug separated by hours as an interrupted service.

This brings us to the second fundamental issue, namely what is an ***encounter***?

In this case the individual presented to the ED and infusions services were provided essentially from 1930-2045 at which point the patient was moved to observation where the infusion services were continued. Are we dealing with two encounters: one for the ER services and another encounter for the observation? Or is there a single outpatient encounter which includes both the ER and observation services?

APCs (Ambulatory Payment Classifications) represent an encounter-driven payment system. Understanding and using APCs is *absolutely dependent upon a precise definition of what constitutes an encounter*. Typically an encounter occurs when a patient presents to the provider (in this case hospital outpatient, specifically the ED) and then leaves the provider (in this case hospital outpatient, observation).

CPT, to some degree, is viewing this whole situation through the lens of treating dates-of-service discretely. Generally, the APC grouping process is driven purely by a single date of service. For example see the description and use of the "-25" modifier.

The exception in APCs is with observation which can span up to 3 dates-of-service. The episode of care could involve possibly 4 dates-of-service if the patient were in the ED late in the evening and was then moved to an observation bed at the beginning of a new date.

According to CMS, if a patient presents to the ER by ambulance with IV infusion(s) already taking place, then the hospital coding starts all over when the ER encounter starts. However, when considering the change from the ER to observation, CMS has not explicitly answered the question as to whether there are two separate encounters.

If we piece together the guidance that is available, CMS does use the phrase *extended care encounter* relative to paying for observation services using the composite APCs. To pay for observation there must be some kind of encounter (ED or Clinic) that is extended by observation. See the Medicare Benefit Policy Manual, Chapter 6, Section 20.6(B). Based on the way that observation services are paid, the provision of services in the ER and then in observation appear to constitute a single outpatient encounter. (See MBP, Chapter 6, Section 20.3).

Note that if we generalize this concept, there are two basic types of encounters: outpatient and inpatient. An ER visit followed by observation is an outpatient encounter. Of course, there could be an outpatient encounter followed by a hospital admission. These

would be separate encounters, and the payment systems used are totally different. For MS-DRGs the 3-day payment window would apply.

Now, in coding infusions and injections, the combined ER and observation services should be considered a single encounter. The coding logic will use the hierarchical approach as provided for facilities in CPT. For this case:

Drug A – 1930 to 0115 – 5 Hours for Billing,
Drug B – 2000 to 2230 – 3 Hours for Billing.

Editor's Note: As usual watch for any guidance to the contrary. Certainly, by coding the infusions as part of a single encounter less reimbursement will be generated, and thus this is a conservative approach to this whole issue.

Question: We have a sleep laboratory with four beds. Studies are conducted at night in a facility on our campus that is outside the hospital itself. Most of the studies are diagnostic. However, there are times when severe sleep apnea is treated by CPAP (Continuous Positive Air Pressure) to attain a proper titration of oxygen. Does this therapeutic service require physician supervision?

Based on the current state of the rules and regulations, the answer appears as yes. Not only is physician supervision currently required, because CMS claims that the changes to physician supervision are simply clarifications, the reinterpreted rule could be retroactively applied back to January 1, 2009. In other words, you need to be able to affirmatively document who was providing the required physician supervision and verify that they were immediately available.

While this type of situation is disturbing, hopefully the expanded APC advisory panel will identify this type of service as one that requires only general supervision. That is, a qualified physician or practitioner could be contacted and could come if necessary.

Hospital compliance personnel should be looking for situations like this in other service areas. Note that for the sleep laboratory operations, physical security is also another issue. Particularly if the operation is outside the main hospital or even off-campus, there may be little in the way of security personnel being routinely available and/or making rounds to assure physical safety. While sleep laboratory operations are not known for security problems, the potential is certainly present. Standby for further guidance on this supervision challenge.

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/JantoDecember2012EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2012. 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 CY2012.

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 April 17th ***"ED & EMTALA Coding and Compliance"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's 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 third book in a series of books on payment systems. The first book is:
"***Healthcare Payment Systems: An Introduction***". The second book addresses fee schedule payment systems and the third in the series addresses prospective payment systems. The fourth, and final, book in this series addresses cost-based, charged-based and contractual payment systems.

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.

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