Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

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APC/APG Update

The *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 3

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

In previous articles we have discussed:

- Short Inpatient Stays
- DRG Transfer Rule
- 3-Day Inpatient Qualifying Stay for SNF

The RAC audits tend to concentrate on medical necessity issues. Medical necessity is subjective. Looking at a case in hindsight is much easier than making judgments at the time care is being provided.

One of these medical necessity issues involves surgical services that can be provided on an inpatient basis or an outpatient basis. Typically, there is a fairly significant payment difference between inpatient and outpatient surgical services. We do have the CMS ***inpatient-only*** list for APCs, that is, these are the surgeries that can only be performed on an inpatient basis to qualify for payment. Hospitals do sometimes perform these surgical procedures on an outpatient basis for which there is no APC payment.[1]

The RAC auditors will look at virtually all surgical procedures that could possibly be provided on an outpatient basis that were, for some reason, provided on an inpatient basis. Now hospital personnel are very sensitive to the fact that this issue is reminiscent of the observation versus short-stay issue. This whole medical necessity process is, again, driven by the physicians.

We will look at three areas that are representative of many other similar areas.

1. Cardiac Catheterizations – There is a fine line between performing these services on an outpatient basis versus an inpatient basis. Not all such services can be performed outpatient. For example, carotid stenting procedures are on the inpatient-only list. However, most diagnostic services will be considered candidates for outpatient. Therapeutic services are generally more risky, but the RAC auditors will be looking for cases in which the outcome was successful and the clinical risks seem minimal.
2. Back Problems – Particularly stress fractures of the back in which the main treatment is rest will certainly be suspect. Instead of several days in the hospital, an observation stay with a discharge home to a skilled nursing bed might be more appropriate, at least in the eyes of the RAC auditors.
3. Laparoscopic Procedures – Laparoscopic cholecystectomies often can be performed on Medicare beneficiaries on an outpatient basis, but the individual will need to be reasonably healthy. For example, with a 95 year old patient in fragile condition, the physician may opt for an inpatient stay. However, the RAC auditors may claim that the same service could have been provided outpatient even if the patient stayed in observation for two days.

[1] Technically, the Medicare beneficiary becomes liable for the payment for these services.

As with our previous discussions, this is another area that is very frustrating because we are dealing with clinical judgment decisions on the part of physicians. If services are to be provided on an inpatient basis, which could otherwise be provided outpatient, then the physician's documentation must be clear, concise and convincing.

The fundamental question is, "What are we, as hospitals, supposed to do?" There is no simple answer to this question. While utilization review and case management personnel at the hospitals can work with the physicians through the medical staff organization in a general way, creating a difference in real time is very much a different challenge. As surgeons schedule less severe surgeries care can be taken to make certain the surgeon has clinical reasons as to why the surgery should be done on an inpatient basis. Even if inpatient criteria are met, we have exactly the same problem as we have with observation services versus inpatient admissions.

Bottom-Line: Medical necessity is an issue that auditors in general, and RAC auditors specially, can easily attack when looking at a record after the fact.

Is It a Billing Issue or a Payment Issue?

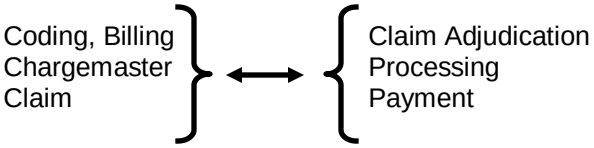

Figure 1 – Billing vs. Payment

Figure 1 illustrates a major challenge that exists in today's environment when coding, billing and filing claims versus the claim adjudication process. With the implementation of the HIPAA TSC (Transaction Standard/Standard Code Set) rule, healthcare providers should be able to generate the same claim for the same service to all third-party payers. This is the very reason that we have standard code sets, standard claims transaction formats and all of the associated HIPAA TSC requirements.

In reality, third-party payers make all kinds of unusual demands relative to coding, billing and claims filing. A small example of this might be a private third-party payer for an ED claim. If there is a surgical procedure, the E/M code is not to be reported, but the charges are to be rolled into the surgical procedure.

Case Study 1 – The Apex Medical Center has been informed by one of their major private third-party payers that the claims filed must be altered. For ED claims that involve both an E/M level and a surgical procedure (e.g., laceration, fracture care, etc.), there is to be no line-item for the E/M service. The E/M code is to be dropped, and any charges are to be bundled into the line-item (and code) for the surgical services.

Claims transaction personnel will confirm that this type of requirement, in many different forms, occurs regularly. A little thought will reveal that the whole issue here is not the coding, billing and claims filing. The claim that is developed should faithfully represent what was done and charges for the services provided. Both the E/M and the surgical CPT codes should appear. The burden is on the third-party payer to properly adjudicate the standard claim. Based upon the requirement altering the claim, it would appear that the third-party payer does not want to pay separately for the E/M level when performed with a surgical procedure. This is a payment, adjudication issue, not a coding, billing and claims filing issue.

Alright, what about the Medicare program? Does this same issue arise? The answer is a resounding, yes. There are many examples. Let us consider a simplified case for which we are all struggling to understand the CMS guidance.

Case Study 2 – At the Apex Medical Center, for certain patients the surgeons order a pre-operative antibiotic injection. These injections are not always given, even for any particular surgery, and the surgeons base these injection based on the medical necessity for the patient. Apex has received what appears to be guidance from their FI that these injections are not to be coded and billed.

This case study takes us into the rather ambiguous area of ***integral-part***. In Case Study 2, because these injections are not always provided, the integral-part concept does not apply. However, our purpose is not to discuss what integral-part injections are or are not. The issue here is that Apex has provided a service, the service was medically necessary, and the service was ordered by a physician. Thus Apex should code and bill for this injection. Well, that is the logical conclusion under the HIPAA TSC.

Interestingly, CMS has issued some rather general guidance relative to this little case study. In Transmittal 1445 to CMS Publication 100-04, Medicare Claims Processing Manual, dated February 8, 2008, CMS updates §230.2B, which is the *Coding and Payment for Drug Administration* section. Here is a new sentence that has been added:

Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.

Taken at face value, this sentence appears to instruct hospitals to code and bill for all drug administration codes (i.e., injections, infusions, hydrations, etc.). What CMS seems to stating is that the payment or non-payment (i.e., not packaged or packaged) is an adjudication issue not a coding and billing issue.

While we will need to await further pronouncements concerning how this statement is to be interpreted, this does raise some very interesting questions surrounding coding and billing for all injections and infusions.

This difference between coding, billing and claims filing versus payment and adjudication is fundamental. If hospitals and other healthcare providers do not have clear guidance and equitable enforcement of HIPAA TSC imperatives, then significant confusion will result.

OPPS Update – Key Definitions – Part 3

Editor's Note: This is the third part of an article discussing important definitional guidance from CMS through Transmittal 82, February 8, 2008, to Publication 100-02 – Medicare Benefit Policy Manual. Note that while this Transmittal is titled relative to OPPS, CAHs are also included.

CMS provides some additional language relative to observation services updating §20.6A. We now have:

> ***Hospitals may bill for patients who are directly admitted to the hospital for outpatient observation services. A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services.***

While the concept of a direct admission is not new, note the wording *bypassing* ***the clinic*** *or emergency department*. CMS using this wording to indicate that on the billing side, a provider-based clinic visit at a level 5 (i.e., 99215 or 99205) qualifies for separate observation payment under the composite APC 8002. If the patient is coming directly from a freestanding clinic, then the G0379 will be used, also generating the payment for observation.

For APC payment, §20.6B has the following paragraph:

> ***Payment for all reasonable and necessary observation services is packaged into the payments for other separately payable services provided to the patient in the same encounter. Observation services that are packaged through assignment of status indicator N are covered OPPS services. Since the payment for these services is included in the APC payment for other separately payable services on the claim, hospitals must not bill Medicare beneficiaries directly for the packaged services.***

Clearly, observation services payments are packaged if you provide a Status Indicator "T" service (i.e., surgery). The APC would have to be analyzed, but there may be more packaging. The phrase, *hospitals must not bill Medicare beneficiaries directly*, is really ambiguous. This may tie back into the whole concepts of *separately billable* and *separately reportable*. However, this language is unclear.

There is also a whole new section on ABNs and observation services.

> ***In making the determination whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services related to an encounter that includes observation care, the provider should follow a two step process. First, the provider must decide whether the item or service meets either the definition of observation care or would be otherwise covered. If the item or service does not meet the definitional requirements of any Medicare-covered benefit under Part B, then the item or service is not covered by Medicare and an ABN is not required to shift the liability to the beneficiary. However, the provider may choose to provide voluntary notification for these items or services.***
>
> ***Second, if the item or service meets the definition of observation services or would be otherwise covered, then the provider must decide whether the item or service is "reasonable and necessary" for the beneficiary on the occasion in question, or if the item or service exceeds any frequency limitation for the particular benefit or falls outside of a timeframe for receipt of a particular benefit. In these cases, the ABN would be used to shift the liability to the beneficiary.***

While this language is new, the concepts discussed are already very much in place. Because observation services are generally covered, the use of ABNs generally should be adopted. Developing a hypothetical situation in which observation would never be covered is difficult due to the definition of observation itself.

Case Study 3 – An elderly patient is scheduled to have an outpatient surgical procedure. While an overnight stay generally is not required, the gentleman has requested to stay overnight. The hospital issues an ABN.

In Case Study 3, there is always the possibility that observation services might be necessary, that is, medically necessary. Thus, the service may be covered although there will be no separate payment.

The final new paragraph presents an interesting concept:

If an ABN is not issued to the beneficiary, the provider may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not have reasonably been expected to know that Medicare would not pay for the item or service.

If anyone has even heard of a hospital being able to gain payment from Medicare because they, the hospital, could not have reasonably been expected to know that the service or item would be deemed not medically necessary, then let us know!

Editor's Note: See the next article for a continuation of the discussion concerning observation services.

Observation Services – Part 1

Observation services represent one of the major challenges for hospitals today. Observation versus inpatient admissions is a major RAC program issue. CMS has long been suspicious that hospitals have inappropriately billed for observation services. Observation services are under the control of physicians all the way from the decisions to admit the patient to observation on through the documentation process.

One of the major concerns with observation is to fully define exactly when observation starts and stops. This is a timed service using one-hour units. As with other time unit services, the half-time unit rule is in place. You may only count the last subsequent time-unit (one hour in this case) if you perform at least half of the time unit.

In Transmittal 1445 to Publication 100-04, Medicare Claims Processing Manual, dated February 8, 2008, CMS provides updated guidance in this area. We will start with the stop time discussion.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

Note that CMS uses the concept of *observation services being completed* as the determiner of when observation stops. This is entirely reasonable because the patient may still be in the ***observation bed***. However, if no services are being provided then the observation time should not be accumulated. The physician may have discharged the patient, but if services are still being provide per the physician's orders, then observation time is still counted.

Now the big question is why don't we use the same concept for observation start time? In other words, observation time starts when the hospital starts providing observation services per a physician's orders. Note that this concept does not involve the ***observation bed***, as such. In theory the patient may still be in the ED or in a waiting area or being transported. However, they are receiving observation services, and the hospital has assumed medical-legal liability

Unfortunately, CMS still uses the concept of an observation bed relative to the start time. From Transmittal 1445:

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in

the units field of the reported observation HCPCS code.

CMS makes the presumption that the clock time documented coincides with the time the patient is ***placed in a bed*** for the observation care. In reality, this presumption is incorrect. There may be a difference of several hours between the initiation of the observation services and the arrival of the patient to the observation bed.

Editor's Note: See the comments made in the APC/APG Update Section. We all need to comment to CMS about getting this definitional guidance revised.

CMS does provide some guidance for overlap situations. Post-operative recovery should not be billed as observation. We have:

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services.

While CMS does not delve into the process of switching from recovery to observation status, they do indicate a ***standard recovery period*** as being 4-6 hours. You may or may not agree with this standard. However, you should develop written policies and procedures as to how the patient should be moved from recovery status to observation status. Some hospitals have adopted different levels of recovery by developing the concept of extended recovery. Normal recovery is reported under revenue code 0710 while extended recovery generally uses 0719. Depending upon circumstances you may want to have different charges for the different levels. Be certain to document all of your decisions including the rationale for making the decisions.

Questions from Our Readers

Question: We are having difficulty getting G0379 and G0378 paid. Claims are being denied stating that G0379 is not payable and G0378 is packaged. The only thing unusual with our claim is that we have C8957 for prolonged infusion. What is going on?

This question is not an isolated incident. There appear to be other observation claims being denied as not being payable. What is necessary is to the "-25" modifier on the G0379, that is, the nursing assessment. Prior to CY2008, using the "-25" modifier was not necessary. Apparently the APC grouping logic has been changed.

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 June 10th is "***Radiology and APCs".*** 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.

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

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FOR UPCOMING ISSUES

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More on Injections and Infusions
Anticipated CY2009 APC Update
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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.