

## Medical Reimbursement Newsletter

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

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### APC/APG Update

The proposed changes for both APCs (Ambulatory Payment Classifications) and MPFS (Medicare Physician Fee Schedule) should be appearing shortly through the *Federal Register* process. Be watching for these FR entries so that you can review and comment as to the proposed changes.

### EMTALA – A Brief Update

EMTALA, the Emergency Medical Treatment and Labor Act, is regularly updated, and litigation surrounding EMTALA seems to never end. While EMTALA is conceptually simple, implementation of the various directives becomes quite complex, convoluted and litigious.

Basically, EMTALA mandates that if an individual presents to a participating hospital's (dedicated) emergency department, the hospital must perform a medical screening examination by a qualified medical person. If a medical emergency exists, then the hospital is to care for the patient and, if necessary, transfer the patient to another hospital for services that the receiving hospital cannot provide.

The last major overhaul of EMTALA occurred during the time from May 9, 2002 to September 9, 2003. While there have been further changes since then, two of the most recent changes are:

1. April, 2009 – Moses versus Providence Hospital, and
2. July 29, 2009, Transmittal 46 to Publication 100-07, State Operations Manual.

The Moses case, which was held at the 6<sup>th</sup> Circuit (Ohio, Kentucky, Tennessee and Michigan), involves a case in which an individual presented, was screened and admitted as an inpatient. Subsequent to discharge, the individual murdered their estranged spouse. At issue is whether or not the hospital can be sued under EMTALA.

One of the key features of the 2002-2003 update was that CMS went to great lengths to indicate that if an individual is a patient at the hospital, then EMTALA does not apply. This is why the word *individual* is used. After an individual becomes a patient (inpatient or outpatient), then the hospital's Conditions of Participation (CoPs) apply, not EMTALA. While there can be significant discussions about when an individual becomes a patient, the basic idea is that EMTALA requirements are for individuals, who are not patients that present to the hospital's emergency department.

The ruling in the Moses case appears to differ from the CMS discussions surrounding this issue. In this case, the court allowed the hospital to be sued under the EMTALA provisions even after the patient was admitted, received care and was discharged.

The full ramifications of this ruling are yet to be fully understood, and further court action will probably be necessary.

The update to the State Operations Manual incorporates many of the changes made during the time period 2004 through mid-2009. Here are some of the issues:

- Medical Screening Examination
- On-Call Physicians and Community Call Plan
- Acceptance from EMS and Moving from Stretcher
- National Emergencies
- Hospital Disaster Protocols
- Emergency Care and Emergency Period
- Restricting Transfer Until the Individual is Stabilized
- Appropriate Transfer Requirements
- Specialty Hospitals – No Emergency Department

The medical screening examination (MSE) is fundamental to EMTALA. From Transmittal 46:

- *An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an*



*EMC or not. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage.*

- *Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP).*
- *Individuals coming to the emergency department must be provided an MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ...*

The requirements surrounding a community call plan are discussed at some length in the interpretive guidelines. Here is a quick synopsis.

- *This on-call list requirement is a general provider agreement requirement for all hospitals and is thus technically an "EMTALA-related" requirement rather than a specific requirement of the EMTALA portion of the Act.*
- *The list of on-call physicians must be composed of physicians who are current members of the medical staff or who have hospital privileges. If the hospital participates in a community call plan then the list must also include the names of physicians at other hospitals who are on-call pursuant to the plan.*
- Simultaneous Call
- Scheduled Elective Surgery
- Medical Staff Exemptions
- On-Call Physician Appearance Requirements

Another issue is that of specialty hospitals that do not have emergency departments. These hospitals would not normally be considered for emergency care. However, CMS is making it quite clear that if an individual presents to a hospital for an emergency medical condition and there is a specialty hospital in the area that can better provide service, then the patient can be transferred to the specialty hospital for care.

While EMTALA is conceptually simple, the rules and regulations surrounding EMTALA have become quite complex. While a hospital's main imperative is to take care of individuals presenting to the emergency department, all of the surrounding compliance issues must also be addressed. Anyone involved in EMTALA should at least review Transmittal 46 and peruse the new and changed language.

*Editor's Note: This is a continuation of an article in the April, 2010 issue of this Newsletter. See page 21.*

A major disconnect that has plagued healthcare providers is that there are different Medicare Administrative Contractors (MACs)<sup>1</sup> who tend to address certain issues somewhat differently. The GAO found what healthcare providers have known for years and that there is a fundamental lack of communication as to who should handle what issues and also the way in which to handle a given issue. From page 17 of the GAO report:

*"According to CMS officials, the agency only takes corrective action for vulnerabilities with national implications, and leaves it up to the Medicare claims administration contractors to decide whether to take action for vulnerabilities with local implications."*

*Editor's Note: See the article on coding and billing for Holter Monitoring in this issue for an example where national guidance would be useful.*

While healthcare providers have repeatedly requested that CMS at the national level promulgate and issue consistent, clear guidance for coding and billing, often the MACs appear to issue guidance in the form of testing the water to see what reaction will occur from the provider community. For instance, while not yet a RAC issue, the proper use of the "-25" modifier has been a long standing issue for physicians and now with APCs for hospitals as well. Formal guidance from CMS has been quite sparse over the years. Yet, occasionally a MAC will release guidance that appears to go well overboard in interpretations.<sup>2</sup> The GAO report continues on page 17:

*"According to CMS officials, the agency only takes corrective action for vulnerabilities with national implications, and leaves it up to the Medicare claims administration contractors to decide whether to take action for vulnerabilities with local implications. However, the IPPP did not specify what type of action was required on the part of CMS or the Medicare claims administration contractors. For example, for inpatient services that did not meet the stated inpatient care criteria, the IPPP neither specified what type of corrective action would be needed to prevent future improper payments nor whether CMS or its Medicare claims administration contractors were responsible for taking action."*

<sup>1</sup> We will use the acronym MAC to represent Fiscal Intermediaries, Carriers and DME Regional Carrier.

<sup>2</sup> For instance, see 'Medicare Alert Bulletin' 2255, dated February 17, 2009, pages 9-10, issued by Georgia Medicare.

In the case of hospital inpatient admission criteria, there should be a national standard set so that all hospitals will know what they need to do in order to maintain compliance. This is an example of a fundamental issue for which CMS has failed totally to provide uniform, clear and consistent guidance. This is certainly a national level issue. This lack of guidance has resulted in enormous costs on the part of hospitals to address RAC findings of possible overpayments for short-stay inpatient admissions.

**Note:** Section 912(g)(2) of the Medicare Modernization Act of 2003 requires the CMS MACs to provide written answers to questions in a *clear, concise, and accurate manner*. Of course, if there is no national policy and the MAC is not willing to develop their own answer, then nothing is likely to happen as evidenced by the findings reported by the GAO.

**Bottom-Line:** The GAO report makes explicit what healthcare providers have known for year. There are fundamental, unresolved issues surrounding the provision of healthcare and the associated coding, billing and reimbursement for such services. Possible improper payments will continue to occur unless and until CMS takes definitive action at the national level to provide clear, consistent and accurate guidance so that the MACs can consistently adjudicate claims and so that healthcare providers can know that claims are being filed correctly. To some extent, the RAC process is a questionable, time wasting process being fueled by CMS's not addressing fundamental coding, billing and claims adjudication issues.

### 48 Hour Holter Monitoring Fiscal Intermediaries and LCDs

*Editor's Note: The following article discusses the coding and billing for 48 hour Holter monitoring. Because there can be variations in directives from different Medicare Administrative Contractors (MACs), be certain to check for specific coding and billing information from your MAC.*

Holter monitoring is a widely used technique to gather data over the period of a day (24 hours) concerning patients' heart rhythms, particularly various types of arrhythmias. CPT has developed a series of codes that break out various technical and professional components of these services. Thus, the use of the "-26", professional component and the "-TC", technical component are not necessary.

There are families of codes:

- 93224-93227
- 93230-93233, and

- 93235-93237.

Let us consider the first set of codes as an example of how the codes are delineated.

- 93224 – Total Component (Recording, Scanning Analysis and Physician Review/Interpretation)
- 93225 – Recording
- 93226 – Scanning Analysis with Report
- 93227 – Physician Review and Interpretation

One of the questions that has been discussed over the past several years is what to do with 48 hour Holter monitoring. The conventional wisdom is to use the appropriate code on two different line items with unit of service '1' and different dates. In some case, the repeat procedure modifier "-76" may be attached to the second line and thus to the second use of a given code.

Now let us consider two different LCDs. The first LCD is issued by Wisconsin Physicians Service Insurance Corporation (WPS) and is LCD L29584. While this LCD discusses medical necessary (via various ICD-9-codes) and documentation requirements, this LCD references an additional document that specifically addresses coding and billing issues.

The LCD itself addresses the extension of the 24 hour monitoring period.

"Extension of 24-hour monitoring CPT codes (93224-93227 and 93230-93237) to 48 hours will be allowed under the following conditions only:

1. To monitor initial antiarrhythmic drug therapy;
2. To monitor for arrhythmia after a change in antiarrhythmic medications; and
3. To document frequent, sporadically occurring arrhythmic events of unknown nature; infrequent episodes of arrhythmia are best evaluated with longer-term ambulatory EKG technologies.
4. To better identify arrhythmias in high risk patients."

Within the coding and billing guidelines, the question of billing for 48 hours of service is addressed:

"If billing for 48 hours for codes 93224-93227 and 93230-93237, indicate this by placing each date of service on a separate line ..."

The guidance indicates that a unit of '1' should be used for each line and that only one type of service (i.e., wearable versus 24-hour monitor) will be paid. This guidance is quite consistent with the conventional wisdom mentioned above. This guidance is dated October 16, 2009 so it appears to be current.

The second LCD is from TrailBlazer Health Enterprises, 4C-48AB-R2. This LCD is current with revisions as of April 7, 2010. The question of timing is addressed by two different statements.

“For monitoring extending beyond 24 hours, the number of services should be listed as ‘1’, and the date of the service is the date of the hookup.”

*“Code monitoring services in which the monitoring period is less than 24 hour using modifier 52, Reduced Service. The actual number of hours recorded and reason for the abbreviated monitoring period should be entered into the Comment field for electronic claims. A medical record attachment should be added to paper claims indicating the number of hours of monitoring accomplished and reason for the abbreviated monitoring period.”*

Outside of these statements, the LCD does not directly address the 48 hour time period question either in terms of medical necessity or for proper coding and billing.

If you study guidance from various Medicare Administrative Contractors (MACs), one question that should be considered is whether there is any difference in coding and billing for physicians versus hospitals. On the technical component side, the increased resource utilization is mainly with the use of the equipment involved. Does this justify additional payment, or should there simply be an increased charge with the same code for the 48 hour service?

On the professional side, there is an increase in the activities of the physician interpreting the results of the monitoring. Thus for physician coding (assuming only the professional interpretation), there may be a better argument that two units should be reported.

Also note that this type of service can be provided through an Independent Diagnostic Testing Facility (IDTF) so that the total component could be reported in these instances on the professional side. Again, this leaves open the question of whether two units should be used with different dates of service.

**Bottom-Line:** Be certain to check your MAC for any sort of LCD guidance. Then be certain to understand how your guidance accommodates both professional and technical coding and billing. While the issue of 48-hour Holter monitoring is not major, CMS really should issue national guidance in the form of an NCD so that coding and billing take place consistently across the country.

## The “-GX” Modifier Reappears

After an absence of several years, the “-GX” modifier is back in a new form. The companion modifier “-GA” has been slightly redefined.

- “-GX” – Notice of Liability Issued, Voluntary Under Payer Policy, and
- “-GA” – Waiver of Liability Statement Issued as Required by Payer Policy.

See Transmittal 1921 to Publication 100-04, Medicare Claims Processing Manual. Significant changes have been made to §60 of Chapter 1, and you should read through the changes. The whole area of ABNs (Advance Beneficiary Notices), HINNs (Hospital Issued Notices of Noncoverage), and expedited determinations has become quite complex.

Also, this is a sensitive public relations area. Medicare beneficiaries are supposed to know that certain services are not covered and/or not medically necessary. Whenever a Medicare beneficiary has responsibility for payment, the healthcare provider would be best advised to issue some sort of notice.

Now that we have the “-GX” and “-GA” pair we can now issue ABNs whenever we determine that a service or item will be denied due to medical necessity, or the service is statutorily not covered. There can still be questions about whether a given service is covered or not covered, but at least we can issue an ABN and then track any adjudication problems.

Be certain to check your editing systems either at the billing level or with back-end systems at your clearing house. In theory, if for instance, the “-GX” is used with a covered code, there should be an edit violation. One way to categorize coverage for CPT/HCPCS codes is to go to the Medicare Physician Fee Schedule or MPFS. The MPFS codes that have status ‘N’ or ‘X’ are not covered, and the use of the “-GX” modifier would generally be appropriate.

### Questions from our Readers

**Question: Now that CMS has introduced the concept of ‘active monitoring’ relative to counting time for observation services, does this apply to situations such a telemetry and continuous pulse oximetry.**

Given that CMS has recently introduced the concept of ‘active monitoring’, there really are no specific definitions in this area. The guidance provided in counting or not

counting time for observation services is at a very informal level. For instance, see CMS Q&A #9774.<sup>3</sup>

This means that coding, billing and reimbursement (CBR) compliance personnel will have to establish policies and procedures to address this issue. Hopefully, CMS will provide further guidance.

The concept of active monitoring appears to suggest that a nurse or other qualified medical personnel are at the patient's observation bedside. Additionally, the nurse is performing a service dedicated to the patient.

For both cardiac telemetry and continuous pulse oximetry, the data is being sent to a central workstation where nursing or other qualified medical personnel are monitoring the patient's condition. Generally, there will be several patients simultaneously monitored.

Chargemaster coordinators generally have taken two different approaches in billing telemetry observation:

- a. Use a slightly elevated charge for the telemetry room rate relative to a medical/surgical bed room rate in which there is no telemetry, and
- b. Create a line-item for an add-on charge on an hourly or flat-rate basis for the telemetry services.

A general default is to not make any special charge and to integrate the costs of resources utilized with the telemetry into the overall observation bed room rate.

These chargemaster approaches do imply that telemetry or continuous pulse oximetry are really just part of the services and resources provided for a given type of room. Thus, this would not constitute active monitoring in the sense of removing the hours for telemetry service from the overall time for observation services.

Now we can also look at this situation the other way around. What if telemetry does constitute active monitoring? This means no observation time would be reported! There are no CPT codes for telemetry. Thus, there may be little to report for claim development. Even if we have continuous pulse oximetry monitoring, any possible CPT codes are packaged for APC payment.

**Bottom-Line:** As with so many issues involving the Medicare program, how you treat telemetry services for observation is a policy and procedure issue. While we await further guidance from CMS, you should establish a policy of continuing to charge and count hours for observation the same way you have in the past.

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<sup>3</sup> See an associated article in the February edition of this Newsletter, pages 7-9.

## 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/JantoDecember2010EdCal.htm](http://www.aaciweb.com/JantoDecember2010EdCal.htm)

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On-site, teleconferences and Webinars are being scheduled for 2010. Contact Chris Smith at 515-232-6420 or e-mail at [CSmith@aaciweb.com](mailto:CSmith@aaciweb.com) for information.

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A variety of Webinars and Teleconferences are being sponsored by different organizations. Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, and the Eli Research Group are all sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2010.

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The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2010. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or [CHughes@gha.org](mailto:CHughes@gha.org). The webinar scheduled for June 22nd "**E/M Coding for Hospitals and Physicians**" that will run from 9:30 a.m. to 11:00 a.m. EST.

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Dr. Abbey's latest book:

**"The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers"** is now available for purchase. This is a companion volume to

**"Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program"**, 2<sup>nd</sup> 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](mailto:Duane@aaciweb.com).

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Also, Dr. Abbey has just finished the second book in a series of books on payment systems. The first book is: "**Healthcare Payment Systems: An Introduction**". The second in the series addresses fee schedule payment systems and should be available shortly. The third book in the series is devoted to prospective payment systems and is currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below.

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