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 proposed rule for the 2012 update to APCs and the Medicare Physician Fee Schedule (MPFS) should be available very shortly. Standby! We will be discussing both new and on-going issues that need attention.

Telemedicine Credentialing – Final Rules

CMS has issued the final rule for telemedicine credentialing. The official date is May 5, 2011 with the examination copy being available on May 2nd. There are no major surprises in the final *Federal Register*. At the same time this FR entry should be read with some care because of some new terminology and concepts.

From page 25558 (76 FR 25558) we have:

> *Based on public comment and our own internal discussions, we are adding new provisions to this final rule that will apply to the credentialing and privileging process and the agreements between hospitals and CAHs and nonhospital, distant-site* ***telemedicine entities*** *that provide telemedicine services (§ 482.12(a)(9) and § 482.22(a)(4) for hospitals; § 485.616(c)(3) and § 485.616(c)(4) for CAHs). These new provisions will require the governing body of the hospital (or the CAH's governing body or responsible individual), through its* ***written agreement*** *with the distant-site telemedicine entity, to ensure that the distant-site telemedicine entity, acting as a contractor of services, furnishes its services in a manner that enables the hospital (or CAH) to comply with all applicable conditions of participation and standards for the contracted services, including, but not limited to, the credentialing and privileging requirements regarding its physicians and practitioners providing telemedicine services.*

First, these changes apply to both hospitals and Critical Access Hospitals. Thus the CoPs for hospitals (i.e., §482) and CAHs (i.e., §485) are both being changed. While the original impetus of these changes involved challenges for CAHs, the final rule also addresses participating hospitals.

Second, we have a new term, *distant site telemedicine entity*. CMS is generalizing those facilities that can provide telemedicine services. From page 25553:

> *In addition, we note that there is no statutory definition for a telemedicine entity contained in the Act. Therefore, for the purposes of this rule, we are defining a distant-site telemedicine entity as one that—(1) Provides telemedicine services; (2) is not a Medicare-participating hospital (therefore, a non-Medicare-participating hospital that provides telemedicine services would be considered a distant site telemedicine entity also); and (3) provides contracted services in a manner that enables a hospital or CAH using its services to meet all applicable CoPs, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital or CAH.*

Third, note that there must be a written agreement between the distant site telemedicine entity and the hospital or CAH.

Continuing the summary from page 25558:

> *Essentially, the new provisions will allow for the governing body of the hospital (or the CAH's governing body or responsible individual) to rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making its own decisions on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body (or the CAH's governing body or responsible individual) ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity's medical staff credentialing and privileging processes and standards meet or exceed the standards at § 482.12(a)(1) through*

§482.12(a)(7) and § 482.22(a)(1) through § 482.22(a)(2) for hospitals, and at § 485.616(c)(1)(i) through § 485.616(c)(1)(vii) for CAHs. Additionally, the hospital's governing body (or the CAH's governing body or responsible individual) must ensure that the distant-site telemedicine entity, through a written agreement, meets three other provisions finalized here (and similar to those proposed and finalized here for agreements between hospitals/CAHs and distant-site hospitals providing telemedicine services).

This means that a hospital or CAH using telemedicine services from a remote site can depend upon the remote entity to conduct privileging activities so long as the various CoPs requirements are met and this credentialing process can be accomplished through a written, contractual agreement with the remote site.

This FR entry also addresses the difference between *telemedicine* and *telehealth*. From page 25556:

The consensus in the telemedicine/ telehealth community appears to be that telemedicine refers to the provision of clinical services to patients by practitioners from a distance via electronic communications and that it is included under the broader scope of telehealth, while the statutory Medicare telehealth payment provisions are considerably narrower.

CMS also recognizes that telemedicine is not limited to rural areas.

However, for the purposes of this rule, we see telemedicine as encompassing the overall delivery of healthcare to the patient through the practice of patient assessment, diagnosis, treatment, consultation, transfer and interpretation of medical data, and patient education all via a telemedicine link (for example, audio, video, and data telecommunications as may be utilized by distant-site physicians and practitioners), and which is not restricted to only patients in rural areas of the nation.

Another issue that was raised by commenters is the definition of a *patient*. Now this really is a more serious question than might be realized. For instance, under EMTALA there are extensive discussions of the definition of a patient. CMS does make the rather interesting comment on page 25557:

We are aware that individuals that are not patients sometimes make use of a rural hospital's or CAH's facilities and telemedicine equipment in order to effect what are essentially office visits with distant-site telemedicine practitioners. Since these individuals are not patients of the hospital or CAH, and the distant-site telemedicine practitioners are not seeing them as patients of the hospital or CAH, the CoPs would not apply in these situations.

While the above statement would not have much of an operational impact from a compliance perspective, it does raise some billing issues. In other words, can the CAH whose facilities are being used bill the Medicare program or other payers the technical component?

On the lighter side, there are some interesting hourly wage assumptions on the part of CMS when they calculated the regulatory impact. Here are CMS's assumed hourly wages:

- Attorney - $86.00 per hour,
- Physician - $103.00 per hour, and
- Hospital Administrator - $69.00 per hour.

Also, the word *believe* occurs 21 times in this relatively short FR entry.

Ambiguous Guidance from CMS: Observation

In the April, 2011 issue of this Newsletter, we started discussing the whole issue of ambiguous guidance from CMS. With increasing frequency CMS seems to provide guidance that is less than explicit often using undefined terms. This ambiguity creates situations in which the burden of proof for maintaining compliance is shifted to hospitals and other healthcare providers.

In response to ambiguous or incomplete guidance, hospital compliance personnel must still develop policies and associated procedures to operationalize the policies. One, on-going issue is that of counting observation hours. While counting hours would not appear a significant issue, in practice there are some very distinct difficulties.

Generally, in order to count observation hours we must precisely know:

- Start Time
- Stop Time
- Precision and Rounding
- Interrupted Time Periods

The definitions of *start* and *stop* times have been extensively discussed by CMS over a period of nearly ten years. Early in the 2000's CMS equated observation status to a bed, that is, observation started when the patient was placed in the observation bed. Over the years CMS has dropped the use of *status* and now recognizes that observation starts with a physician's

order and the provision of observation services. Observation ceases when the physician discharges the patient and observation services are stopped.

The concept of *precision* and *rounding* affects the way in which we count the hours for observation. This seems trivial! What if the elapsed observation time is 32 hours and 40 minutes? Are you going to report 32 hours by truncating the 40 minutes or round up because 40 minutes is more than half the time unit? In other words use what is called the *half-time unit rule*. Using this rule, the last subsequent time-unit will be counted only if more than half of the time unit is achieved. Medicare uses this approach with certain time units such as physical therapy (15 minute time units) and critical care (30 minute time unit after the first hour). Of course there are always exceptions, such as cardiac rehabilitation that uses one hour units, and the full hour must be achieved to count the last subsequent hour.

This same concept arises when we start addressing interrupted observation. The basic idea is that if the observation services are interrupted by other separately reportable diagnostic and therapeutic services, then the time that the patient is out of the observation bed should be subtracted from the overall time for observation.

> **Case Study 1** – ***Patient Taken to Radiology*** – A patient has been admitted to observation through the ED. Approximately four hours into observation, the patient is taken to radiology to have a CAT scan performed. The patient was removed at 2:50 p.m. and returned at 4:23 p.m.

Case Study 1 is conceptually simple. The patient was out of the observation bed from 2:50 p.m. to 4:23 p.m. or 1 hour and 33 minutes. However, there are some significant operational concerns. First of all, how will the time that the patient left the bed be captured? The same issue will occur when the patient is returned. Secondly, how will we count the 1 hour and 33 minutes. Will this time be rounded up to 2 hours and subtracted or will the time be count everything precisely down to the minute? And, who is going to do all this counting?

Similarly, if there are bed-side services that require *active monitoring*, then the time periods for services requiring active monitoring should be subtracted for the overall time of observation. At issue is the precise meaning of the phrase *active monitoring*.

From Chapter 6, §290.2.2, of the Medicare Claims Processing Manual (CMS Publication 100-04), we have:

> *Observation services should not be billed concurrently with diagnostic or therapeutic services for which **active monitoring** is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour).*

The two examples of colonoscopy and chemotherapy are only partially helpful. Certainly, colonoscopy performed at the bedside would require active monitoring. Similarly, chemotherapy generally requires nursing staff to be present in case of any adverse reactions.

From the CMS Q&A website,[1] we do have the following question and answer from CMS.

> *Question #9974: May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?*
>
> *Answer –*
> *The Medicare Claims Processing Manual (Pub 100-4), Chapter 6, Section 290.2.2 states that "observation" services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy)." In situations where such a procedure interrupts observation services and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the lengths of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services under HCPCS Code G0378 (Hospital observation service, per hour).*
>
> *The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug*

[1] Note that this guidance is at the lowest possible level of formality. Q&As can come and go in the blink of an eye. Thus, if you develop policy and procedure statements based on the Q&As, be certain to save them electronically in case they suddenly disappear.

*administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require **constant active monitoring** by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require **significant active monitoring**. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.*

If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

While this answer seems to provide additional guidance, overall this answer really muddies the water relative to establishing any sort of policy. Within this answer we have three phrases:

- Active Monitoring,
- Constant Active Monitoring, and
- Significant Active Monitoring.

What, exactly, is the difference between these three phrases? Also, note that in the third paragraph of the answer the burden is on the hospital to determine if active monitoring is a part of the drug administration.

Case Study 2 – ***Slow IV Push*** – A patient is in observation. An IV was started when the patient presented through the ED. Only incidental hydration has occurred and there are no formal orders for hydration. A nurse is directed to provide a slow IV push that requires 6 minutes to complete.

Ostensibly the 6 minutes for the IV push require active monitoring, in this case constant active monitoring, and should be subtracted from the observation time. Are 6 minutes long enough to actually subtract? That is, are you going to precisely count each minute? As far as documentation, nursing staff will have to document fastidiously the precise start and stop time for the slow IV push.

Case Study 3 – ***Hydration*** – A physician has ordered hydration provided to a patient for a 2 hour time period. The physician has documented dehydration. A nurse starts an IV and commences the hydration. The time period for starting the IV and initiating the hydration is 8 minutes. The nurse also checks the progress of hydration every 20 minutes. Each check requires 3 minutes. Hydration is discontinued at the end of 2 hours.

Presuming that the hospital's policy and procedures requires counting the time to a precision of minutes, the various time periods will need appropriate documentation. Then someone will need to count all of the time periods and subtract from the overall observation time.

The Latin phrase, *ad nauseam*, comes to mind when approaching the counting of hours for observation in this fashion. This approach even assumes that we have correctly interpreted CMS's guidance.

A more conservative approach, and simpler approach, would be to subtract any time periods when there are injections, hydration and/or IV infusions. In other words, for Case Study 3, simply subtract the two hours for the whole duration of the hydration. Someone will still need to identify the hours for hydration (from nursing documentation) and then appropriately subtract them.

There are numerous other situations that will be encountered, for instance, providing multiple IV pushes to achieve a given titration of morphine. No matter how you approach developing a comprehensive observation policy and then associated procedures, this area is very complicated, and hospitals really need absolutely precise guidance on how they should handle issues such as counting hours of observation services.

Bottom-Line: As long as CMS provides ambiguous guidance and moves the decision making burden to hospitals, we will have to develop policies and various procedures to address situations such as counting observation hours. In some cases, conservative approaches may be needed to assure compliance with possible future clarifying guidance from CMS. In some cases, CMS has appeared to change significantly guidance and then claim that the new guidance is only a clarification and not a change. That is, CMS maintains that its guidance has always been what they have clarified even if the new guidance is quite different from the old.

Questions from Our Readers

Question: At our hospital we are in the midst of conducting an internal review of physician supervision and adhering to the requirements of the provider-based rule. One of those requirements is to report material changes. However, CMS does not provide instruction for reporting. How should we handle this?

You are quite correct that there is a reporting requirement. However, CMS has provided almost no

guidance on when, where and to whom such reports should be provided. With all of the changes in the physician supervision requirements, provider-based reviews are certainly necessary. In conducting such reviews you may find it necessary to make changes, and thus the reporting issue will arise.

In theory, the reports would go to your Fiscal Intermediary or regional Medicare Administrative Contractor, if you have one. What the FI or MAC will do with them is anybody's guess. Note that such reporting is also intertwined with any requests for formal determination and any attestations that may have been filed. If there are changes, you may need to update any information provided for a formal determination and/or detailed information provided with an attestation.

Also, CMS does not define the phrase *material change*. In theory a material change would be any change that could affect the provider-based status of a clinic, department, operations, organization, etc. This then takes us into a consideration for dividing provider-based operations into three relative geographical locations:

- In the hospital,
- On-campus but outside the hospital, and
- Off-campus.

The requirements for off-campus clinics and other operations are more stringent than for on-campus or in the hospital operations. For instance, with an off-campus clinic there may be a formal policy addressing what to do if an individual presents to the clinic with a possible emergency medical condition. This policy is generally to call '911', and the policy is typically approved at the hospital board level. Keep in mind that an off-campus provider-based clinic is part of the hospital and is thus hospital property. Thus, such an individual so presenting to the clinic will actually be entering hospital property, and EMTALA applies.

If there were a change in this policy, then this change most likely would be a material change and should be reported because the policy change affects meeting all the requirements for provider-based status.

Keep in mind that most changes you would report relative to provider-based status would also be reported when updating the various CMS-855 forms relative to billing privileges. Thus, a very logical question is whether any changes that are otherwise reported relative to the CMS-855 forms must also be reported relative to the provider-based rule.

Bottom-Line: CMS has not provided any specific guidance for the reporting requirement. Thus a conservative approach is recommended so that any possible changes should be reported to your FI/MAC.

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/JantoDecember2011EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2011. 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 CY2010 and planned workshops for CY2011.

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 June 21st "***Pricing Strategies and the Chargemaster"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

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***", 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 second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

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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FOR UPCOMING ISSUES

****** ACTIVITIES & EVENTS ******

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Need an Outpatient Coding and Billing review? Charge Master Review? Concerned about maintaining coding billing and reimbursement compliance? Contact Mary Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com