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 examination copy of the APC update *Federal Register* became available at the CMS website on October 30, 2009. The examination copy is nearly 2,000 pages long. While various APC topics are addressed, there is also additional material on topics such as physician supervision relative to the provider-based rule. The official *Federal Register* will be issued on November 20, 2009.

Physician Supervision – CMS Retreats, a Little

Physician supervision requirements are addressed in the APC update *Federal Register*, amounting to more than a hundred pages. Starting in CY2008 and continuing on into CY2009, CMS appeared to change (a clarification to CMS) the supervisory requirements for on-campus but out-of-hospital provider-based clinics and operations. In the April 7, 2000 *Federal Register*, CMS indicated that physician supervision was assumed for on-campus and in-hospital operations because a physician would be close by.

Then in 2008 CMS indicated that direct physician supervision was required for on-campus situations if the provider-based operation was not in the hospital. While CMS reiterated this policy statement in 2009, CMS has received numerous comments and questions regarding this policy clarification. Hospitals were thrown into a limbo situation for certain types of operations.

For instance, a hospital might have an infusion center in a separate building on the hospital's campus. However, there may not be a physician present in the infusion center except on infrequent occasions. As a result, the modified physician supervisions requirement would cause this type of situation to be out of compliance possibly to the extent that all payments would be considered overpayments.

A corollary issue was raised as to whether or not mid-level practitioners (e.g., Nurse Practitioners, Clinical Nurse Specialists, Physician's Assistants) could meet the supervisory requirements. For our infusion center example, perhaps a mid-level might be stationed in the center. However, CMS carefully analyzed this situation and indicated that mid-levels cannot meet the supervisory requirements.

Here are the final decisions that CMS has made in this area.

Direct Physician Supervision – From page 982 of CMS-1414-FC, Examination Copy:

> ***"For services furnished on a hospital's main campus, we are finalizing a modification of our proposed definition of "direct supervision" in new paragraph (a)(1)(iv)(A) of §410.27 that allows for the supervisory physician or nonphysician practitioner to be anywhere on the hospital campus, including a physician's office, an on-campus SNF, RHC, or other nonhospital space. Therefore, direct supervision means that the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure."***

Thus, we are essentially back to where we were in 2000 except that the physician, or now also mid-level, can be on the campus but in a non-hospital area. While there are many different scenarios that can be referenced, this would allow physicians in a freestanding clinic on the hospital's campus to meet this requirement.

Note that physician supervision means *immediately available*. This is an area in which hospitals will need to establish very careful policies and procedures in order to meet any compliance metrics that CMS might choose to enforce. The burden for justifying direct physician supervision is now in the hands of hospitals.

Note that CMS did give us the following guidance from Page 950:

"***This means that the physician or nonphysician practitioner must be prepared to step in and perform the service, not just to respond to an emergency. This includes the ability to take over performance of a procedure and, as appropriate to both the supervisory physician or nonphysician practitioner and the patient, to change a procedure or the course of treatment being provided to a particular patient***."

The compliance issue is where we draw the line between being available for any reason versus being available in case there is a problem or emergency. For instance, most hospitals have emergency physicians on campus, but can these physicians fulfill the 'immediately available' criterion? From a compliance perspective, hospitals should always be in a position to establish exactly what physicians or non-physician practitioners are being used to meet the direct physician supervision requirement for any given provider-based situation.

Time will tell the degree to which these supervisory physicians or practitioners must be documented. For instance, will this need to involve a daily log of physicians' and practitioners' providing the supervisory services? If so, what if the supervisory physician or practitioner is performing an operative procedure or extensive diagnostic test? In other words must a log be maintained showing that the given physician or practitioner was 'immediately available'?

Mid-Level Practitioners Meeting Supervisory Requirements – CMS is proceeding with allowing certain non-physician practitioners to meet the *physician supervisory* requirement. Clinical Social Workers (CSWs) have been added to the list.

"***In summary, for CY 2010, nonphysician practitioners who are specified under §410.27 of the final regulations as clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves within their State scope of practice and hospital-granted privileges, provided that they meet all additional requirements, including any collaboration or supervision requirements as specified in §§410.71, 410.73, 410.74, 410.75, 410.76, and 410.77."*** (Page 995 of CMS-1414-FC)

In Hospital Definition – While there were some concerns expressed by commenters, CMS is basically adopting the proposed definition for in the hospital:

"…***to mean areas in the main building(s) of a hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital or CAH; and for which the hospital or CAH bills the services furnished under the hospital's or CAH's CCN."*** (Page 995 CMS-1414-FC)

Terminology and Provider-Based Determinations – While CMS mentions questions from commenters about determining when and if a *department* has provider-based status, this topic is not really addressed by CMS. Because CMS is liberalizing the physician supervisory requirements, the need to know exactly what organizational structures need to have provider-based status is not particularly severe.

For instance, in the preamble discussions, commenters point out that if a patient is admitted and receives inpatient services for two days and then at the very end of the stay, Condition Code 44 is used and the services turn into outpatient observation, the direct physician supervision requirements may not be met for the, now outpatient service. With the liberalized supervision requirements, this does not appear as a problem.

However, be careful with terminology. CMS is now liberally using the phrase *Provider Based Department* with the acronym PBD. This phrase does not appear in the Provider-Based Rule (PBR) itself. The fundamental terms used in the PBR are *facility* or *organization*. Neither of these terms is defined in the PBR.

Diagnostic Testing Supervision – CMS has provided clarifying language relative to diagnostic testing supervision. There do not appear to be any substantive changes in guidance, per se, but the language is now quite precise.

Diagnostic testing supervision involves three levels of supervisions:

- General,
- Direct, and
- Personal.

In the RBRVS file for the Medicare Physician Fee Schedule (MPFS), the different levels of supervision are provided for select diagnostic tests. While commenters requested that this information be provided in the Addendum B file for APCs, CMS indicated that hospitals could transfer the necessary information from the RBRVS file over to Addendum B.

Here is CMS's statement relative to diagnostic testing supervision for hospitals.

"***For CY 2010, we are finalizing the proposal to require that all hospital outpatient diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS Relative Value File."*** (Page 996 CMS-1414-FC)

Note: While not consistent with rest of CMS's decisions in this area of supervision, mid-levels are NOT allowed to meet the supervisory requirements for diagnostic testing. A physician must provide the supervisory duties whether general, direct or personal.

Also, for Cardiac Rehabilitation and Pulmonary Rehabilitation, direct physician supervision is required. Mid-levels are not allowed to meet this physician supervisory requirement.

Additional References -

- July 18, 2008 *Federal Register* – Section XII – Page 41518 (73 FR 41518)
- November 18, 2008 *Federal Register* – Section XII – Page 48702 (73 FR 48702)
- July 20, 2009 *Federal Register* – Section XII – Page 35358 (74 FR 35358)

To access most, if not all, of the CMS materials on the Provider-Based Rule, see our website:

http://www.APCNow.com/PBRInformationToolkit.htm

CY2010 APC Update – Part 1

There are many changes and extensive discussions involving APCs. APC issues will be discussed in the next several Newsletters.

Technical Component E/M Coding – This is an important area for hospitals because of CMS's failure to provide national guidelines. Here are the key points in this Federal Register entry.

- **New vs. Established Patient Visits** – The use of new and established codes will continue with the 3-year registration rule in place.

  "***Because hospital claims data continue to show significant cost differences between new and established patient visits, we continue to believe it is necessary and appropriate to recognize the CPT codes for both new and established patient visits and, in some cases, provide differential payment for new and established patient visits of the same level.***" (Page 815 CMS-1414-FC)

- **Type B ED Visits** – "***In addition, we are adopting new APC 0630 (Level 5 Type B Emergency Visits) and will pay for level 5 Type B emergency department visits through this new APC. We are assigning HCPCS codes G0380, G0381, G0382, G0383, and G0384 (the levels 1, 2, 3, 4, and 5 Type B emergency department visit Level II HCPCS codes) to APCs 0626, 0627, 0628, 0629, and 0630, respectively, for CY 2010.***" (Page 829 CMS-1414-FC)

- **Nurse's ED Triage Billing** – CMS does not seem to really address the issue. A patient may present to the ED, be triaged by an ER nurse but then leave before being seen by a physician. Thus, the question of whether there were any services incident-to those of a physician and/or if the EMTALA mandated Medical Screening Examination (MSE) is not answered.

- **National E/M Coding Guidelines** – CMS is indicating that there is no progress toward establishing national guidelines and that it would now be disruptive to establish guidelines.

  "***As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2010 according to their own internal hospital guidelines. In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services.***" (Page 836 CMS-1414-FC)

  "***We [CMS] acknowledge that it would be desirable to many hospitals to have national guidelines. However, we also understand that it would be disruptive and administratively burdensome to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals.***" (Page 839 CMS-1414-FC)

- Anticoagulation Clinics – A question was asked about provider-based medication management clinics, specifically the so-called Coumadin Clinics. The suggestion was to use the relatively new CPT codes, 99363 and 99634 to establish a composite payment for a series of visits involving the INR test along with adjusting the medication which invokes a 99211 clinic visit. While CMS seems to have missed the point of the question, read the following statement with great care. This statement seems to establish some sort of new policy for addressing non-face-to-face services in-between visits.

  "***We expect that a patient undergoing anticoagulation management by hospital staff for a significant medical condition would periodically have hospital visits, and we would package payment for the non-face-to-face management of the patient's therapy between visits into payment for the visits themselves. Our usual policy is to package payment for the hospital resources associated with managing patients' medical conditions between hospital encounters for patients who undergo surgery or receive hospital visits for any medical condition, including diabetes, hypertension, or cardiac arrhythmias, and we do not believe that payment for anticoagulation management services should be made differently than payment for other medical or surgical management services***." (Page 842 CMS-1414-FC)

CPT & HCPCS Update for CY2010

The CPT Manual and the CMS HCPCS file are now both available. As usual, there are numerous changes.

For CPT, the number of new codes and changed codes is not overwhelming. Within the Musculoskeletal System there are new and changed codes for tumor excisions. For instance, the sequence 22900-22905 addresses tumor excisions relative to the abdominal wall.

The major changes for CPT are buried within the coding guidelines. For instance, there is a new subsection, 'Implantable and Wearable Cardiac Device Evaluations' within the Cardiovascular Medicine section within the 90000 series of codes. The only real way to identify these changes in guidance is to leaf through the CPT Manual and look for pairs of triangle indicators (►◄).

Also check the significant additions to Category II and Category III codes.

For HCPCS, here are the numbers relative to the changes in the HCPCS file.

New Codes or Modifiers Added	146
Description Changes	25
Deleted Codes or Modifiers	64
Other Technical Changes	39

Because HCPCS covers all types of services and supplies, the challenge is to identify those changes that apply to your specific situation. Also, we do not always have guidance on when, where and how to use new and or changed codes.

For instance, there are seven new modifiers. Five of these new modifiers are:

"-V5" – VASCULAR CATHETER,
"-V6" – ARTERIOVENOUS GRAFT,
"-V7" – ARTERIOVENOUS FISTULA,
"-V8" - INFECTION PRESENT,
"-V9" - NO INFECTION PRESENT.

Now, are these for physicians? Hospitals? Both? And when should these modifiers be used? We also have the "-AI" modifier for PRINCIPAL PHYSICIAN OF RECORD. Watch for guidance from CMS and other third-party payers that may want to utilize these new modifiers.

For the new and/or changed codes, you will need to simply go down the list to see if any of them apply to your healthcare provider. As always, we have new J-codes for drugs, G-codes for reporting a variety of circumstances, and a few L-codes in the prosthetic/orthotic area.

Note: One of the easiest ways to analyze the HCPCS file is to download it in MS Excel format and then sort on the 'Code Add Date' and/or 'Action' columns.

Questions from Our Readers

Question: In off-campus wound-care centers, can the specially trained nurses, such as, WOCNs meet the supervisory requirements.

This question was raised and addressed in the November 20, 2009 *Federal Register*. On page 955 of CMS-1414-FC we have:

"***Other commenters requested that pharmacists be permitted to supervise medication therapy management services and that specialty certified registered nurses, such as wound care nurses, also be able to provide the direct***

supervision of hospital outpatient therapeutic services."

The answer to this particular comment appears on page 956:

"***We [CMS] are not expanding the regulations further to allow supervision by pharmacists, registered nurses, or other medical professionals."***

CMS is using the ability to gain billing privileges with the Medicare program as the criteria for considering the supervisory conditions

Note: Be certain to check on any off-campus medical management clinics because this language seems to indicate that at an off-campus medical management clinic (e.g., Coumadin clinic) must meet the supervisory requirement outside the pharmacist.

Question: Can DPMs, Doctor of Podiatric Medicine, meet the physician supervision requirements?

This same question can be asked relative to dental surgeons, chiropractors and optometrists. While this specific question is not answered in the *Federal Register*, there is a discussion concerning these types of doctors. For instance, from page 936-937 we have:

"***We noted that section 1861(r) of the Act defines a physician as follows: "[t]he term 'physician', when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action . . . ; (2) a doctor of dental surgery or of dental medicine [legally authorized to practice in the State and acting within the scope of his license]; (3) a doctor of podiatric medicine [for certain purposes and to the extent authorized by the State]; (4) a doctor of optometry [for certain purposes and to the extent legally authorized by the State]; or (5) a chiropractor [for certain purposes and to the extent legally authorized by the State and consistent with the Secretary's standards]."***

Note that for physicians, other than MDs and DOs, there is reference to scope of practice. While you will have to develop your own interpretation, this seems to imply that the other types of physicians can supervise services, ***but only with their scope of practice***. Thus, if you have a provider-based clinic situation in which general physician supervision is required, then you will probably need to have a physician or one of the approved non-physician practitioners in order to meet the requirement.

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/JantoDecember2009EdCal.htm

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

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 CY2009.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2009. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for December 8th "***Medicare Conditions for Payment***" that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's eighth book, "***Compliance for Coding Billing & Reimbursement: a Systematic Approach to Developing a Comprehensive Program***" is now available. 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.

Also, Dr. Abbey's ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro. His tenth book, "***Introduction to Healthcare Payment Systems***" is available from Taylor & Francis.

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**
- **Introduction to Payment Systems** is available from Francis & Taylor.

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

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Worried about the RAC Audits? Schedule a special audit study to assist your hospital in preparing for RAC audits. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.

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: Chris@aaciweb.com.