Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

November 2010– Volume 22 Number 11

ISSN: 1061-0936

APC/APG Update

The APC update *Federal Register* that delineates all the change for Medicare's OPPS (Outpatient Prospective Payment System) officially appeared on November 24, 2010. The MPFS (Medicare Physician Fee Schedule) *Federal Register* appears on November 29, 2010. Hospital personnel should also review the MPFS update as well as the APC update.

Note that both of these *Federal Register* entries address several issues that go beyond either OPPS or MPFS. CMS has a tendency to include issues in these *Federal Registers* that should really have their own independent entries.

APC Issues and Changes for CY2011

There are numerous changes for APCs for CY2011. Some are major, others minor. Then there are the new CPT and HCPCS with which to contend. Some of the changes are discussed in this Newsletter, and the OPPS issues will be continued in future Newsletters. Also, keep in mind that Congress is, and probably will continue, being extremely active in the healthcare area. Some of the legislative changes will affect coding, billing and associated compliance issues as well.

Here are several on-going APC issues along with current discussions from CMS.

- ***Variation Within APC Categories*** – CMS uses a rather liberal statistical measure for determining if there is too much variation in a given APC category. This is the '2-Times Rule'. While the list of APCs that violate the 2-times rule is slowly shrinking, there are some APCs that seem to remain on the list, year after year. Here are some high frequency APCs in which payment is probably skewed.
  - 0058 Level I Strapping and Cast Application
  - 0080 Diagnostic Cardiac Catheterization
  - 0133 Level I Skin Repair
  - 0303 Treatment Device Construction
  - 0304 Level I Therapeutic Radiation Treatment Preparation
  - 0604 Level 1 Hospital Clinic Visits
  - 0607 Level 4 Hospital Clinic Visits

- ***Payment Offset Policy for Diagnostic Drugs*** – Here is a new coding/billing directive from CMS. "***Establishing the "FB" modifier to correctly account for diagnostic radiopharmaceuticals received free of charge allows for the diagnostic radiopharmaceutical to be reported and coded correctly on the same claim as the nuclear medicine scan, therefore fulfilling the required radiolabeled product edits."*** (Page 71935 – 75 FR 71935**)**

- ***Brachytherapy Sources*** – CMS has worked very hard to get around any requirements to pay for brachytherapy sources on a pass-through basis. Basically, CMS has developed a mini-APC system to provide payment even over the objections of healthcare providers in this area. Here are two interesting quotes.
  "*Nevertheless, we believe that prospective payment for brachytherapy sources based on median costs from claims calculated according to the standard OPPS methodology is appropriate and provides hospitals with the greatest incentives for efficiency in furnishing brachytherapy treatment."* (Page 71879 – 75 FR 71879)

  "*Under the budget neutral provision for the OPPS, it is the relativity of costs of services, not their absolute costs, that is important, and we believe that brachytherapy sources are appropriately paid according to the standard OPPS payment approach."* (Page 71879 – 75 FR 71879)[1]

[1] This statement by CMS appears to explain why you can be underpaid for brachytherapy sources and it is still appropriate.

- ***Drug Administration Services*** – Chemotherapy, injections and infusions have, after a decade, finally settled down into fairly normal annual increases.

- ***Inpatient-Only Procedures*** – Comments and hospitals continue to decry the inpatient-only listing. CMS is just as adamant about continuing the list even though significant payment issues arise if a physician decides to perform a procedure on the inpatient-only list on an outpatient basis. Here are two quotes that represent CMS's position:

  "***We continue to believe that the inpatient list is a valuable tool for ensuring that the OPPS only pays for services that can safely be performed in the hospital outpatient setting, and we will not eliminate the inpatient list at this time.***" (Page 71997 – 75 FR 71997)

  "***We expect hospitals to be aware of the services that are being provided in the outpatient setting. Hence, we do not believe that it is appropriate to pay the hospital for the ancillary services furnished when the patient receives an inpatient only service in the hospital outpatient setting.***" (Page 71997 – 75 FR 71997)[2]

- ***"-CA" Modifier*** – When a patient is rushed to the Emergency Department, taken immediately to surgery and then expires, the "-CA" modifier causes the case to group to APC=0375. This modifier is being more frequently utilized, and the payment for APC=0375 has now risen to $6,372.10. Note that this APC is inclusive of all services.

  Question: Why don't we use this same "-CA" modifier process to make a blanket payment for inpatient-only procedures that are inadvertently performed (safely) on an outpatient basis?

- ***Visit Reporting Guidelines*** – CMS continues to refuse to develop visit reporting guidelines. Although there is a new twist as indicated in the second quotation below.

  "***We continue to believe that, based on the use of their own internal guidelines, hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2011 according to their own internal hospital guidelines.***" (Page 71989 – 75 FR 71989)

  "***We agree with the commenters that national guidelines should be clear, concise, and specific with little or no room for varying interpretations, and that hospitals should have at least 1 year to prepare for the transition. If the AMA were to create facility specific CPT codes for reporting visits provided in HOPDs, we would certainly consider such codes for OPPS use.***" (Page 71990 – 75 FR 71990)

  This second quotation is almost amazing! CMS is now saying that the AMA should develop hospital outpatient coding guidelines for the E/M levels. The bottom-line on this issue is that hospitals will have to continue their own internal guidelines. There is no way to know for certain that any given set of guidelines is appropriate. In time, the RACs (Recovery Audit Contractors) will become involved in this issue.

- Preventative Services – The ACA (Affordable Care Act) increases Medicare coverage of preventative services. For instance, PSA (Prostate Specific Antigen) is now fully paid. Also, the AWV (Annual Wellness Visit) is paid through the MPFS.

  "***That is, we will pay either the practitioner or the facility for furnishing the AWV providing PPPS in a facility setting, and only a single payment under the MPFS will be allowed.***" (Page 72016 – 75 FR 72016)

  The PPPS stands for Personalized Preventative Plan Services. This payment approach is similar to services such as medical nutrition therapy (MNT). Hospitals with provider-based clinics providing such services will need to adjust the coding and billing process in this area.

- ***GME/IME Costs*** – This issue was included in the OPPS update *Federal Register*. For those in academic medical centers, this can be a significant cost-reporting issue.

  "***The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111-148),***

[2] Ostensibly the real reason for the inpatient-only list is that APC assignment would have to be made for any surgical procedure that might be performed on an outpatient basis. CMS has developed no mechanism for this process.

***as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances.*"** (Page 72134 – 75 FR 72134)

- ***CRNA Services at Rural Hospitals and CAHs*** – There are special CRNA reimbursement processes for CAHs and rural hospitals.

  "***In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50299), we adopted a policy that would allow otherwise eligible critical access hospitals (CAHs) or hospitals that have reclassified from urban to rural status under section 1886(d)(8)(E) of the Act and 42 CFR 412.103 to receive reasonable cost payments for anesthesia services and related care furnished by nonphysician anesthetists (referred to in this section as CRNA pass-through payments), effective for cost reporting periods beginning on or after October 1, 2010."*** (Page 72256 – 75 FR 72256)

Critical Care – A Slight Change for Hospitals

CPT codes 99291 and 99292 have proven difficult for hospitals on the outpatient side. APCs pays only for 99291, that is, the first hour, and then there is no payment for 99292 (i.e., Status Indicator "N"). In CPT there are several services that are bundled on the physician side such as interpretation of chest x-rays and intubations.

During the early years of APC implementation, these additional services could be reported separately and paid. The NCCI edits for OPPS were adjusted to allow this. However, over the past several years CMS has been claiming that these services are, as indicated in CPT, paid as part of critical care.

Now CPT, starting for CY2011, explicitly states that these services are separately reportable for hospitals. Needless to say, CMS has no plans to pay separately for these services.

Therefore, for CY 2011, we will continue to recognize the existing CPT codes for critical care services and are establishing a payment rate based on our historical data, into which the cost of the ancillary services is intrinsically packaged, and we will implement claims processing edits that will conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment." *(Page 750 – CMS-1504-FC)*

Physician Supervision – Yet Again!

The OPPS update Federal Register has yet another significant discussion concerning physician supervision. Because of the problem with CAHs (Critical Access Hospitals) needing to meet the supervision requirement of having a physician or qualified practitioner ***on the campus*** when services are being provided, CMS again is modifying the language for physician supervision.

Basically, the change is removing the requirement that the physician or qualified practitioner be on the campus.

The definition of direct supervision will be revised simply to require immediate availability, meaning physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary. Since the new definition will now apply equally in the hospital or in on-campus or off-campus PBDs, we are removing paragraphs (a)(1)(iv)(A) and (B) of §410.27 altogether. The new definition of direct supervision under §410.27(a)(1)(iv) will now state, "For services furnished in the hospital or CAH or in an outpatient department of the hospital or CAH, both on- and off-campus, as defined in section 413.65 of this subchapter, 'direct supervision' means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be present in the room when the procedure is performed. **(**Page 828**,** CMS-1504-FC)

While this change is welcome, all hospitals must recognize that the burden of proof for maintaining proper physician supervision lies with the hospital itself. There is no longer a presumption on the part of the Medicare program that such supervision is maintained by default. Thus, hospitals must establish affirmative mechanisms to document that proper physician supervision is being maintained. Developing such documentation and making certain that everything is in order are no small tasks depending upon how many provider-based operations are in place.

Note that CMS is explicitly exempting CAHs from any possible problems in this area through CY2011.

APCs – By the Numbers

Here are some of the update factors for the OPPS update for CY2011.

- 2.6% Market Basket Update Less 0.25% by ACA; thus, 2.35% Increase
- Conversion Factor = $68.876
- SCHs → 7.10% Increase on Budget Neutral Basis (Includes EACHs)
- Wage Indexes – See the IPPS Update
- Cost Outlier Formula - Fixed Threshold from $2,175.00 for CY2010 to $2,025.00 for CY2011
- Drug Packaging Threshold - $60.00 for CY2009 moved to $65.00 for CY2010 and $70.00 for CY2011
- Labor Related Formula – Remain the Same
- Final ASC Conversion Factor - $41.939 ($41.939/$68.876 = 60.89%)
- Co-Payments – Still Moving Toward the 20% Coinsurance
- Recalibration – Same Formula with Continuing Challenges Relative to Singleton Claims

CPT and HCPCS Changes

While there are some major changes for CPT, a smaller change is the addition of three new codes for subsequent observation care. These codes will be used by physicians; hospital billing for observation care generally does not use the CPT observation codes.

The three new codes are:

- 99224 – Subsequent observation care, per day. Level 1 – 15 Minutes
- 99225 – Subsequent observation care, per day. Level 2 – 25 Minutes
- 99226 – Subsequent observation care, per day Level 3 – 35 Minutes.

For instance, if a physician places a patient into observation on Tuesday, sees them again on Wednesday and then discharges then on Thursday, the subsequent visit code would be used on Wednesday. The observation admit would be used on Tuesday and the observation discharge on Thursday.

As usual, both the new CPT book and the new HCPCS manual should be reviewed with care. On the HCPCS side, there are two new modifiers of interest:

- "-PT" – Colorectal Cancer Screening Converted to Diagnostic Test, and
- "-GU" – Wavier of Liability Statement Issues As Required By Payer Policy, Routine Notice.

The "-GU" modifier joins the other ABN (Advance Beneficiary Notice) modifiers, namely, "-GA", "-GY", "-GZ" and "-GX".

Among the new HCPCS codes we have:

- G0157-G0161 – PT/OT/ST Services in the Home
- G0162-G0164 – Skilled Services by LPN or RN
- G0438-G0439 – AWV with PPPS
- G0436-G0437 – Smoking and Tobacco Cessation Counseling
- G8647-G8674 – Orthopedic Functional Status Change

Cardiac Catheterizations – New Codes

The diagnostic heart catheterization codes have been stable for many years. The APC payment process involves paying for the heart catheterization (e.g., right heart catheterization) and then packaging (Status Indicator "N") the injection procedure and the radiological S&I.

The new codes for diagnostic heart catheterizations involve a single code combining the catheterization, injection and radiological S&I.

While this does not create a significant change in APC grouping and/or payment, the chargemaster and the billing process are certainly affected. ***Thus, chargemaster coordinators, coding personnel, billing personal and catheterization laboratory service personnel should meet and review the new processes that will be required for proper billing***.

Note: APC=0080, Diagnostic Cardiac Catheterization, pays $2,726.85. This APC is also on the 2-Times Rule listing so that this payment may or may not be appropriate.

Vascular Catheterizations – New Codes

For CY2011, CPT has made several significant changes for vascular catheterization services. Here is an example of the new sequence of codes for sub-inguinal level codes.

37224 – Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

37225 – with atherectomy, includes angioplasty within the same vessel, when performed
37226 – with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37227 - with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel

Note*: It is absolutely vital that coding staff, billing staff and chargemaster coordinators go through the new guidance in CPT itself. You will need to carefully parse the guidance.*

There are now three territories for the lower extremities:

1. Iliac Territory
2. Femoral/Popliteal Territory, and
3. Tibial/Peroneal Territory.

Note that these code sequences are hierarchical, that is, as you go down the list of codes, the services above are included. Thus, only one code should be used for each lower extremity vessel treated. Also, coding is performed by territory, that is, one primary lower extremity revascularization code is used for each territory treated.

If a lesion crosses a vessel boundary and can be treated with one intervention, then it is coded only once. The ***radiological S&I is being included*** in these surgical codes. Also, the catheterization codes are being included in the therapeutic interventions. This movement from component coding will create some very delicate coding situations. It is possible that there may be a catheterization for diagnostic purposes in which the component coding is still necessary.

Also if both lower extremities are treated, there is interesting guidance concerning the use of the "-59" modifier.

> "***When the same territor(ies) of both legs are treated in the same session, modifiers may be required to describe the interventions. Use modifier 59 to denote that different legs are being treated, even if the mode of therapy is different***." (2011 CPT Manual, Professional Edition, page 209)

This is interesting guidance from CPT because, in theory, the "-LT" (left) and "-RT" (right) modifiers should separate the services.[3] As always with APCs, group cases to assure that the modifiers are working properly.

[3] Of course, the left and right modifiers are HCPCS modifiers and not CPT modifiers.

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

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 December 7th is "***OPPS/APC Update CY2011"*** 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 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.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
http://www.HIPAAMaster.com

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

INSIDE THIS ISSUE

APC/APG Update
APC/OPPS Changes for CY2011
Physician Supervision Yet Again!
CPT and HCPCS Changes
Cardiac and Vascular Catheterizations - Changes

FOR UPCOMING ISSUES

More on RAC Audits and Issues
Behavioral Assessments – Coding & Billing
More on Coding, Billing Compliance
More on Payment System Interfaces

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

Schedule your Compliance Review for you hospital and associated medical staff now. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement. These reviews also assist in preparing for the RACs.

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: Duane@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: Duane@aaciweb.com.