Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

November 2011– Volume 23 Number 11

ISSN: 1061-0936

APC/APG Update

The APC update *Federal Register* and the MPFS update *Federal Register* entries are both out. The examination copy of both *Federal Registers* appeared at the beginning of November. The official publication dates are:

- OPPS Update – November 30, 2011, and
- MPFS Update – November 28, 2011.

Be extremely careful to note that these *Federal Register* entries include topics that may go beyond just APCs and MPFS, respectively. While CMS is not officially providing 60-day notice, practically they are meeting this commitment with the examination copy process.

This issue of the Medical Reimbursement Newsletter, and for the coming months, will discuss pertinent issues that are discussed in these *Federal Register* entries. Note that the citations to these two entries use the page numbers from the examination copy because the printed version is not yet available.

Physician Supervision – A Little More Guidance

The issue of physician supervision requirements has taken on a life of its own starting in 2008. For some reason CMS decided to clarify the physician supervision requirement for on-campus provider-based operations, and these discussion are continuing on into 2012.

The two main issues discussed in the current OPPS update *Federal Register* are:

1. Scope of application of supervision requirements, and
2. Creation of a panel to determine proper levels of supervision.

There are some other changes including the definition of general supervision on the therapeutic (i.e., non-diagnostic) side. For a number of years there have been three level of physician supervision defined on the diagnostic side. These are:

1. General supervision,
2. Direct supervision, and
3. Personal supervision.

CMS is now taking these same three concepts and incorporating them into the supervision rules on the therapeutic side as well. General supervision means that a physician is contactable by telephone, FAX, interactive communication, etc. Direct supervision means that the physician is immediately available. For personal supervision, the physician must be in the room where the procedure or service is being provided. Care must be taken to distinguish when the supervision must be provided by a physician versus those situations in which a qualified practitioner can also meet the supervision requirements.

One slight difference between the diagnostic and therapeutic definitions occurs with direct physician supervision. On the MPFS side, for direct physician supervision the physician must be in the office suite or on the premises. With the recent changes in CMS's explanation of direct physician supervision on the OPPS side, the physician or qualified practitioner does not have to be on the hospital campus. However, even this is a little misleading because for an off-campus provider-based operation the physician, for direct physician supervision, would have to be in the facility, that is, on the premises of the off-campus location.

The physician supervision requirements generally arise from the fact that hospitals are paid for services incident-to those of a physician. See SSA 1861(s)(2)(B). CMS seems to have interpreted this as both a sufficient and necessary statement. Hospitals are paid for those services that are incident-to those of a physician. Also, hospitals are paid for all services that are incident-to those of a physician. For example, a physician might bring a nurse to the hospital and direct the services of the nurse. The physician can only bill for what the physician personally performs. The services of the

nurse are incident-to those of the physician and thus are paid to the hospital not to the physician.

There are other benefit categories. For instance radiation therapy (§1861(s)(4)) and ASC services (§1832(s)(2)(F)(i)) are examples. CMS discusses the expansion of the supervision requirements and concludes:

> "***Thus, we have long maintained that all hospital outpatient therapeutic services are, according to our policy, furnished "incident to" a physician's service even when described by benefit categories other than the specific "incident to" provision in section 1861(s)(2)(B) of the Act. Because hospital outpatient therapeutic services are furnished "incident to" a physician's professional service, we believe the conditions for payment, including the direct supervision standard, should apply to all hospital outpatient therapeutic services."*** (Page 858, CMS-1525-FC)

This statement, taken at face value, is alarming! What about physical therapy and occupational therapy. These services are under yet a different benefit category, namely §1861(s)(2)(D) and (p). Speech language pathology generally fits into this area as well. Here is a pertinent question and answer from the examination copy of the *Federal Register*.

> ***Comment: Several commenters requested that CMS clarify that certain services which are not paid under the OPPS are excluded from the requirements of § 410.27 and thus from our proposed clarification, especially physical therapy (PT), speech language pathology (SLP) and occupational therapy (OT); diabetes self management training (DSMT); medical nutrition therapy; end-stage renal disease (ESRD) services; and services paid under the MPFS or the Clinical Laboratory Fee Schedule (CLFS).***
>
> ***Response: The requirements of § 410.27 must be met for payment of the facility component of hospital outpatient therapeutic services. They do not apply to the professional component of the services or to services that are paid under other fee schedules such as the CLFS.*** (Page 860, CMS-1525-FC)

Thus, CMS appears to delimit the application of the supervision rules to those therapeutic services that are provided and paid under the OPPS. If the service is paid under a fee schedule, such as PT and OT, then the supervision rules do not apply, as such.

In addition to the overall applicability of the supervision requirements, CMS is undertaking what will probably be a long-term process of identifying different supervision levels for various services. This will be accomplished by establishing an advisory committee to address and make recommendations to CMS.

Based on the discussions from CMS, it will take some time to establish the committee, determine membership, and develop the way in which services and procedures will be categorized for different supervision levels. It is difficult to predict how quickly the committee can be developed and then actually generate meaningful results.

It appears that the already existing APC panel will be used, but the membership will be augmented with additional members representing CAHs and small rural hospitals at the least. Obviously, time will be needed to determine membership and organize the processes under which the committee will work.

While the work of this committee is geared up, hospitals must contend with the fact that the only one general category of services that is at the general supervision level is the non-surgical extended duration services. This includes observation services along with routine hydrations and infusions. However, there are certain services that for initiation of the service, physician supervision is required. Then once the patient is stable, only general supervision is required.

> **Case Study 1** – It is 8:00 p.m. and an elderly patient is not feeling well. The patient goes to an urgent care clinic and sees their primary care physician. The physician orders observation at the hospital, writes an order that includes starting an IV and providing an infusion of a mild antibiotic. The patient presents to the hospital observation unit and is assessed. The nurse starts an IV and provides the ordered antibiotic. The patient receives the infusion over a two hour period and is then discharged the next morning.

Physician supervision will be required when the nurse starts the IV. The other observation services appear to require only general supervision. The question becomes, how can the hospital establish direct physician supervision for the time period during which the IV is initiated?

Unless there is a physician or qualified practitioner that is immediately available, then physician supervision is not being provided. Generally, hospitals would defer to the Emergency Department for such supervision. However, at any given point in time the ER physicians and practitioners may not be immediately available. So where does this leave a hospital with these types of situations?

The basic answer to this question is that it leaves these hospitals in a severe quandary. To maintain physician supervision over extended periods when there *may be a service that briefly requires physician supervision* is not financially feasible.

In the coming years the committee that is currently being established may classify starting an IV as a service that requires only general supervision. For the time being, and going back to 2009, hospitals will need to cope with the supervision requirements as CMS has interpreted them currently.

Editor's Note: We will continue to follow the on-going saga of physician supervision. Note that CMS has indicated that for auditing purposes, hospitals are held harmless for the years prior to 2009.

DRG 3-Day Payment Window – Part 1

As anticipated, the final update to the MPFS (Medicare Physician Fee Schedule) did address some of the concerns for freestanding, physician clinics that are wholly owned or wholly operated by a hospital. This discussion appeared in the November 28, 2011 *Federal Register*.

The trigger for applying the 3-day payment window (also known as the DRG pre-admission window and/or the 72-hour rule) involves outpatient services provided at an entity that is either wholly owned or wholly operated by the admitting hospital. This certainly includes provider-based operations by definition, that is, to attain provider-based status the given operation must be wholly owned by the hospital along with other requirements (e.g., subordinate integral part and financial integration and medical records integration, etc.). With the recent changes with the 3-day payment window, CMS has realized that services provided in a freestanding, physician clinic need special attention under the rule.

The basic idea is that:

1. All diagnostic services provided in the clinic must be bundled into the inpatient billing, and
2. Also, any therapeutic services that are clinically related to the inpatient admission must be bundled. That is, the technical component part must be bundled as with provider-based clinics.

Because of the technical component charges being bundled into the inpatient billing, the physician services should be paid at the reduced, facility rate under MPFS. The freestanding, physician clinic files only a 1500 claim form. In provider-based clinics, the place-of-service (POS) would be '22' for 'Hospital, Outpatient'. This POS drives the reduction in payment, that is, the site-of-service (SOS) differential under MPFS.

Because for freestanding, physician clinics, only a 1500 claim form is filed, in order to invoke the SOS reduction, some other mechanism is necessary. CMS has chosen to use a modifier for this process. The new modifier is:

"-PD" – Inpatient admission within 3 days

Thus, when a diagnostic or related therapeutic service is provided at the wholly owned or operated freestanding, physician clinic, the "-PD" modifier is attached to the appropriate line items. This will cause a reduction in payment.

A little thought and you will realize that there are some significant, complicating factors. First of all, how will the clinic know that an individual treated at the clinic has been admitted to the hospital within the window? Such an event will have to be reported to the clinic so that the proper billing can take place. CMS is indicating that the burden of notification lies with the hospital.

Second, if the hospital is reporting certain charges from the clinic on the hospital UB-04 claims, then the associated costs will also have to be reported on the hospital's cost report. How is this going to occur?

Third, there can be an overlap of the global surgical package (GSP) with the MPFS and the application of the 3-day payment window. In some sense for inpatient surgical cases, the 3-Day Payment window is a form of a surgical package, pre-surgical services in this case.

Of these three issues, let us address the issue of hospitals being required to notify the wholly owned or wholly operating freestanding physician practice. Note that the requirement to use the "-PD" modifier does not go into effect until July 1, 2012. CMS is allowing some leeway for hospitals to prepare.

> ***"We believe that hospitals can assist their wholly owned or wholly operated entities in managing the unique aspects of billing for services subject to the payment window policy."*** (Page 669 CMS-1524-FC)
>
> ***"We expect hospitals and wholly owned or operated entities to ensure that claims submitted to Medicare for payment are in compliance with Medicare policy."*** (Page 671 CMS-1524-FC)

Case Study 2 – Sam, an elderly resident of Anywhere, USA, presents to the Acme Medical Clinic on Wednesday morning complaining of cough, congestion and a fever. The Acme Clinic is owned by Apex.

Tests are performed and Sam is given several prescriptions to address what appears to be a mild influenza. Sam goes home and does feel better until late Friday evening when concerned neighbors take him to the Apex Medical Center where he is admitted with pneumonia.

Case Study 2 provides a nice, straightforward application of the 3-day payment window. The services at Acme were provided within the three dates-of-service preceding the admission. The diagnostic services will be bundled into the inpatient billing. The related therapeutic service, which in this case is mainly the E/M level, must also be reported on the inpatient claim. This appears to mean that the hospital must generate a charge for the E/M level much as is done with provider-based clinics.

For Case Study 2 on the professional side, the 1500 will be filed using the "-PD" modifier. It appears that for services with a TC/PC[1] split, the physician payment will be only for the PC component. For services such as the E/M level where there is no split, as such, the site-of-service differential will be invoked for adjudicating the professional 1500 claim.

Note: For a hospital that has no provider-based clinics, but may have one or more of these freestanding physician clinics, this inpatient billing requirement is confusing. The hospital will have to develop charge structures for clinic services in case the 3-day payment window comes into play.

Case Study - 3 – Early on Tuesday morning an elderly gentleman presents to the Acme Medical Clinic. This clinic is owned by the Apex Medical Center, but files only a 1500 professional claim form. The patient has a cough, slight fever and nasal congestion. Laboratory tests are inconclusive and the physician prescribes a mild antibiotic, decongestant and expectorant. Late in the afternoon, the gentleman is feeling much better and is working on his porch when he takes a tumble. Unfortunately, he is injured and is taken by ambulance to the Apex Medical Center where he is admitted with a fractured hip.

In Case Study 3 all of the activities are on the same date of service. The services at the Acme Medical Clinic appear unrelated to the admission. However, because the services are on the same date of service as the date of admission, even the unrelated therapeutic services will need to be bundled into the inpatient billing, that is, the technical component part. Personnel who are responsible for determining if services are related or unrelated will need to fully understand this nuance.

One of the major concerns within the provider-based rule (PBR)[2] and with the discussions surrounding the 3-Day payment window is *terminology*. Terminology in this area can become quite confusing very quickly. Notice that in this article we are using the generic provider-based *operation*. For the 3-day payment window CMS is stating that applicability applies to 'wholly owned or wholly operated entities'. This means that not only are provided-based operations covered, but also other *entities* that are owned and operated by the hospital.

The use of the word *entity* in this context must be separated from the same word in the phrase *provider-based entity* which has a special meaning under the PBR.

One of the questions that arise is whether RHCs (Rural Health Clinics) and FQHCs (Federally Qualified Health Centers) are included in the definition of these entities. CMS addresses this question on page 661 of the examination copy of the MPFS Federal Register (CMS-1524-FC):

> ***"Although rural health clinics (RHCs) and federally qualified health centers (FQHCs) would be considered "entities," we are not applying the 3-day payment window policy to these entities."***

CMS discusses the reason for not including these entities, which basically consists of the fact that all of the services are bundled into an encounter. Separating out professional services for which there should be a reduction would become quite involved.

Note also that the information concerning ownership is reported to CMS through the enrollment process. For a freestanding physician clinic that is owned or operated by a hospital, the hospital's CMS-855-A would report this and the CMS-855-B for the clinic would also show this information. Anticipate that CMS may modify both of these forms to more overtly support this reporting requirement.

Editor's Note: In Part 2 of this article, the issues of the cost report, organizational ownership structuring, and the physician surgical package will be discussed.

Questions from Our Readers

Question: **At our hospital patients sometimes present to the ED, are triaged by an ER nurse but the patient leaves before being seen by an ER physician. Also, certain diagnostic tests may be performed**

[1] Note that the "PC" and "TC" being used are **acronyms only** and **NOT** as modifiers.

[2] See 42 CFR §413.65.

based upon approved standing orders. Can we bill out an E/M level, such as 99281, for these services?

This question arises at many hospitals. While there are some rather complex issues involved, the general answer to this question is that the hospital must establish a policy relative to coding and billing. As is often the case with policies, you can be conservative or aggressive or sometimes something in between.

The conservative stance would be to bill for nothing. That is, no E/M level and no billing for the diagnostic tests. On the other hand you may decide that resources are consumed so that the services should be billed such that an E/M level along with the tests are billed. Or, you could decide to bill only for the tests and not bill the E/M level.

The complicating factor in this case involves the fact that the Medicare program pays hospitals for services that are incident-to those of a physician or qualified practitioner. In the question above, there have been no physician services. Thus, there cannot be any services that meet the incident-to requirement. Because the services are not incident-to those of a physician, these services are not payable.

Note that the real issue here is between *payment* and *billing*. Theoretically, you can bill for these services. Then Medicare should properly adjudicate the claim and make (or not make) payment accordingly. As a practical matter, if the claim is filed, most likely it will be paid. However an auditor at a later date might review the case and determine that the hospital was inappropriately paid and then recoup the payment.

This question has been presented to CMS. For example, see the November 24, 2010 Federal Register on page 71987 (75 FR 71987). While the question is specifically stated relative to the ED, CMS's response is more general and does not appear to specifically address the payment only for incident-to services.

> "***Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services furnished must be medically necessary and documented***." (75 FR 71987)

Bottom-Line: Billing the E/M is a policy decision. Assess the risks, establish your policies and proceed accordingly.

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 December 6th . ***"APC/OPPS Update for 2012"*** 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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****** 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: 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: Duane@aaciweb.com