Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

October, 2008 – Volume 20, Number 10

ISSN: 1061-0936

APC/APG Update

We are all on standby awaiting CMS's release of the final *Federal Register* entry for the changes to APCS for 2009. Whether there will be any significant surprises or just a continuation of increased bundling and highly variable payments is yet to be determined. Be certain to set aside a little time to review the FR entry.

CY2009 CPT/HCPCS – Part 1

The 2009 CPT manual is already out. Often we have to wait until late November or early December to see all the changes and new codes. Note that the AMA did not change the color scheme. So we will all have to carefully distinguish between the 2007, 2008 and now 2009 manuals.

While there are many changes, there is one surprising change involving hydration, infusions, injections and chemotherapy. The AMA has decided to renumber all of the hydration, infusion and injection codes. Also, these codes will now appear just before the chemotherapy section. This placement is quite logical relative to the relationship between all of these codes.

This does appear to be primarily a renumbering exercise. The descriptions do not appear to have changed. This means that chargemaster coordinators will have to spend considerable time adjusting the chargemaster.

Of greatest importance is that the coding guidelines preceding the hydration, injections/infusion and chemotherapy sections have all been revised. While the coding logic does not appear to be changed, all coding, billing and service area staff involved with these services will need to carefully read and re-read these new guidelines. Literally, this means taking the 2008 and 2009 manuals, laying them side-by-side and comparing each of the statements.

For 2009, CPT is very clear in distinguishing between physician coding and hospital or facility coding in this area. Here is the instruction for physicians:

> ***"When these codes are reported by the physician, the "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur."***

For the facility side we have:

> ***"When these codes are reported* by the facility*, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections."***

The use of the hierarchical approach was present in the 2008 CPT manual, but the new additional language for physicians makes very explicit that we are to distinguish between physician and facility coding.. The hierarchical approach does create some unusual coding sequences , but at least we know how we are supposed to code.

Distinguishing between physician and facility coding really goes to the type of *encounters* involved in the different settings. In the physician, freestanding (i.e., non-facility) setting, encounters are generally very brief. An injection or infusion is provided, and the patient leaves. Even for freestanding chemotherapy or infusion centers, the encounters are delimited and generally involve very specific services.

In the facility setting, such as a hospital, the encounter can be much longer. For observation services in which a wide variety of injection and infusions can be provided, the encounter may span several dates of service.

Editor's Note: The fact that the AMA through the CPT manual is differentiating between physician and facility

coding is of note. While there is no difference in coding with most surgical and medical procedures, in areas such as injections and infusions there can be differences. Perhaps the AMA will continue this process and extend different guidance in the E/M area for hospitals and the facility setting.

The FY2009 OIG Work Plan Is Out! – Part 1

The new FY2009 OIG Work Plan is out and longer than ever. We will discuss selected topics from the new work plan. Of particular interest are issues that seem to carry over from year to year.

Provider-Based Status for Inpatient and Outpatient Facilities and **Ownership of Physician Practices** – These two related issues are new for FY2009. The OIG is concerned about CMS granting provider-based designation to hospital inpatient and outpatient services. Potentially, there are increased payments available through several different sources. The main increase comes from provider-based clinics.

The OIG seems to view provider-based status as a designation that is affirmatively granted by CMS. We usually see the word 'designation' for Sole Community Hospitals or Critical Access Hospitals where there is a very formal process to apply for and gain the specific designation. When CMS developed the provider-based rule (PBR), the rule became much more of a voluntary reporting situation.

While there are attestation processes and a hospital can formally request a determination, in many cases, particularly for in-hospital operations, there is often no reporting to CMS through the Fiscal Intermediary and/or the Regional Office. Note that the OIG recognizes that the PBR applies to both inpatient and outpatient situations. It will be interesting to see what the OIG thinks about this rather lax process.

The ownership of physician practices is closely related. In the Q&A section of this Newsletter, the question of when a clinic is freestanding versus being provider-based is raised. If a clinic is owned and operated by a hospital and all the PBR criteria are met, does the clinic have to be treated as provider-based?

The answer to this question has not been clearly enunciated by CMS. It appears that if the hospital does not treat the clinic as provider-based, then the clinic is freestanding, and the full RBRVS payment under the Medicare Physician Fee Schedule can be made by filing only the 1500 claim. The phrase 'not treating the clinic as provider-based' means that the clinic operation is not on the hospital's cost report. The mere fact that it is not on the hospital's cost report means that one of the PBR criteria is not met.

Medicare As Secondary Payer - MSP is an ongoing issue. The simple fact is that Medicare expends significant amounts that should be paid by other insurance and/or through liability claims. Hospitals and clinics must constantly review systems to make certain that all appropriate information is being gathered.

If any sort of accident is involved, such as identified by an ICD-9-CM External Cause Code (E-Code), then the additional information of who, when, where and how must be carefully investigated. For Medicare beneficiaries, many accident occur in the home, but there are also many accidents at neighbors, relatives, shopping and the like. Make certain that you have proper systems in place to capture the critical information and properly bill Medicare as secondary or sometimes tertiary.

Critical Access Hospitals – CAHs appear to be an on-going concern for the OIG. Besides general payment concern through the cost-reporting process, the OIG also has an issue relative to payment through the Part C, Medicare Advantage program.

For Medicare Advantage Organizations, the same 101% payment of costs is in place, and the OIG was to be assured that proper payments are being made.

Diagnostic X-Rays in the ED – This issue seems to reincarnate itself every year. The general issue is over utilization of diagnostic testing in the Emergency Department. This is a medical necessity issue. The OIG has long maintained that there is entirely too much diagnostic testing. This is an issue that may become a RAC audit issue as well.

Note that this issue relates back to medical necessity and is thus subjective in nature.

EMTALA – The Emergency Medical Treatment and Labor Act seems to come up every few years. While EMTALA is a conceptually straightforward law (encounter individual, perform medical screening examination, take care of patient or transfer), in practice there are enormous complexities. Additionally, CMS continues to refine guidance, and there is active litigation over various issues.

In this case, the OIG will be examining CMS's oversight of the EMTALA requirements. From page 7 of the Work Plan:

A previous OIG review raised concerns about CMS's EMTALA oversight, specifically regarding long delays to investigate complaints and

inadequate feedback provided to hospitals on alleged violations. We will identify any variation among regions in the number of EMTALA complaints and cases referred to States, examine CMS's methods for tracking complaints and cases, and determine whether required peer reviews have been conducted prior to CMS's making a determination about whether to terminate noncompliant providers from the Medicare program.

Coding and Documentation for MS-DRGs – Well, DRGs was off the OIG's radar screen for only about a year. Now the OIG wants to take a look at the new system. Fundamentally, the OIG is addressing the very same issue that all inpatient auditors are addressing, namely, which combinations of MS-DRGs are candidates for possible upcoding and thus abuse. From page 8 of the Work Plan:

"We will examine coding trends and patterns under the new system and determine whether specific MS-DRGs are vulnerable to potential upcoding."

Physician Place of Service Coding – While this issue is in the physician section of the OIG's Work Plan, this issue relates back to the hospital issue of provider-based status. When a physician performs services in a facility setting (i.e., a provider-based setting), then, under RBRVS, there is a reduction in payment. Because the physician is not incurring overhead costs (the facility is providing the overhead), there is a site-of-service reduction.

The physician must accurately report the correct place-of-service or POS. For provider-based clinics the burden of assuring that physicians code the correct POS falls to the hospital.[1] This is true even if the hospital has nothing to do with the physician claim.

Be certain to be familiar with the POS codes. Particularly, be careful to understand which codes are facility based and which codes are for freestanding operations.

Compliance Guidance from the OIG

On September 30, 2008 the OIG issued another *Federal Register* entry addressing supplemental compliance program development or what the OIG calls CPG. This is an update to the March 16, 2000 *Federal Register*.

[1] See the April 7, 2000 *Federal Register*, page 18519 (65 FR 18519).

While this is a relatively short entry, only 17 pages, there are 139 footnotes! Yes, that is a little more than 8 footnotes per page

This CPG includes both SNFs (Skilled Nursing Facilities) and NFs (Nursing Facilities). Both Part A and Part B coverage can occur depending upon circumstances. As with most Medicare payment systems, there is a complex prospective payment process including:

- RUGs – Resource Utilization Groups, Version III,
- MDS – Minimum Data Set,
- RAI – Resident Assessment Instrument, and
- Consolidated Billing.

Consolidated billing includes a number of Part B services such as physical therapy, occupational therapy, speech therapy, braces and orthotics. The basic idea is that because SNF reimbursement is through Part A, virtually everything is bundled.

Even without going into detail, the nursing facility payment process under Medicare generates numerous areas in which mistakes can be made let alone overtly perpetrating fraud. Thus, any healthcare facility that is involved in nursing facility care should read this FR entry, including the footnotes, with care. This includes hospitals and other types of healthcare providers that contract with a SNF to provide services under the Consolidated Billing concept.

Note: A major RAC audit issue is the medical necessity of the 3-day hospital inpatient qualifying stay prior to SNF services. A RAC auditor might claim that a 3-day stay was not medically necessary and that only 2 days was needed. Thus, the hospital may have been overpaid as well as the SNF.

ICD-9-CM for FY2009

There are an unusually large number of new and/or changed ICD-9-CM codes for FY2009. Here are the numbers:

	Diagnosis Codes	Procedure Codes
New	373	60
Revised	70	34
Deleted	26	3

Some of the major categories addressed include:

- Secondary Diabetes Mellitus
- Headaches and Migraines
- Pressure Ulcer Stages
- Laparscopic Surgeries
- Repair Spontaneous Laceration During Delivery

While these new codes are certainly welcomed, there will be a learning curve to become accustomed to the new codes and also to experiment with any impacts on MS-DRGs.

Also, keep watch on ICD-10 and/or ICD-11. We may finally be moving closer to possible implementation.

Medicare Odds & Ends

Medically Unlikely Edits – In a Press Release dated October 1, 2008, CMS has indicated that *most* of the MUEs will be published. You can find the edits out at the NCCI web site:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/

Just click on the MUE menu item. The MUEs have created a number of questions. What CMS means by the word 'most' is not explained.

Medicare Premiums and Deductibles – Part B premiums will stay at $96.40 for CY2009. This is rather surprising because the premium rate typically goes up each year. Likewise, the Part B deductible is staying at $135.00. The Part A deductible is going up by $44.00 to $1.068.00. Keep in mind that the Part A deductible is the limit on the APC (i.e., Part B OPPS) copayment amount. Yes, this may seem a little strange, but this was determined directly by Congress.

Questions from Our Readers

Question: At our hospital we have two provider-based clinics located inside the hospital itself. The physicians and staff at the clinics are all employed by the hospital. We are having great difficulty being competitive with freestanding clinics in our community. Thus, we are filing only a 1500 claim. While we indicate a POS of 22 on the 1500 claims, we are not filing a UB-04 at all. Is this correct? Is this the way we should be doing the billing?

This question has some very significant subtleties. Fundamentally, a hospital (main provider) must treat a clinic as provider-based and must meet all the criteria for being provider-based found at 42 CFR §413.65. If the hospital does not treat the clinic as provider-based and/or does not meet all the criteria, then the clinic is not provider-based, but is classified as freestanding.[2]

Even though a clinic is inside the hospital, the clinic can still be organized as freestanding. As a freestanding clinic, only the 1500 claims form is filed, and the place of service (POS) will be 11, office. The full RBRVS payment will be received by the clinic for professional services.

Now the hospital must treat the clinic as freestanding. In other words such a clinic operation would not be on the cost report of the hospital. Typically, there would be some sort of internal accounting arrangement whereby the clinic paid rent for space, staff, supplies, equipment and the like. Also, the NPIs (National Provider Identifiers) and TINs (Tax Identification Numbers) would have to be appropriately arranged.

An unanswered question under the provider-based rule concerns the situation in which a clinic meets all the provider-based criteria does the clinic have to be classified as provider-based? The answer seems to be 'no'. While all the criteria may be met, if the hospital does not treat the clinic as provider-based (e.g., cost report, rent, etc.), then the clinic is still freestanding.

Note: The provider-based rule is particularly difficult to understand because when CMS formalized this rule starting in 2000, we thought that provider-based status would have to be affirmatively sought and approval for the designation granted from CMS. In the end, being provider-based involves meeting the criteria. For some situations, filing an attestation that the hospital is meeting the criteria or even possibly requesting a formal determination is appropriate. Otherwise, as long as the criteria for being provider-based are met, then a hospital can treat the given situation as provider-based.

For this specific question, the hospital would, most likely, be better off to treat the clinic as freestanding and file only a 1500 claim form. This would be a hospital owned physician practice. Note that the DRG Pre-Admission Window would apply because the trigger for the pre-admission window is wholly owned or operated by the hospital. The freestanding clinic would meet this trigger.

Question: If an observation patient receives diagnostic and/or therapeutic services, are we supposed to deduct the time for these services from the total number of hours reported?

Observation patients generally receive diagnostic services and often therapeutic services as well. The recently revised language at Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.2.2 is:

"Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of

[2] See CMS Transmittal 87 to Publication 100-02, Medicare Benefit Policy Manual. This Transmittal has been rescinded, but it provides some insight into how CMS is approaching the issue of classifying clinics.

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 service HCPCS code G0378 (Hospital observation service, per hour)."

This guidance raises a very real question as to what should or should not be counted. Consider the following case study:

> Case Study – An elderly patient is admitted to an observation bed overnight stay at 8:00 p.m. Infusion therapy of an antibiotic is provided at the bed for a two hour period from 9:00 p.m. to 11:00 p.m. The patient is discharged the next morning at 11:00 a.m.

The total number of hours the patient is in the observation bed is 8:00 p.m. to 11:00 a.m., a total of 15 hours. Now the question becomes should we subtract the 2 hours for the infusion therapy and report 13 hours?

CMS's guidance is not completely precise. Note that in this case study, the patient never left the bed. While we could also discuss whether the infusion therapy meets the *active monitoring* criterion, we still need to have some precise operational procedures to correctly capture the time the patient is in observation.

One approach is to use CMS's proclivity toward defining observation services as a 'bed'. If the patient does not leave the observation bed, then all the hours should be counted. However, if the patient is taken from the bed to go to a treatment room for a procedure, then the observation time should be appropriately reduced.

What is really needed is a specific definition of what an *interrupted* observation stay means. Otherwise some sort of interpretation necessitating a written policy and procedure will be needed. The discussion above does seem to be supported by the language in the Medicare Claims Processing Manual.

Note: This is almost purely a compliance issues with almost no payment overtones. The only time that payment would be affected is if the patient were in observation for 9 hours and two of those hours should not have been counted. This would reduce the number to 7 hours and this would not qualify for separate payment because the 8 hour threshold was not reached.

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:
http://www.aaciweb.com/July2008June2009EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2008 Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information. Workshop planning information can be obtained from our password protected website.

A variety of Webinars and Teleconferences are being sponsored by different organizations. Instruct-Online, AHC Media, LLC, Accuro Health, Progressive Business, and the Eli Research Group are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008 and CY2009.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2008. Contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for November 4th, "***The Emergency Department and EMTALA Complaince***". The presentation will run from 9:30 a.m. to 11:00 a.m. EDST.

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 has completed his ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro.

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**
- **Chargemaster Coordinator's Handbook** is currently in preparation.

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

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FOR UPCOMING ISSUES

More on Coding, Billing Compliance
More on Payment System Interfaces
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More on the CY2009 APC Update

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

Compliance Reviews are being scheduled for hospitals and associated medical staff concerning the various areas of compliance audits and inquiries. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement.

Interventional Radiology, Catheterization Laboratory and Vascular Laboratory a Challenge? Special studies are being provided to assist hospitals in coding, billing and establishing the Charge master. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about preparing for the RAC audits? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.