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

We are in a standby period for both APCs and RBRVS. In theory there will be final Federal Register entries for each payment system on or about November 1st.

Stand-by!

More on Devices & Implantable DME

CMS is moving ahead with changes to the cost report particularly relative to devices and implantable DME. CMS is changing the cost report so that there is one CCR (Cost-to-Charge Ratio) for supplies charged to patients and another for Implantable Devices Charged to Patients. This latter category is to include:

- 0275 - Pacemaker
- 0276 - Intraocular lens
- 0278 - Other implants
- 0624 – FDA investigational devices

The major point of concern has been the other implants category and what, exactly, is or is not included in this category. CMS has proposed using a definition using time as a criterion, that is, if the implants stay in the patient. This approach has created some significant discussions.

CMS has indicated that we should turn to the NUBC definition of an implant. This definition has its own concerns. Here is the definition:

> ***"That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in area traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes."***

This definition is fairly liberal. For instance, within this definition we can consider:

- Permanent Devices
- Minimally Invasive Devices
- Wound Glues
- Cutting Tools
- Endoscopic Alternatives

Chargemaster coordinators along with cost reporting personnel will need to carefully review all items going into revenue code 0278. Because a number of private third-party payers pay more for revenue code 0278 items, many hospitals have already moved as many items as possible into the other implants category.

Note that it will take three years for this cost reporting change to take effect. Thus, charge compression will be around for several years and may not totally be resolved even years down the road. For instance, CMS realizes that charge compression also occurs with pharmaceutical items, and although discussed, no definitive action has been taken in this area.

To review some of the discussions in this area, see the minutes from the August 11-12, 2009 meeting which can found at:

www.nubc.org/public/pubagenda/aug09TENTagenda.pdf

OIG Work Plan for FY2010 – Part 1

The OIG has released the FY2010 Work Plan. This report is longer than ever! There are more topics, and now they are even including concerns about reviewing the RAC program. Compliance personnel from all types of healthcare providers should carefully read and study this report. Note that for each of these topics there will be audits and eventually reports issued. (See related article concerning several recent reports.)

Part A Hospital Capital Payments - The OIG will review Medicare inpatient capital payments and

determine whether the capital payments are appropriate and analyze the appropriateness of the payment level. The OIG basically thinks that there should be no capital payments, and CMS seems to be coming around to this stance as well. This comes at a time when it would be appropriate to have capital payments for APCs.

Provider-Based Status of Inpatient and Outpatient Facilities - The OIG will review cost reports of hospitals' claiming provider-based status for inpatient and outpatient facilities. The OIG will determine the appropriateness of the provider-based designation and the potential impact on Medicare and its beneficiaries of hospitals improperly claiming such provider-based status. This is really the first time that the OIG has addressed the overall provider-based rule. While the OIG opposes any sort of payment differences based on site of service, hospitals should carefully review their compliance with the Provider-Based Rule (PBR).

Part A Inpatient Prospective Payment System Wage Indexes - The OIG will review hospital and Medicare controls over the accuracy of the hospital wage index data used to calculate wage indexes for the inpatient prospective payment system (IPPS). The OIG will determine the effect on Medicare of incorrect diagnosis-related group (DRG) reimbursement caused by inaccurate wage data. The OIG will also examine the appropriateness of using hospital wage indexes for other provider types. CMS has been expending considerable resources in analyzing and adjusting the wage index.

Hospital Payments for Nonphysician Outpatient Services Under IPPS - The OIG will review the appropriateness of payment for nonphysician outpatient services that were provided shortly before or during Medicare Part A covered stays at acute care hospitals. By any other name, this is the DRG Pre-Admission Window although CMS seems to be extending this to include outpatient services during the hospital stay.

Medicare Secondary Payer - The OIG will assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage including procedures for identifying and resolving credit balance situations. This is an on-going issue and is even being addressed under the Medicare RAC program.

Reliability of Hospital Reported Quality Measure Data - The OIG will review hospitals' controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement and determine whether there are sufficient controls to ensure quality measurement data is valid. This issue is being raised at a time when CMS is requiring significantly more information relative to quality.

Hospital Admissions With Conditions Coded Present-On-Admission - The OIG will review Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being present-on-admission (POA) and determine which of the diagnoses were most frequently coded as POA. The OIG will also determine which types of facilities are most frequently transferring patients with a POA diagnosis specified by CMS to hospitals and whether specific providers transferred a high number of patients to hospitals with POA diagnoses. As expected the OIG is going to take a look at the POA coding, but there is a twist in this issue. The issue seems to address the frequency of POA data and the specific providers or provider types generating POA conditions.

Hospital Readmissions - The OIG will review Medicare claims to determine trends in the number of hospital readmission cases. Based on prior OIG work, CMS implemented an edit in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. The OIG will test the effectiveness of the edit. The OIG will also determine the extent of oversight of readmission cases. This is an on-going issue. This situation may well be reviewed by the RACs as well.

Transmittal 574 – OIG Reports

On October 9, 2009, CMS issued Transmittal 574, a one-time notification to Publication 100-20. This transmittal instructs the Medicare Administrative Contractors to note and take appropriate action relative to four reports recently issued by the OIG.

Medicare Part B Chemotherapy Administration: Payment and Policy (OEI-09-08-00190)
http://oig.hhs.gov/oei/reports/oei-09-08-00190.pdf
Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services (OEI-09-06-00430)
http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf
Inappropriate Medicare Payments for Chiropractic Services (OEI-07-07-00390)
http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf
Medicare Part B Billing for Ultrasound (OEI-01-08-00100)
http://oig.hhs.gov/oei/reports/oei-01-08-00100.pdf

Coding and billing compliance personnel should download and review these reports in order to determine if any of the situations found by the OIG exist within their healthcare provider organizations. Appropriate action should be taken.

While issues such as chemotherapy administration, chiropractic services and unnecessary ultrasound services are fairly typical compliance concerns, the issue of unqualified personnel providing services incident-to physician services is unusual. Typically, in a physician office setting,[1] as long as the physician is directly supervising an individual there are few requirements demanded of the individual actually performing the services. In a facility setting, this situation changes because the incident-to services are being paid to the facility, typically a hospital, so that the individuals performing services will come under greater scrutiny.

Updated Appeal Thresholds for 2010

CMS has issued the updated thresholds for Medicare appeals. This appeared in the September 25, 2009 *Federal Register* page

The AIC threshold amount for ALJ hearing requests will rise to $130 and the AIC threshold amount for judicial review will rise to $1,260 for the 2010 calendar year. These new amounts are based on the 26.3 percent increase in the medical care component of the CPI from July of 2003 to July of 2009.

RAC Update

Be certain to check the FAQ out at the CMS web site. Activity continues with the RACs as healthcare providers have operational questions. Also, note the following from Transmittal 303, September 25, 2009, to the Program Integrity Manual.

In rare and unusual circumstances during complex medical review, ACs, MACs, CERT, and RACs have the authority to make single claims exceptions of an LCD. For ACs and MACs exceptions can be applied during all complex reviews including redetermination. This exception authority applies only to clinical criteria, and cannot be applied to override missing or insufficient documentation. Only the CMD has the authority to apply an exception. ACs, MACs, and CERT can use the exceptions process to approve or deny a claim. Unless otherwise directed by CMS, RACs can only use the exceptions process to not deny a claim ACs, MACs, CERT, and RACs shall not make exceptions to NCDs, CMS manuals, or MAC articles.

The ACs, MACs, CERT, and RACs shall exercise their exception authority only after a thorough review of the patient's medical record and a comprehensive analysis of the evidence in the medical literature. The reviewer shall document the specific claim and detail the rationale for the exception in a log maintained at the contractor. Relevant citations to the evidence based literature shall be included in the log. The AC and MAC exception logs shall be accessible to the AC and MAC appeal units. In addition, this log shall be available to CERT, RACs, and CMS upon request.

One of the major issues, particularly for complex reviews, is how to judge issues such as medical necessity. The LCDs are a tool that can help providers as well as the Medicare program as long as they are properly written and the language is clear. As the RACs conduct their reviews, the way in which they interpret the LCDs may vary from provider interpretation. This Transmittal provides operational guidance in what will probably become contested territory.

MedPAC Publications

MedPAC or the Medicare Payment Advisory Commissions generally is viewed as a body that makes suggestions for changes to the various Medicare payment systems. However, MedPAC also publishes some fairly nice summaries for what are becoming a large number of different payment systems under the Medicare program.

- **Oxygen and oxygen equipment payment system**
- **Skilled nursing facility services payment system**
- **Physician services payment system**
- **Psychiatric hospital services payment system**
- **Rehabilitation facilities (inpatient) payment system**
- **Part D payment system**
- **Outpatient therapy services payment system**
- **Medicare Advantage program payment system**
- **Outpatient dialysis services payment system**
- **Outpatient hospital services payment system**
- **Home health care services payment system**
- **Hospice services payment system**
- **Hospital acute inpatient services payment system**
- **Long-term care hospitals payment system**
- **Clinical laboratory services payment system**
- **Critical access hospitals payment system**
- **Durable medical equipment payment system**
- **Ambulatory surgical centers payment system**

[1] This is basically a freestanding facility versus a provider-based facility.

While these publications are not intended to give detailed, explicit guidance for coding and billing, if you need to have a nice synopsis of a particular Medicare payment system with which you are not familiar, then these publications can be useful.

You can download them from:

http://www.medpac.gov/payment_basics.cfm

Most these have been updated as of October 14, 2009.

Medicare Odds & Ends

Here is some miscellaneous information concerning the Medicare program.

- Transmittal 160 – Effective October 21, 2009 - Interest Rate – Overpayments/Underpayments 11.250% → 10.875%
- Deductible Changes for 2010 - Inpatient - $1,100.00 – Outpatient $155.00
- Upcoming Open Door Forums –
    - Physicians, Nurses & Allied Health Professionals Open Door Forum at 2:00 p.m. (ET) on November 17, 2009.
    - Hospital & Hospital Quality Open Door Forum at 2:00 p.m. (ET) on November 19, 2009.
- CMS Publication – October 2009 **-** ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians and Other Health Care Professionals***

Questions from Our Readers

Editor's Note: Questions from our readers arrive almost every day. Questions, comments and suggestions are always welcome. Selected questions are addressed here in the Newsletter.

Question: What revenue codes do we use for procedures that are done on ICU or Medical-Surgical units for Observation patients? Examples would be Temporary Pace Maker, CPT=33210, G-Tube Placement CPT=43760, or Tracheotomy, CPT=31603. When choosing Revenue Codes, how do we decide which is the best? Do we use 361 for minor surgery, or cardiology revenue codes for the pace maker and gastro revenue codes for the G-Tube placement? We try to verify it with the UB Editor, but not sure how they relate to the cost center in which the procedure is performed. Is 0361 only used in the OR setting? Is 0490 appropriate in these settings?

The approach you decide to take in this area is mainly a matter of personal preference as long as the charges are correctly associated with the proper cost centers. This latter concern must be addressed jointly by the Chargemaster Coordinator and the cost reporting personnel.

One approach to this question is to separate procedures that are actually performed at the observation bed versus those that are performed by taking the patient to the service area. If you have minor surgical procedures performed while the patient is in the observation bed, then the associated CPT codes can be used with the 0762, observation revenue code. This may seem a little strange. So if you decide to take this approach, check to make certain it does not violate any edits.

Note that for Medicare, if the patient is in a separately payable observation stay, performing a minor surgical procedure will negate the observation payment. If you provide any Status Indicator "T" service during the observation stay, then the APC grouper will bundle the observation payment into the payment for the surgical procedure.

For minor procedures provided in a different setting, that is, by removing the patient from their observation bed, then the revenue code to assign will depend upon the location of services. If the patient is taken to the GI Laboratory, then a GI Laboratory revenue code will be used. If the patient it taken to an operating room, then 0361 would be appropriate or 0761 for a special procedure room. Generally 0490 is used when you cannot get any other revenue code to work.

Again there are some concerns with this approach. When you take the patient away from their observation bed, then you are supposed to stop counting the hours for observation. Also, you may encounter significant charge capture issues if patients are being moved around to perform procedures.

The bottom-line is that developing a comprehensive policy and procedure in this area is not at all a trivial task. You will need to think things through carefully and also check for any claims editing and adjudication issues.

Be prepared for unusual twists in areas like this. For instance, a patient in observation may be taken to the recovery area for a cardioversion. There will be no surgery charge because the service was not in surgery as such. There may be a recovery charge with Revenue Code 0710, but can you code the cardioversion with the 0710? Note that while this is unusual, physicians tend to provide services based upon patient needs, not on the difficulties that occur with properly billing for the services.

ESRD - Yet Another New Medicare PPS

In the September 29, 2009 *Federal Register*, CMS is proposing a new prospective payment system for End-Stage Renal Disease facilities. You will have until November 16, 2009 to make your comments.

This will be a case-mix adjusted payment system that is scheduled to start on January 1, 2011. As with other PPSs, there will be adjustments for various comorbidities and special conditions. The estimated payment per session is $198.64.

The GAO Proposes Increasing Multiple Procedure Discounting

The GAO (Government Accountability Office) has issued the following report:

Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together

While this report is issued in the context of physician payments, the same concepts would be easily transferred to the hospital outpatient side under APCs.

The basic thrust of the report is that the Medicare program could save significant sums of money by increasing procedure discounting and/or increasing the amount of the discounting. Currently, for both MPFS (Medicare Physician Fee Schedule) and APCs (Ambulatory Payment Classifications) the first procedure is paid at 100% with the second and subsequent procedures paid at 50%.

On a formulaic basis, it would not be difficult to adjust the discounting to something like:

100% - 50% - 25% - 25% - 0%

While this has been discussed over the years, at least on the physician side, it is interesting that it is the GAO that is promoting the study and consideration of this type of change. Given the current rush for some sort of healthcare reform that needs to include significant savings, this change in the formula may merit much closer attention.

We have seen this same concept slowly work its way through certain radiology services for multiple imaging when related body areas are addressed.

You can download the report at:

www.gao.gov/new.items/d09647.pdf

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 November 10th "***Radiology and APCs***" 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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FOR UPCOMING ISSUES

****** 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: Chris@aaciweb.com.