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

Watch for the OPPS update *Federal Register*. This should be out, at least in examination copy, around November 1, 2010. The MPFS (Medicare Physician Fee Schedule) update should also be out at about the same time. For hospital personnel, yes, you should also look at the physician information. Also, watch carefully for the final changes involving physician supervision under the Provider-Based Rule (PBR). This should be in the OPPS update *Federal Register*.

The CPT manual for CY2011 is also out. Coding staff along with Chargemaster Coordinators should be reviewing the new codes and updating the billing system as appropriate. Of course, we will need the OPPS update *Federal Register* to see how these new and revised codes will be treated by APCs. While the overall number of changes is not that great, there are several areas of significant concern. These include:

- Complete revision of the coronary catheterization codes, and
- Complete revision of the therapeutic vascular catheterization codes (e.g., angioplasties, atherectomies and stent placements).

These new code sets and other CPT/HCPCS changes will be discussed in coming newsletters.

FY2011 OIG Work Plan - Overview

The OIG's Work Plan for FY2011 is now available. Anyone involved with compliance should download this document for careful review.

See: www.hhs.oig.gov. The 2011 version of the work plan is longer and more detailed than ever! Clearly, the OIG's activities are expanding, particularly in the coding, billing and reimbursement area for both Medicare and Medicaid. While some issues have carried over from past years (e.g., diagnostic testing in the ED), there are quite a few new issues and/or areas of investigation including addressing the provider-based rule.

Here is a brief listing of some pertinent issues.

- Provider-Based Status for Inpatient and Outpatient Facilities
- Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System
- Noninpatient Prospective Payment System Hospital Payments for Nonphysician Outpatient Services
- Medicare Secondary Payer/Other Insurance Coverage
- Hospital Readmissions
- Payments for Diagnostic Radiology Services in Hospital Emergency Departments
- Hospital Reporting for Adverse Events
- Hospitals'• Compliance With Medicare Conditions of Participation for Intensity• Modulated and Image Guided Radiation Therapy Services
- Observation Services During Outpatient Visits
- Place-of-Service Errors
- Coding of Evaluation and Management Services
- Payments for Evaluation and Management Services
- Appropriateness of Medicare Payments for Polysomnography
- Medicare Payments for Sleep Testing
- Medicare Payments for Claims Deemed Not Reasonable and Necessary
- Medicare Billings With Modifier GY

Hospital personnel should expand their review to physician issues. Conversely, physician compliance personnel study the hospital issues.

Some of these issues have been on the OIG's Work Plan for years. Consider:

- Hospital Readmissions, and
- Radiology Services in the ED.

Hospitals should have mechanisms in place to catch readmissions either on the same date of service or on subsequent dates of service. Due consideration can then be given to whether the claims should be combined

or separate claims filed because of different reasons for the admissions. Also, hospitals may be violating readmissions in that they should be a transfer from one hospital to another. Monitoring the fact that a patient is discharged from your hospital and then admitted to a different hospital can be difficult. You may have no knowledge that there was such an admission.

Excessive diagnostic testing has been on the OIG's agenda for years. While this issue may be stated differently from time-to-time, the OIG considers excessive diagnostic testing, particularly in the ED, as a major issue.

Bottom-Line: Hospital, clinic and physician compliance personnel should take the time to carefully review each and every issue in the OIG's Work Plan. Read through all of the issues even if they do not directly apply to your type of healthcare provider. Additionally, correlate the current issues with issues over the past several years.

Physician Supervision - Congressional Action??

H.R. 6376 is a proposed bill that has been introduced into Congress. The rather long description is:

> *To amend title XVIII of the Social Security Act with respect to physician supervision of therapeutic hospital outpatient services.*

The whole issue of physician supervision has taken on a life of its own starting in 2008 when CMS started clarifying the regulations relative to physician supervision of both therapeutic and diagnostic services under the Provider-Based Rule (PBR). Physician supervision of diagnostic services did not change materially. However, for therapeutic services, the supervision requirements have changed[1] dramatically.

CMS has maintained that hospitals misinterpreted the guidance provided in the April 7, 2000 *Federal Register*. With the clarifying guidance provided in CY2008-CY2010, this whole issue places hospitals in a precarious position at least for the time period CY2001 on through the present day.

While the changes from CMS are subtle, the burden of establishing proper physician or practitioner supervision has definitely been moved to the hospital. The main area of impact is for on-campus provider-based clinics, although the way the language is provided, there can also be concerns on the inpatient side inside the hospital.

H.R. 6376 is a bill that would revise the SSA to more fully delineate physician supervision of therapeutic services. The concept of *general supervision* is borrowed from the diagnostic side and applied to therapeutic services. This means that most therapeutic services would require only general supervision (i.e., physician/practitioner contactable) except for those that are specifically designated through a determination process. The determination process, according to the proposed bill, would involve the development of a panel of physicians who would then determine services that do require direct physician supervision.

This bill also has a hold harmless provision so that hospitals and CAHs would be protected during the period CY2001 through CY2011. In other words, CMS and/or auditors such as the RACs would not be allowed to claim possible civil or criminal claims for recoupment due to lack of direct physician supervision. Given the language contained in the April 7, 2000 *Federal Register* relative to direct physician supervision being required only for off-campus clinics, such hold harmless language is quite appropriate.

Editor's Note: What, if anything, will happen relative to H.R. 6376 is not known. However, this type of specification is helpful even though it increases the bureaucratic overhead.

Predictive Modeling Requirements Small Business Jobs Act

2010 has been a very busy year for Congress relative to Medicare/Medicaid fraud, abuse and recoupment activities. One of the latest developments is from the Small Business Jobs Act of 2010, namely, Section 4241, entitled:

> **Use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse in the Medicare fee-for-service program.**

The basic idea is to develop software programs that prospectively identify possible fraudulent activities. Here is some of the key language from this bill.

> **(b) Predictive Analytics Technologies Requirements- The predictive analytics technologies used by the Secretary shall—**
>
> **(1) capture Medicare provider and Medicare beneficiary activities across the Medicare fee-for-service program to provide a comprehensive view across all providers, beneficiaries, and geographies within such program in order to—**

[1] Keep in mind that CMS maintains these are not changes, but only clarifications.

(A) identify and analyze Medicare provider networks, provider billing patterns, and beneficiary utilization patterns; and
(B) identify and detect any such patterns and networks that represent a high risk of fraudulent activity;
(2) be integrated into the existing Medicare fee-for-service program claims flow with minimal effort and maximum efficiency;
(3) be able to—
(A) analyze large data sets for unusual or suspicious patterns or anomalies or contain other factors that are linked to the occurrence of waste, fraud, or abuse;
(B) undertake such analysis before payment is made; and
(C) prioritize such identified transactions for additional review before payment is made in terms of the likelihood of potential waste, fraud, and abuse to more efficiently utilize investigative resources;

As you read through this description you will probably realize that this is essentially what the RACs do on an after-the-fact retrospective basis. In some respects the software and analytical algorithms that can be used will be similar to what the RACs use in analyzing claims data.

Note that the scope of the efforts is across all providers, that is, these analytics will look at and correlate claims from multiple providers for the same patient. This process is something that has only recently become available on the retrospective side.

Also, these analytics are prospective in that the claims will be analyzed ***before payment*** is made. Ostensibly, claims would be flagged for further review before payment made. This process in and of itself will probably introduce payment delays when implemented.

The Secretary is directed to issue an RFP by January 1, 2011, and then select vendor(s) for use in 10 states starting July 1, 2011. Depending upon how successful, this process is slated for implementation for an additional 10 states starting October 1, 2012. Beyond that, the Secretary will need to evaluate the results of utilizing these predictive analytics technologies.

The law also dictates some requirements for the contractors selected. Consider:

(1) SELECTION -
(A) IN GENERAL- The Secretary shall select contractors to carry out this section using competitive procedures as provided for in the Federal Acquisition Regulation.
(B) NUMBER OF CONTRACTORS- The Secretary shall select at least 2 contractors to carry out this section with respect to any year.
(2) QUALIFICATIONS-
(A) IN GENERAL- The Secretary shall enter into a contract under this section with an entity only if the entity—
(i) has leadership and staff who—
(I) have the appropriate clinical knowledge of, and experience with, the payment rules and regulations under the Medicare fee-for-service program; and
(II) have direct management experience and proficiency utilizing predictive analytics technologies necessary to carry out the requirements under subsection (b); or
(ii) has a contract, or will enter into a contract, with another entity that has leadership and staff meeting the criteria described in clause (i).

The Provider-Based Rule Enforcement
The OIG's Version

From the FY2011 OIG Work Plan, page 1, we have:

Provider-Based Status for Inpatient and Outpatient Facilities
We [OIG] will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. Pursuant to 42 CFR § 413.65(d), Medicare may permit hospitals that own and operate multiple provider-based facilities or departments in different sites to operate as a single entity, so long as specific requirements are met. Hospitals that receive this "provider-based status" may receive higher reimbursement when they include the costs of a provider-based entity on their cost reports. Freestanding facilities may also benefit from enhanced disproportionate share hospital (DSH) payments, upper payment limit (UPL) payments, or graduate medical education payments for which they would not normally be eligible. Provider-based status for outpatient clinics may increase coinsurance liability for Medicare beneficiaries. We will determine the appropriateness of the provider-based designation and the potential impact on the Medicare program and its beneficiaries of hospitals improperly claiming provider-based status for inpatient and outpatient facilities.

This OIG Work Plan issue is rather broadly stated. The statement starts out with an evaluation of cost reports and then ends with provider-based status resulting in excessive payments. The excessive payments include increased co-payments by the beneficiaries.

We will have to watch developments in this area. How adamant will the OIG be relative to checking that hospitals have met all the provider-based rule criteria? Also, will the OIG be looking at the newly revised supervisory requirements?

In the past, when the OIG looked at this situation in general, the OIG indicated that there should be no increased payment relative to provider-based status. In other words, for a given service the payment should be the same whether provided in a freestanding clinic, a provider-based clinic or some other site of service.

While meeting the requirements of the PBR is an appropriate area for the OIG to investigate, the real question for hospitals is how to insure compliance in this area. One approach is to perform an internal PBR audit or retain external consultants to come into the hospital and perform such a review.

The PBR allows for significant latitude, and there are a number of issues that have never been fully explained by CMS. For instance, in the PBR there is a prohibition against under arrangement services. This prohibition, which applies to both inpatient and outpatient services, is found at 42 CFR §413.65(i) and reads:

> ***Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.**

CMS has never explained exactly what this prohibition involves. Early training material on the PBR seemed to indicate that if a hospital is to bill on a UB-04 for a service, then some modicum of the service must be provided by hospital clinical personnel. Consider a simple case study.

> **Case 1 – *Hyperbaric Oxygen Turn-Key Operation*** – At the fictitious Apex Medical Center an HBO turn-key operation has been established in space owned by the hospital two blocks from the campus. All of the equipment is provided by the outside company as well as all nursing and technical support including physician services as needed. The outside company also provides all clerical support staff. Basically, Apex pays the contract amount and bills for the services.

The facts in Case 1 seem to violate this under arrangements prohibition in that there are no clinical personnel from the hospital involved in this operation. Thus, there is not even a modicum of clinical services provided by the hospital, but yet the hospital is filing claims for the services.

The issue of *under arrangements* is but one of many unresolved issues under the PBR. How deeply the OIG will investigate issues in this area is unknown. Also, whether the RACs (Recovery Audit Contractors) will become involved is this area is not known. Note also that the recent controversy concerning physician supervision in on-campus, provider-based facility is yet another facet of the concerns surrounding the Provider-Based Rule.

Bottom-Line: Hospitals should carefully conduct internal and/or external audits to determine if there is reasonable compliance with the PBR. At the very least, questionable areas for compliance should be carefully considered relative to possible risk.

Nonphysician Hospital Services OIG Work Plan Issue

Short term, acute care hospital services are paid through MS-DRGs, that is, the Inpatient Prospective Payment System (IPPS). Payments under DRGs are highly encompassing and cover virtually everything that is provided.[2] Presuming that the word physician encompasses qualified non-physician practitioners, services provided in the hospital, which must be incident-to those of a physician, by anyone else is paid through the DRG payment.

The concept of nonphysician services being paid to the hospital through DRGs seems straightforward. However, in practice there can be considerable complexities. Here is the OIG's statement for this issue.

> ***Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System***
> **We will review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals. Pursuant to the Social Security Act, § 1886(a)(4), and 42 CFR § 412.2, inpatient prospective payment system (IPPS) payments to hospitals for inpatient stays are payment in full for hospitals' operating costs and hospitals generally receive no additional payments for nonphysician services. For nonphysician**

[2] As with everything involving Medicare, there can be exceptions. For DRGs, one exception is DME provided shortly before discharge. You may see this referred to as the 2-day rule.

services provided to inpatients by entities under arrangements with the hospitals, the Social Security Act, §§ 1862(a)(14) and 1861(w)(1), as interpreted by CMS in its FY 1983 IPPS final rule, prohibits submissions of any additional claims to Part B. Section 1886(a)(4) prohibits separate payments for outpatient diagnostic services and admission-related nondiagnostic services rendered up to 3 days before the dates of admission. Prior Office of Inspector General (OIG) work in this area found significant numbers of improper claims.

Note that the OIG's statement goes beyond just looking at nonphysician services that may be paid inappropriately outside the hospital's DRG payment. This issue also addresses the 3-Day Pre-Admission Window as well. As discussed in recent articles in this Newsletter, the 3-Day Pre-Admission Window is undergoing some significant changes as well.

Thus, this issue is broadly stated and investigators could go in different directions. To show the complexities that can be involved, consider the following simple case.

Case 2 – *Specially Trained Nurse Assistant* – A specialty physician utilizes a specially trained nurse to assist with care of hospitalized patients. The nurse performs assessments and develops documentation for use by the physician. The physician then develops an E/M level based on the overall care including that of the specially trained nurse.

The basic facts of Case 2 appear quite innocuous until you carefully analyze the situation. The nurse is a non-physician provider providing services incident-to those of the physician. The hospital is paid for all services incident-to those of the physician. Thus, the DRG payment includes payment for the services of the specially trained nurse. If the physician is using the work of the nurse to determine an E/M level, then the physician is also being paid for the nursing services.

Note: This same type of situation arises with outpatient services as well, particularly in provider-based clinics.[3]

Bottom-Line: For hospitals, the issues contained in this OIG Work Plan item present very real challenges. Given the changes that are occurring to the 3-Day Pre-Admission Window along with the need to work closely with medical staff to make certain there is no incorrect billing is taking place, compliance officers need to really think through how compliance can be gauged and properly maintained.

[3] See the Social Security Act, §1861(s)(2)(A) and §1861(s)(2)(B).

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 November 9th is "***Injections and Infusions: Coding and Compliance"*** 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 should be available shortly. The third book in the series is devoted to prospective payment systems and is currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below.

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