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 on or about November 1st for each payment system.

Observation – Yet Again!

For the past ten years hospital coding, billing and compliance personnel have struggled with properly filing claims for observation services under the Medicare program. The biggest stumbling block has been CMS's insistence that observation equates to a *bed* as opposed to being a *status* regardless of where the services are provided. The simple fact is that observation services are ordered and provided for sometimes significant amounts of time before the patient is or can be placed in the actual observation bed.

With very little fanfare CMS has changed their stance as indicated in Transmittal 1760 to Publication 100-04, the Medicare Claims Processing Manual. The concept that CMS has finally adopted is that of observation *services*. CMS reserves the word *status* to refer to either inpatient status or outpatient status. However, the concept of services is what we have needed, namely, recognition that the patient may be receiving observation services while not yet being in the observation bed.

We now have the following regulations for observation time from §290.5.1: (Red indicates a change.)

1. Observation Time

a. Observation time must be documented in the medical record.

b. Hospital billing *for observation services* begins *at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services*.

c. A beneficiary's time *receiving* observation *services* (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

While CMS had moved to observation ending when observation services ceased, even if the patient was still in the bed, the language addressing start time for observation has been drastically revised. The start time is now when a hospital begins providing services, and there is no mention of the *observation bed*.

As you study this updated language concerning observation, you will also see that CMS is reserving the word *admission* for inpatient services. Thus, what we used to call direct admissions to observation services are now referred to as direct *referrals* for observation care.

There are no other substantive changes in the payment or processing of observation claims. Coding, billing and compliance personnel can finally update their policies and procedures in this area. No longer will we have the specter of an auditor claiming that a policy based on when observation services started as opposed to when the patient was placed in the observation bed.

Observation & Condition Code 44

In the same transmittal discussed in the preceding article, CMS also provides some additional guidance on how CMS wants Condition Code 44 used. Note that the NUBC definition of Condition Code 44 and CMS's requirements are significantly different. Often when CMS issues guidance, there are then additional questions.

Here are the four requirements made by CMS:

1. **The change in patient status from inpatient to outpatient is made prior to discharge or**

release, while the beneficiary is still a patient of the hospital;

2. **The hospital has not submitted a claim to Medicare for the inpatient admission;**

3. **A physician concurs with the utilization review committee's decision; and**

4. **The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.**

§50.3.2 of Chapter 1 of the Medicare Claims Processing Manual states that the entire episode of care should be billed as an outpatient episode of care. What it does ***not*** state is whether or not the entire episode of care can be classified as observation services.

Here are two more statements with new language.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

A careful reading of these statements along with the start time for observation services suggests that the observation services can start only after the physician orders the services. Let us consider a simple case study.

Case Study – Sarah has not been feeling well. She presents to the Apex Medical Center's ED. Her attending physician, Dr. Brown is called. After an examination, Dr. Brown decides to admit Sarah as an inpatient at 4:00 p.m. The next morning, utilization review personnel review the records and determine that inpatient criteria have not been met. Dr. Brown comes over at noon. There is a discussion, and Dr. Brown agrees that the inpatient admission should have been for observation. Dr. Brown writes new orders for the observation. At 4:00 p.m. Dr. Brown returns, examines Sarah and decides to discharge her from the hospital.

The fundamental question is whether or not, for billing purposes, did observation services start at 4:00 p.m. on the first day or did the observation actually start at noon on the second day? If observation started on the second day, then Sarah was in observation for only four hours. While this can be reported, APCs will pay for observation only if it is provided for at least eight hours. Apex will only be able to bill for the ancillaries and any Part B services furnished to an inpatient in which the inpatient admission is not medically necessary.

In other words, the switch to observation is made at the time of the physician's order and does not carry back to the original inpatient admission, which has now been determined to be medically unnecessary.

Bottom-Line – Watch carefully for any additional guidance concerning this type of situation. Mixed answers to this question have been received from different CMS sources.

DME Closets – A Little Guidance

CMS has issued Transmittal 300, to Publication 100-08, Medicare Program Integrity Manual, dated September 1, 2009. This transmittal addresses the popular concept of the 'DME Closet'. The basic idea is that a DME supplier rents some space (or is even given free space) in a clinic or hospital and places various types of DME in the space or closet. When the clinic or hospital needs to dispense a piece of DME, the DME supplier is notified, and the DME supplier then bills for the item. You may also see phrases like *consignment closet* or *stock and bill arrangements*.

Note: When using the acronym DME, we are referring to true DME, that is, DME items that must be billed to your geographic DME Regional Carrier (DMERC) or, with the new terminology, DME MAC (Medicare Administrative Contractor). There are other DME items that hospitals

can bill to their Fiscal Intermediary (FI) or physicians to their Carrier. Distinguishing the different types of DME and to whom you can file claims and/or even be paid, is a major project for all healthcare providers.

Hospitals have a difficult time avoiding involvement with DME items. For instance, in the ED items such as crutches, canes and walkers are often needed. Also, hospitals typically have physical therapy services, which may also involve providing crutches, canes and the like. Over the years hospitals have gone to great lengths to avoid becoming a DME supplier. In some cases these items are categorized as general supply items (Revenue Code 270) and thus bundled. In other cases the DME items are simply given away at no charge. Some hospitals have foundations that may be able to provide the DME on some sort of a charitable basis.

If a hospital is to avoid becoming a DME supplier, one approach is the DME closet. Using this approach the hospital can have common DME items on hand so that they can be easily dispensed. The hospital avoids all the hassles of billing which generally achieves the hospital's immediate goal.

However, the DME closet approach has some possible disadvantages, particularly on the compliance side. Probably the biggest concern is the anti-kickback statute (AKS). If a hospital is purposely giving away DME, then this may be construed an inducement to attract patients. Another concern is freedom of choice on the part of the patient. A hospital will usually have a contract with one DME supplier. This can create animosity with other DME suppliers that are left out of the arrangement. Also, should the space for the DME closet be provided free of charge or should rent be paid at fair market value?

The OIG has issued some Advisory Opinions in this area such as AO 02-4 issued on April 26, 2002. These AOs tend to be limited in scope and cannot usualy be used in more general circumstances.

Now with Transmittal 300, CMS is definitely giving definitive guidance. ***Note that this guidance is directed toward physicians, non-physician and, presumably, clinics. Hospitals are not mentioned, BUT hospitals should carefully study this transmittal because the directives may well be extended to hospitals in the future***.

Basically what CMS is stating is that there can be a DME closet or stocking arrangement. However, when the DME item is dispensed, it is the physician or non-physician who must file the DME claim. This means that the physician or non-physician would have to apply for and gain billing privileges for the DME. This involves filing the CMS-855-S, gaining a DME billing number from the National Supplier Clearinghouse (NSC), and then billing the DMERC on the CMS-1500 claim form.

Starting March 1, 2010 here is the key language that will appear in Chapter 10 of the Medicare Program Integrity Manual, §21.8.

1. **The title to the DMEPOS shall be transferred to the enrolled physician, non-physician practitioner practice at the time the DMEPOS is furnished to the beneficiary;**

2. **The physician or non-physician practitioner shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number;**

3. **All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, and not by any other DMEPOS supplier; and**

4. **The beneficiary shall be advised that if he or she has a problem or question regarding the DMEPOS, then the beneficiary should contact the physician or non-physician practitioner, and not the DMEPOS supplier who placed the DMEPOS at the physician or non-physician practitioner's practice.**

This means that the DME closet concept can be used only as a convenient inventory mechanism. The physician, non-physician or clinic is truly the DME supplier.

Note: Many healthcare providers are reluctant to become DME suppliers through the CMS-855-S process. If CMS extends this guidance to hospitals, then many hospitals will need to go through the DMEPOS enrollment process. Note that a separate CMS-855-S is required for each dispensing location, and there are now surety bond requirements in some cases. See Transmittal 287 to publication 100-08 issued March 27, 2009.

CAHs and the Provider-Based Rule

CMS has become interested in correctly applying the provider-based rule (PBR) to Critical Access Hospitals. There are two issues addressed in the July 27, 2009 *Federal Register* entry.[1] The two areas of concern are:

[1] Yes, this is the MS-DRG or IPPS update, but CAHs are also included in the FR entry.

1. Laboratories, and
2. Ambulances.

The PBR is generally found at 42 CFR §413.65. While this is not a long entry in the CFR, it is very difficult to read and understand what CMS is trying to say. Also, the development of the PBR operationally over the past fifteen years has been very tortuous with CMS going in one direction only to reverse and then go in another direction.

For most purposes, if a hospital has a department or organizational unit that files a UB-04 (CMS-1450) claim form, then this unit is provider-based.[2] However, for determination purposes, that is, qualifying the unit for provider-based status, CMS is interested only in those units where there is the potential of a payment differential. The payment differential occurs when comparing the hospital-based unit against a similar freestanding unit. The payment differential will occur if there are two different types of payment systems in use.

CAHs are cost-based reimbursed whereas larger hospitals are under various prospective payment systems and/or fee schedule arrangements. Thus a CAH may have a cost-based unit that can be compared to a similar unit that is freestanding or even possibly provider-based to a PPS hospital.

Let us take ambulance services as an example. If a CAH can meet certain requirements, the CAH can own and operate an ambulance service that is cost-based reimbursed. If this same ambulance service was freestanding or even part of a PPS hospital, then reimbursement is made through the ambulance fee schedule (AFS). Thus, there is the potential for a payment differential, and CMS is interested in determining or assuring provider-based status.

Note: The concept of *determination* is a little misleading. In the early years of the PBR development, it appeared that CMS wanted to affirmatively approve, that is determine, that any given provider-based unit met all of the requirements. CMS realized that they would be receiving tens of thousands of applications, so that CMS has modified their approach and will allow the hospital to file an attestation indicating that all the requirements are met.

We have the same situation with a CAH laboratory unit. The CAH is cost-based reimbursed while other laboratories are paid on the clinical laboratory fee schedule (CLFS). Again, there is the potential of a payment differential, and CMS becomes interested in making a determination and/or otherwise satisfying that all the PBR requirement are met. From the July 27, 2009 Federal Register, we have:

> **However, upon further review of existing § 413.65(a)(1)(ii), we believe that a clinical diagnostic laboratory, when operated as part of a CAH, generates a higher Medicare payment than when operating as a freestanding facility. When a clinical diagnostic laboratory is part of a CAH, the services furnished by the laboratory are generally paid 101 percent of reasonable cost. Otherwise, clinical diagnostic laboratory services provided by a freestanding diagnostic laboratory are paid under the CLFS. Currently, because the services of a clinical diagnostic laboratory of a CAH are paid at a higher rate by virtue of being provided by a CAH department, we believe they should be subject to the rules under the provider-based status regulations at § 413.65.** (74 FR 43941)

There could be some highly unusual situations in which a CAH might have a satellite laboratory operation that is provided-based and might not meet the PBR proximity requirements. Typically, CAH laboratories are inside the hospital and meet all of the PBR requirements.

Ambulance services are more susceptible to problems.

> **The existing regulations at § 413.70(b)(5) provide that ambulance services are paid at reasonable cost if the services are furnished by a CAH or by an entity owned and operated by a CAH, but only if the CAH or entity is the only supplier or provider of ambulance service within a 35-mile drive of the CAH or entity.** (74 FR 43943)

> **In summary, while we still believe that it may be appropriate to require any part of a CAH to meet the provider-based rules in order to be paid at reasonable cost, we are not at this time proposing or adopting any changes to the regulations at § 413.65 to require CAH-owned and operated ambulance services that are eligible to be paid at reasonable cost to meet the provider-based status rules.** (74 FR 43944)

CMS seems to be stating that even though there could be a violation with an off-site ambulance service that is provider-based, i.e. cost-based reimbursed, CMS will not pursue the formal application of the PBR. For those CAHs in situations in which there is some parts of the

[2] The language used in the PBR is an *organization* or *facility*. These two fundamental terms are not further defined. This appears to apply to departments and generally to organizational units.

PBR requirements that are not being attained, due consideration should be given for coming into compliance in the future.

Stark Rules May Affect Hospitals

Starting October 1st certain extended Stark rules for physicians will go into effect. The Stark compliance issues are fairly extensive and surround physician ownership and self-referrals along with violations of the anti-kickback statute (AKS).

Effective October 1, 2009, CMS has changed the definition of *entity*, which broadens the scope of physician-owned companies subject to the Stark Law regulations and throws most *under arrangements* relationships out of Stark Law compliance.

Note: The whole area of under arrangements for the Medicare program needs additional guidance. There is a prohibition in the Provider-Based Rule[3] against under arrangements. However, CMS has never elaborated on how this prohibition should be interpreted.

If a hospital has contracted with a physician or organization that has physician ownership, then such under-arrangement operations may need to be altered. Note that physician ownership extends to the immediate family of the physician

> **Case Study** – Acme contracts with a physician organization that provides Holter monitors and the interpretation of Holter monitors. Apex technical services personnel setup the Holter monitors, disconnect them and send the results for analysis. The hospital pays the contracted amount to the physician organization, and then Apex files a claim for the services.

Under the extended Stark rules this type of arrangement violates the AKS. There is a *rural* exception so that hospitals in rural areas have fewer concerns than those in MSAs (Metropolitan Statistical Areas).

Bottom-Line – Indentify any and all under arrangement agreements that you have with anyone or any organization outside your hospital. Then check to see if there is any physician ownership that would invoke the Stark limitations. If you are in a rural area, then verify that the rural exception applies in your particular circumstance.

[3] See 42 CFR §413.65.

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 October 13th:is "***Hospital Pharmacy Coding and Billing***" 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.

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