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

As we go into the fourth quarter of the calendar year, be certain to review quarterly changes. The major occurrence will be the final *Federal Register* entry for updating APCs for CY2011. Anticipate further packaging and bundling of payments that is consistent with CMS's major change in direction starting in CY2008. Thi update should be out on or about November 1st. CMS is supposed to give us 60-days' notice prior to implementation on January 1, 2011. However, watch for the examination copy of the *Federal Register* entry. The official paper entry may not occur until well into November.

3-Day Pre-Admission Window

CMS continues their discussions of the changes to the 3-Day Pre-Admission Window. With the change made to the Social Security Act (see §1886(a)(4)) the definition of ***related to*** has been broadened, and the burden for determining if outpatient services in the window are unrelated has been placed squarely on hospitals.

Notes:

1. There are actually two different windows: a 3-day window for hospitals under the Inpatient Prospective Payment System (IPPS) and another 1-day window for hospitals not under the IPPS;
2. Prior to June 25, 2010, the date that Public Law 111-192 was passed; there was a specific formula for determining if an outpatient therapeutic service was related. This involved checking the principal diagnosis for the inpatient admission against the primary diagnosis for the outpatient service. An exact match was required for bundling to occur.
3. The trigger for applying the pre-admission window is that the outpatient services must be provided at the hospital or a wholly owned or wholly operated facility. Outpatient services at another hospital do not apply.

In the August 15, 2010 *Federal Register*, CMS issued an Interim Final Rule for the 3-Day Pre-Admission Window. Yes, this is the IPPS update *Federal Register*. The comment period for this interim rule is until September 28, 2010.

All diagnostic tests performed at the hospital or a facility that is wholly owned or wholly operated by the hospital must be bundled into the inpatient billing. This part of the rule has not changed.

What has changes is that all non-diagnostic (i.e., therapeutic) services that are clinically related must be bundled into the inpatient billing. While CMS needs to ***clearly and explicitly define*** the phrase clinically related, ostensibly, many more pre-admission services will now be included in the inpatient billing.

Previously (i.e., prior to June 25, 2010), therapeutic services for which there was an exact match between the principal diagnosis for the inpatient admission and the primary diagnosis for the outpatient therapeutic service were bundled. The number of cases in which there was such a match is limited.

On August 9, 2010, CMS issued a memorandum discussing this issue and repeating language from the Federal Register entry. There is a fairly nice summary on page 50349 of the Federal Register.

> *In the near future, we also expect to update the instructions in the Medicare Claims Processing Manual, Chapter 3, section 40.3, to conform to the requirements of section 102 of Public Law 111–192. Even before the final regulations, instructions, and process for attesting to certain services as being unrelated to an admission are in place, hospitals are required by law to comply with the requirements of section 102 of Public Law 111–192. That is, hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and*

charges for all outpatient preadmission diagnostic services and all outpatient preadmission nondiagnostic services that meet the requirements of section 1886(a)(4) of the Act, as amended by section 102 of Public Law 111–192. If a hospital believes that outpatient nondiagnostic services provided during the first, second, and third calendar days (first calendar day for a nonsubsection (d) hospital) preceding the date of a beneficiary's admission are unrelated to the inpatient admission, the hospital may separately bill for the service to Medicare Part B, provided that the hospital can document, and maintain such documentation as part of the beneficiary's medical record to support its belief, that the service is unrelated to the admission. Such separately billed outpatient preadmission services may be subject to subsequent CMS review.

If we parse this rather lengthy paragraph, here are the main points:

a. CMS has not determined how this whole process is to occur, that is, how will hospital attest to the fact that a given non-diagnostic service is unrelated;
b. The CMS manuals, and the CFR, for that matter, have not yet been updated although in the meantime hospitals have the burden of deciding what is related or not;
c. Hospitals are to determine whether they, the hospital, *believe* that the non-diagnostic service is unrelated to the hospital admission;
d. Separately billed non-diagnostic services will be subject to review and, most likely, will be reviewed.

What is missing in this particular summary statement is just how CMS is going to define the phrase *clinically related*. This phrase needs explicit definition to the point that it can be programmed into the billing systems and/or associated editors. For instance, for each principal diagnosis there should be a listing of diagnoses that are not clinically related. Using such a list approach, which is not dissimilar to other aspects of MS-DRGs, everyone will know what is or is not related.

Bottom-Line: The comment period for the August *Federal Register* is not until September 28th. Thus, specific guidance from CMS probably will not occur until later 2010 and possibly not until the beginning of 2011. While we all await specific guidance, hospitals should take a very conservative stance and generally bundle any non-diagnostic services that could possibly be construed as related to the hospital admission. Anticipate that the new guidance from CMS will be quite general and that hospitals will be on their own in establishing policy that probably will be reviewed by CMS and eventually by the RACs (Recovery Audit Contractors).

Mandatory Compliance Plans – Audit Programs

The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, is thousands of pages long, and we really are just starting to sort things out. One of the provisions is that healthcare providers and suppliers ***are required*** to have compliance plans. This requirement is found at §6401(7)(B).

A significant part of any healthcare provider's compliance plan involves an auditing program. An audit program can be established in a number of different ways. We will look at different approaches and then briefly categorize different types of audits.

External Audits vs. Internal Audits – Hospitals, hospital systems and integrated delivery systems often establish internal auditing programs. Smaller healthcare providers such as physicians, clinics, skilled nursing facilities and home health agencies may not have the luxury of internal auditing staff.

Even if there is no explicit internal staff, internal auditing and review activities are typical. These activities can range from a simple study of a few cases to determine if coding and billing is being accomplished correctly.

> **Exercise 1 – *Small Case Sampling Review*** – Take 20 outpatient cases from an area of your choice,for instance, the Emergency Department, Physical Therapy, endoscopies, technical services or some other service area can be selected. Examine the claim that was filed, the itemized statement and then also look at clinical documentation that accompanies the cases.

Now you may do this simply as an auditing exercise on your own, or you may decide to perform such an informal review with a small team. Having billing and coding staff join such an exercise can be quite enlightening for everybody!

Be certain to consider physician orders and medical necessity justification through the diagnosis coding. If you consider anything amiss as constituting an error, you will hard pressed to have an error rate of less than 30%. This does not mean that there was any sort of false claim and/or incorrect payment, only that some sort of error was discovered.

For internal auditing keep in mind that the final product (i.e., the claim and associated itemized statement along with the documentation) of the overall coding and billing system is not the only place to conduct reviews. You

should also be concerned about the process that actually generated the final product. Is the system set up correctly? Is the coding and billing working properly? If working properly, is the coding/billing/documentation process efficient?

> ***Exercise 2 – Chargemaster Processing*** - Someone, or possibly a small group in a large hospital setting, is in charge of the Chargemaster. Review the policies and procedures surrounding the care and maintenance of the Chargemaster. How are changes made? How is the Chargemaster organized? Are the departments and service areas routinely visited to review given sections of the Chargemaster?

In Exercise 2, we are looking at a small part of the overall coding and billing process. The Chargemaster is a lynchpin within the overall coding and billing process. Thus, due concern should be given to whether the Chargemaster is working properly.

With these two major perspectives, that is, the end product and then the process producing the end product, there are three types of audits that can be considered. Namely,

- Retrospective Audits,
- Concurrent Audits, and
- Prospective Audits.

While larger organizations may have dedicated auditing staff that conducts routine audits of various types, all organizations need to avail themselves of external auditors through what all called Independent Review Organizations or IROs. For many years almost all hospitals have contracted for inpatient and outpatient coding reviews. Often these reviews have focused only on coding with billing and claims as a peripheral part of such studies.

External auditors or consultants are really needed in order to provide objectivity in conducting studies. While a coding study may result in suggestions relative to correct coding according to coding guidelines, today there is a much broader array of concerns, particularly with the RAC (Recovery Audit Contractor) program.

Bottom-Line: The need to increase both internal and external auditing for proper coding, billing and reimbursement is rapidly becoming paramount in today's healthcare environment.

In the next article in this series, we will look at these three types of audits as generally used by external consultants.

Editor's Note: In future issues of this Newsletter, the various elements of coding, billing and reimbursement programs will be discussed. See also Dr. Abbey's book, "***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition, published by Taylor & Francis.

Myocardial Perfusion – An APC Case Study

Starting in CY2008, CMS's approach for APCs took a very sharp turn away from the approach that was taken back in CY2000 when APCs were implemented. The new approach employs significantly ***increased packaging*** at several different levels.

Myocardial perfusion illustrates this increased bundling as CMS has changed APCs to almost complete packing and payment on an highly averaged basis.

The unbundled approach separates out all of the services and supplies much like a fee schedule approach.

- There were four base codes: two for tomographic studies (single/multiple) and two for planar studies (single/multiple).
- There were two add-on codes: one for wall motion and one for ejection fraction.
- There were codes for the relatively expensive radiopharmaceuticals that have very short life spans.

In the unbundled approach the base code plus add-on code(s) and the radiopharmaceuticals were all paid separately. There were three different APCs, one for the single study, one for multiple studies and one for the add-on codes. The radiopharmaceuticals were paid on a pass-through basis which was appropriate due to the variability in costs.

Example from CY2007 –

78460 → APC 0377 - $400.00 (Base Test)
78478 → APC 0399 - $100.00 (Wall Motion)
78480 → APC 0399 - $100.00 (Ejection Fraction)
A950X – Per Study Dose - $200.00

Total Payment = $800.00.

The cost for the radiopharmaceutical and thus the payment is variable depending on the specific drug.

Starting in CY2008, CMS's first step in bundling was to package the add-on codes. These were simply moved to Status Indicator "N". In theory, hospitals were to code the add-on codes with appropriate charges which would

then be integrated into the costs for the base code on an averaged basis.

The second step was to package the payment for the radiopharmaceuticals into the base code. While the A9500 series of codes is used, care must be taken to charge correctly for the radiopharmaceuticals. Given the variability in costs for these drugs, the averaging process may not accurately pay hospitals for these drugs.

The final step occurred in CY2010 when the AMA actually changed the CPT coding structure to recognize that the old add-on codes are essentially gone. There are now four codes, which include the old add-on codes:

- 78451/78452 – Tomographic single/multiple studies
- 78453/78454 – Planar single/multiple studies

All four of these codes map to the same APC, namely 0377, with a national payment of $775.09, and this includes the radiopharmaceuticals. Thus, you may be performing a simple base test with a relatively inexpensive radiopharmaceutical, and the APC=0377 payment will be well over your costs. On the other hand, if you are routinely performing complicated tests including wall motion and ejection fraction and you are comparing at rest versus exercise stress, then you will be grossly underpaid.

Bottom-Line: Welcome to the world of APC averaging! About the only action step you can take is to make certain that the charges being made include all of the resource being consumed. Because the add-on codes are gone, you will need to make certain that charges for the four new codes include the add-ons and also include the cost of the radiopharmaceuticals. Chargemaster coordinators should work closely with clinical staff to capture all costs. Also, work with cost reporting personnel to make certain that the radiopharmaceuticals are being correctly charged including the handling costs for these short-lived substances.

Medicare Odds & Ends – Enrollment Issues

We are receiving many questions concerning the filing of and the response to filings of the various CMS-855 forms. Some of the questions involve the issuance of NPIs (National Provider Identifiers) and Tax Identification Numbers (TINs).[1]

CMS is in the process of checking the consistency of Legal Business Names (LBNs) between the NPI data and TIN/EIN information. Keep in mind that NPI assignments and TIN assignments are made for very different reasons. There is not always a one-to-one correspondence between NPIs and TINs. There may be little correlation between the two sets of numbers.

At issue is that when the NPIs were established, including NPIs for organizational subparts, those making the application may not always know the official, legal business name. In more complicated organizational structures, there may be significant numbers of organizational units that fall under the category of DBA, Doing Business As. Thus, the name commonly associated with a business entity may be the DBA name not the official LBN.

> **Case Study 1** – ***Acme Medical Clinic*** – The Acme Medical Clinic is a freestanding clinic owned and operating by four physicians. In turn, the clinic also employs two nurse practitioners (NPs). The clinic is organized as a limited liability partnership[2] using the four last names of the physicians. This partnership is held out to the public as DBA Acme Medical Clinic.

Given these basic facts, what kind of issues do we have for obtaining NPIs and then filing the appropriate CMS-855 forms?

Case Study 2 will illustrate that organizational structuring can become quite complicated and thus influence NPIs along with IRS reporting, which then affects the various CMS-855 forms.

> **Case Study 2** – ***Apex Medical Center*** – Apex is a small integrated delivery system. While many different services are provided, among the providers are the following:
> **a.** Home Health Agency DBA Aspire Home Health,
> **b.** Three freestanding clinics all DBA Center Clinics, and
> **c.** Three provider-based clinics all DBA Family Practice Associates.
>
> All of these organizations are wholly owned and operated by the Apex Medical Center. There is a single TIN for everything. Apex did obtain separate NPIs for each of these three organizational structures as subparts. All of the physicians along with non-physician practitioners (NPPs) are employed by the hospital (i.e., Apex Medical Center).

Case Study 2 illustrates a somewhat more complex structure even given that we are looking at only part of the overall organization. Let us consider the two clinic organizations each of which has three separate physical locations. Because the hospital did obtain separate

[1] Note that you will see TINs along with EINs (Employer Identification Numbers) and FINs (Financial Identification Numbers).

[2] Assume that state law allows for a limited liability partnership or LLP.

NPIs for each of these two sets of clinics, a CMS-855-B would be filed to obtain billing privileges for each group as a clinic for Part B claims. The locations will be listed on the CMS-855-B.

N.B. – CMS has made it very clear in various pronouncements that the Medicare Administrative Contractors are under no obligation necessarily to recognize the NPIs obtained for subparts of the organizations.[3] The general rule seems to indicate that the number of NPIs recognized should be minimal.

For the freestanding clinics, that is, Center Clinics, the CMS-855-I and CMS-855-R forms would need to be filed. For the provider-based clinics, Family Practice Associates, the hospital would also need to indicate practice locations on the CMS-855-A along with the necessary CMS-855-I and CMS-855-R forms.

Bottom-Line: There are both general and specific steps that your organization should take relative to making certain that your NPIs, TINs and CMS-855 forms are all consistently being maintained.

1. Determine exactly who is maintaining the various NPIs for the organization and all of the providers along with the various CMS-855 forms;
2. Check to see if the LBN or LBNs indicated in the NPI database[4] are accurate and correlate appropriately with the TINs or EINs.
3. Be certain to respond timely to any letters that indicate any sort of mismatch. Technically, there is only a 15-day response period.
4. If an NPI is deactivated, then be certain to follow-up immediately to provide correcting information to have the given NPI reactivated.

If you are in a smaller organization, these action steps can be addressed fairly quickly. If you are in an integrated delivery system mode, that is, a hospital with many different service providers, you may have trouble even determining who has obtained NPIs and/or who is filing the many different CMS-855 forms to obtain and maintain billing privileges with the Medicare program.

Editor's Note: Because of all the questions that we are receiving, enrollment and NPIs will be discussed in coming issues of this Newsletter.

[3] See " Medicare Expectations on Determination of Subparts By Medicare Organization Health Care Providers Who Are Covered Entities under HIPAA" published in January 2006.

[4] This is the NPPES or National Plan and Provider System see: https://nppes.cms.hhs.gov/NPPES/.

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 September 28th is "***CMS 855-A Form for Hospitals***" 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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INSIDE THIS ISSUE

APC/APG Update
Compliance Plans Mandated by PPACA
3-Day Pre-Admission Window- Guidance Coming!
CMS-855 Forms – Problems & Challenges
Myocardial Perfusion – An APC Example

FOR UPCOMING ISSUES

More on RAC Audits and Issues
Behavioral Assessments – Coding & Billing
More on Coding, Billing Compliance
More on Payment System Interfaces

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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: Duane@aaciweb.com

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