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

Be certain to review the latest APC and I/OCE transmittals. CMS is updating these on a quarterly basis.

- Transmittal 1700, March 13, 2009, April 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.1.
- Transmittal 1702, March 13, 2009, April 2009 Update of the Hospital Outpatient Payment System (OPPS).

RACs and the Extrapolation Process - Part 3

Editor's Note: This is the third article in a series of articles concerning the extrapolation process for determining recoupment amounts.

We will now walk through a case study for actually using the extrapolation process. In order to perform the statistical calculations we will refer to the different features available in RAT-STATS. The features we will reference are:

1. ***Variable Appraisals*** – To determine the error rate for the sample size determination.
2. ***Sample Size Determination*** – To determine the size of the sample for review.
3. ***Random Numbers*** – To determine the actual cases for review.

First, let us assume that the RAC has identified a specific problem or area for investigation - perhaps the E/M level, the "-25" modifier or a host of other issues that are systematic or repetitive in nature.

Second, we will use slight variation on the statistical variables generally directed by the OIG when a healthcare provider is having audits conducted to show compliance with a Corporate Integrity Agreement or CIA. The OIG likes a 90% confidence interval with 25% precision. For educational purposes, we will use:

90% Confidence with
20% Precision.

Third we will assume a universe of 1,000 cases.

In order to determine how big a sample must be used from the 1,000 in order to validly extrapolate to the entire universe, we must have an error rate. In order to determine the error rate, a probe audit of 30 cases chosen randomly will be conducted.

The RAC will use the Random Numbers generator to select the probe audit 30 cases. These cases will be audited to determine overpayments. Assume the results of this probe audit are:

Case 3 - $20.00
Case 9 - $40.00
Case 11 - $10.00
Case 14 - $40.00
Case 18 - $10.00
Case 19 - $20.00
Case 22 - $40.00
Case 26 - $20.00
Case 29 - $10.00
Case 30 - $10.00

From this data we must determine the mean and standard deviation. While any statistical program can be used, including MS Excel, we will use the Variable Appraisals feature of RAT-STATS. The output is:

Mean =7.33
Standard Deviation = 12.85

The next step is to use the Sample Size Determination feature to see how big a sample must be audited. We have all the information we need, namely, confidence level, precision level, and the error rate using the mean and the standard deviation.

Table 1 shows the different sample sizes for different precision and confidence levels. For our parameters, the necessary sample size is 172.

Precision Level	Confidence Level			
	80%	90%	95%	99%
1%	981	988	992	995
2%	927	954	967	981
5%	669	769	825	891
10%	335	***454***	541	671
15%	183	270	344	475
20%	112	***172***	228	338

Table 1 – Sample Size for Extrapolation

Does this seem reasonable? Keep in mind that in this case the RAC will need to audit 172 cases and then will be able to extend or extrapolate to the entire 1,000 universe.

What if the error rate were 41% with an average overpayment of $31.00? This would extrapolate to 410 cases times $31.00 which is $12,710.00. Would you be more confident if the precision were moved to 10% with the same confidence level? As you can see from Table 1, the RAC would have to audit 454 cases. Quite possibly the error rate might move down to 28% with an average overpayment of $25.00. This moves the overpayment down to $7,000 or a 45% decrease.

Let us assume that the calculated overpayment is $12,710.00. Is this the amount that the RAC would request for recoupment? The answer turns out to be, 'no'. In using this type of methodology, the request for recoupment is to be the lower one-sided 90% confidence interval (or whatever confidence interval is being used). How is this determined?

The overpayments determined from auditing the 176 cases are statistically processed through the Variable Appraisals feature of RAT-STATS which generates the following:

$14,607.00 ← 90% Upper Limit
$12,710.00 ← Audited Amount
$10,848.00 ← 90% Lower Limit

The request for recoupment will be $10,848.00. This process of requesting less is to preclude any arguments against the statistical process being used.

Editor's Note: The numbers used in this example have been kept relatively small. In actual application, significantly larger recoupment amounts will be generated, but the process will be the same.

Technical Component "-25" Modifier Moving Into the Limelight

After years of neglect with sparse guidance, the "-25" modifier is now becoming an issue. Suddenly we are being *reminded* that certain conditions pertain to the use of this modifier on the technical component side. However, it is difficult to determine the original source of these *reminders*. Additionally, the DOJ has been conducting audits in Western Pennsylvania concerning the proper use of the "-25" modifier on the hospital side. These audits have resulted in assertions of significant improper use of the "-25" modifier.

The abbreviated CPT description of the "-25" modifier is:

> **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

Of course, for the hospital side we must translate this because the E/M services provided on the technical side may not be made by the same physician. For that matter, on the hospital side we are reporting the E/M services relative to resources utilized which are often nursing services, but they could represent any resource utilization. Keep in mind that the E/M code sequences are just placeholders for different levels of resource utilization.

This modifier is used only on E/M codes. For hospitals this means in the Emergency Department or at provider-based clinics. ***Also, note that the whole compliance issue with the "-25" modifier is driven by the fact that CMS has failed to issue any guidelines for technical component E/M coding.*** If we had guidelines, then we would be able to discern when the resource utilization for an encounter goes above and beyond that associated with a given diagnostic or therapeutic procedure.

When CMS issued the final *Federal Register* for APCs on April 7, 2000, it came as a surprise that E/M services would be paid separately using the "-25" modifier. The precursor system, APGs – Ambulatory Patient Groups – automatically bundled any E/M service if there was a surgery or medical procedure performed. The only time that E/M services were paid was if they were performed independently from any other services.

While CMS made the decision to allow the use of the "-25" modifier and thus pay separately for E/M services, there was very little guidance on when and how this modifier could be used. Additionally, CMS has never issued any guidance on E/M coding guidelines, which would also affect the "-25" modifier utilization.

The limited guidance issued by CMS was in two Program Memorandums:

- A-00-40 – July 20, 2000,
- A-01-80 – June 29, 2001.

Both of these PMs provided only a little more guidance. The CPT definition for the "-25" modifier was reinforced in that using this modifier required appropriate documentation. Here is Example #1 from A-00-40:

> *Example #1:* A patient is seen in the ED with complaint of a rapid heartbeat. A 12-lead ECG is performed.
> In this case, the appropriate code(s) from the following code ranges can be reported:
> 99281-99285 (Emergency Department Services) with a modifier –25
> 93005 (Twelve lead ECG)

While there would be more detail in actual cases, the way this example reads, there is a single diagnostic condition being addressed along with a diagnostic test. The key guidance provided in these PMs is that the use of the "-25" modifier is a documentation issue. Obviously, judging whether there is sufficient documentation becomes subjective, but the guidance from the PMs does not appear to raise a particularly high bar on this issue.

Now we are seeing new language relative to the "-25" modifier. Here is an example from Medicare Alert Bulletin 2255, February 17, 2009, pages 9-10, issued by Georgia Medicare.

> "Modifier 25 should be appended only to E&M service codes. **Only** in those instances where a medical visit (E&M) on the same date as a diagnostic or therapeutic procedure ('S' or 'T' APC status indicator code) is **separately identifiable service for an unrelated problem** should the facility receive separate reimbursement for the evaluation and management service. A modifier 25 appended to the E&M code would be used in these cases to indicate that a medical visit occurring the same day was **unrelated** to any "S or T" procedure that was performed. The modifier 25 allows the facility to receive a separate reimbursement for the evaluation and management service. Modifier 25 should not be appended to an E&M code unless there is a diagnostic or therapeutic (S or T procedure) billed on the same claim **and then only when the evaluation and management service is unrelated to the diagnostic or therapeutic procedure performed**. *(Bold as found in the document.)*

This language is a major departure from any previous guidance and also appears to go well beyond the language in CPT describing the "-25" modifier.

At issue is the use of the word *related* or in this case *unrelated*. In other words, taken at face value, this directive indicates that in order to use the "-25" modifier, any technical component E/M services must not be related to the diagnostic or therapeutic service provided.

> Case Study 1 – **Pain Management Clinic** – The Apex Medical Center has a pain management clinic that is operated three days a week by two anesthesiologists. Community physicians refer patients to the clinic. The anesthesiologists perform a consultation on the first visit and then periodically re-assess the patient during the course of injections. These assessments are made in an examination room. Typically, injections are provided during the first visit and during subsequent visits as well. Injections are provided in a treatment room.

If we take the *unrelated problem* as the standard, then the "-25" modifier could not be used on the technical component E/M for the initial assessment and the periodic re-assessments because all the services being provided relate to pain management. This would also be true in many other provider-based clinic situations.

However, the use of *unrelated problem* as a standard is ***quite contrary*** to CPT's definition of the "-25" modifier for hospitals. From CPT:

> "A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting E/M services on the same date."

The AMA added the language indicating that different diagnoses (i.e., different problem) were not a requirement starting in 1999. Thus, the need for differentiating diagnoses or having a different or unrelated problem is not required by CPT for using the "-25" modifier.

Note that the CPT definition requires documentation that substantiates the separateness of E/M service.

> Case Study 2 – **Emergency Department** – A 66 year old gentleman presents to the ED with a laceration of the right hand. He suffered the laceration while washing his car. The bleeding is controlled due to pressure from a wrapping. The triage nurse does an assessment of vitals, and interviews the patient relative to any dizziness, disorientation, headache and/or any other symptoms that might be present. The patient is taken to an ED bay. The physician sees the patient, reviews the nurse's documentation and then proceeds

to examine the wound. The wound is cleansed, and two sutures are applied along with steri-strips. The nurse reviews wound care instructions with the patient, and the patient is discharged home.

While there are some very fine nuances in this small case study, the EMTALA mandated MSE (Medical Screening Examination) was performed, in this case, jointly by the ER nurse and ER physician. This MSE certainly goes beyond evaluation of the laceration. This MSE, and the resources consumed (nurse time, room, etc.) would certainly appear to justify a technical component E/M along with the "-25" modifier.

However, if we apply the *unrelated problem* criteria, then the use of the "-25" will break down because there is no other problem or diagnosis. This would mean that the MSE is to be paid as a part of the laceration repair or, more generally, as part of any diagnostic or therapeutic service provided. This seems to be contrary to CMS's previous guidance on coding for E/M services.

Note: One of the nuances in Case Study 2 is that the physician may not have an E/M level because the physician did not perform any sort of general E/M service. A second and interlaced nuance is that because the physician did not generate the documentation for the E/M service (other than that related to the laceration) the ED physician cannot use the nurse's documentation to code an E/M level. Keep in mind that physicians and practitioners in a facility setting can generally code and bill only for what they personally perform.[1] Another concern relates to post-operative care.

Bottom-Line – It is difficult to assess the language found in this bulletin. If this language is taken at face value, then the use of the "-25" modifier will be highly limited and would be used only if there were an unrelated problem and thus differentiating diagnoses. This type of guidance is particularly troublesome when we are just about to face extensive RAC audits. If 'unrelated' is the standard, then the RACs will be able to claim significant overpayments in this area.

Also, in the guidance from Georgia Medicare, the title to the section used the word 'reminder'. Not only does this appear to be a significant change in policy, there also appears to be an attempt to claim that this has been the guidance all along so that this new standard can be applied retroactively.[2]

Everyone, standby!

[1] There is an exception for joint E/M services performed by a physician and a non-physician practitioner. See Transmittal 1776 dated October

[2] See Section 903 – MMA 2003.

Editor's Note: Given CMS's movement toward significantly increased packaging, this new language almost seems to herald a rule change in which the "-25" modifier will be used much less frequently. If the unrelated criterion is followed, then many E/M levels will be packaged.

ICD-10 & Electronic Transactions

Well, it is finally going to happen. **ICD-10 is on the way!** The implementation date is October 1, 2013. This is only about ten years behind the expected implementation. Also, there is a new version of the X12 standard for electronic health transactions. We are moving from the 4010 to the 5010 version. The new version fully accommodates the expanded ICD-10 format.

Also, there is a new Pharmacy Claims version. We are moving from Version 5.1 to Version D.0. This change was made to accommodate Medicare Part D and also to address Medicaid requirements for drug reporting. You may see the transaction standards referred to as '5010/D.0'. The general date for the new transaction standards is January 1, 2012 with a grace period for small health plans to January 1, 2013.

Questions & Answers

Editor's Note: Readers are encouraged to submit questions for consideration.

Question: We are a small Critical Access Hospital. We have a contracted ER physician. When a patient presents and is placed in observation our (attending) physician takes over care. Can I code and bill an observation admission for both doctors? Also, how do I code for a second day of observation for out physician? Also, what if the patient is admitted as an inpatient on the third day?

The coding on the physician side is the same whether you are a CAH or a PPS hospital. CAHs tend to become more involved in physician coding especially if you are using Method II and filing the services on a single UB-04. Normally, the ER physician and the attending physician would file individual claims (1500).

While ER physicians can have admitting to observation privileges, the normal structuring of the process for admitting to observation is that the ER physician codes and bills the ER level. The ER physician may do all of the paperwork and physically admit the patient to observation under the attending physician's name. Presumably, the ER physician has consulted with the attending physician. If the ER physician does not

provide the initial observation care, then the ER physician will code an ED level, probably something in the 99283-99285 range.

The attending physician will see the patient and then code and bill an initial observation care code, something from the 99218-99220 range depending upon the services provided by the physician. The second day, the attending physician will code an outpatient visit from the 99212-99215 range. If the attending then discharges the patient on the third day, the attending would use 99217.

However, in this case the attending physician decides to admit the patient to the hospital, and a code from the 99221-99223 range will be selected for the physician code.

Keep in mind that all of this is occurring on the professional side. On the technical side the process for CAHs and PPS hospitals will be different. If the patient is admitted as an inpatient, the CAH will bill everything. However, the PPS hospital will need to appropriately bundle under the DRG Pre-Admission Window.

There can be significant complications in this process. For instance, the ER physician may admit the patient to observation in the attending physician's name in the evening. The attending physician may not see the patient until the next day. The attending will then code the initial care for the next day and then code and bill depending on the services provided.

For small hospitals such as CAHs, another complication is that the attending physician may serve as the ER physician. For instance, the single physician may be contracted to cover the ED. In performing services in the ED the physician reassigns his/her Medicare payment to the hospital that employs them. When a patient is encountered, the physician as an ED physician may code and bill (through the hospital) for the ED services. The physician may decide to admit the patient to observation under their own name but as an attending physician.

Now what if this physician performs this service in the morning, is no longer covering the ED in the afternoon, and then in the afternoon sees the patient as the attending under whose name the patient has been placed in observation?

Needless to say, this type of situation requires careful study and consideration. Care should be taken to identify the specific arrangements between the hospital and the physician. Also the NPIs in use will need to be carefully considered. If you have this type of situation, or something similar, then analyze carefully and contact your FI or MAC for specific guidance.

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 2009Contact 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. Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Accuro Health, Progressive Business, 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 CY2008. Contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for May 12th "***The ED and APCs***". The presentation 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 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**
- **Introduction to Payment Systems** is currently in preparation.

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

E-Mail us at Duane@aaciweb.com.

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****** 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.

Worried about the RAC Audits? Special audits and studies are being provided to assist hospitals 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.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried 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.