Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

A Newsletter for Physicians, Hospital Outpatient
& Their Support Staff Addressing Medical Reimbursement Issues

August, 2008 – Volume 20, Number 8

ISSN: 1061-0936

APC/APG Update

The proposed APC update for CY2009 is out! The examination copy of the Federal Register appeared on July 3rd, and the official FR entry appeared on July 18th.

Please take the opportunity to send comments to CMS concerning a multitude of issues surrounding APCs and the proposed changes for CY2009.

Your comments can be sent by mail or submitted electronically. The deadline is September 2, 2008, no later than 5:00 p.m. EST. Note that for written comments, you must submit an original plus two copies.

In this August Newsletter we continue discussing a number of topics relating to APCs and other concerns relative to CMS's pronouncements. In some cases we will provide suggestions for possible comments. You may use any of our suggestions at your discretion.

CY2009 APCs – IVIG HCPCS G0332

CMS is proposing to bundle payment for G0332. This does not come as a great surprise.

Recommended Comments:

While you can comment to this issue and advocate for separate payment, this is most likely a change that CMS will implement regardless of comments.

CY2009 APCs – Cost Outlier Formula

The cost outlier formula continues to change from year to year. In theory the changes result in trying to insure that a certain percentage of the overall APC payments are in the form of cost outlier payments. Over the years for both APCs and DRGs, CMS has kept the formulas so that underpayments actually occur at least in terms of the overall APCs (and DRG) payments. Thus, the concern with this formula is the process of recalibrating the cost threshold. If CMS underestimates one year, the next year they should take steps to reduce the cost threshold to increase the overall percentage of outlier payments. Thus, over a period of years the average percentage of outlier payments would meet the goal.

Recommended Comments:

CMS should adjust the cost outlier threshold formula from year to year so that the overall average percentage of cost outlier payments is achieved. This may require actually lowering the cost threshold to the point that in a given year the percentage goes slightly above the goal

CY2009 APCs – Drug Overhead Charges/Costs

CMS continues their concern about hospitals' properly charging for drugs, particularly including drug overhead costs. This is a chargemaster charging issue that has a number of overtones. CMS's concern is well justified although they have not always helped in this area. For instance, there have been discussions of certain drugs being an *integral part* and thus not separately reportable.

Recommended Comments:

You will have to make your own decisions in this area. At the very least, CMS should take steps to make certain that drug overhead costs are being included in the claims through proper charging. Perhaps having separate HCPCS codes (with proper charges) for drug overhead is appropriate.

CY2009 APCs – Co-Payment Amounts

CMS should now be at a point that the coinsurance percentage is 20% for all APCs. The movement toward this goal has been agonizingly slow, and we continue to have some copayments that are based on a coinsurance percentage that is well above 20%.

Recommended Comments:

CMS should immediately set the copayment amounts so that they are calculated on a straight 20% coinsurance percentage.

CY2009 APCs – Closed Fracture Treatment

The proposed changes for APCs do include a reworking of closed fracture treatment for fingers, toes and trunk. Well, the APCs in this area are highly confusing because many of the fracture care codes (e.g., broken leg or arm) are outside the descriptor of 'finger/toe/trunk'. While we are moving in the right direction, the real issue of proper coding is not being addressed!

When APCs were started, we had two closed fracture care APCs just as we did with APGs.

- APC 0043, Closed Fracture Care Finger/Toe/Trunk, and
- APC 0044 – Closed fracture Care Except Finger/Toe/Trunk

APC 0044 has been dropped, but the descriptor for APC 0043 has never been changed. Now CMS is proposing three new APCs as follow:

- APC 0129 Level I Closed Treatment Fracture Finger/Toe/Trunk Payment $ 103.70
- 0138 Level II Closed Treatment Fracture Finger/Toe/Trunk Payment $ 398.09
- 0139 Level III Closed Treatment Fracture Finger/Toe/Trunk Payment $1,341.89

This three category delineation is an excellent start. Now we need to make certain that fractures of the fingers, toes and ribs map into the Level I APC, 0129, while the more expensive legs, arms, shoulders, etc. map into the Level II APC, 0138. If you look at the mappings, you will find that this is not the case!

Recommended Comments:

At the very least, CMS should change the descriptors to indicate that this is simply closed treatment of fractures. Also, the fractures of arms, legs and the like should map into APC 0138.

Additionally, CMS should issue guidelines on the proper coding of low level fractures of the toes, fingers and ribs. This was the original intention of APC 0043 in order to distinguish between relatively inexpensive care for fractured toes, figures and ribs, versus the more expensive fracture legs, arms, etc.

NCCI – Medicare Rescinds a Paragraph Therapeutic Vascular Catheterizations

In a letter dated August 6, 2008, Correct Coding Solutions, LLC (the Medicare Contractor for NCCI) issued a letter rescinding a paragraph concerning atherectomies performed after performing a percutaneous angioplasty in the same vessel. The new language that was placed in the NCCI Policy Manual for Medicare Services, Version 13.3 effective October 1, 2007, had the new following paragraph, which extended an old statement partially addressing this overall issue. The new language from Chapter V, Section D, Paragraph 16. was:

> *"16. If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures."*

Note that this new language brought bundling to vascular (i.e., non-coronary) therapeutic services that was essentially the same as that for coronary angioplasties, atherectomies and stenting, namely, that angioplasties bundle into atherectomies that also bundle into stenting services. On the coronary side, this bundling process is embedded directly in CPT itself through extensive parenthetical guidance.

CMS is indicating that the old Paragraph 16 will be reinstated, at least for the time being. Here is the old Paragraph 16, which is being reinstated.

> *"When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M)."*

A fairly common circumstance in vascular procedures is that a surgeon will attempt to address a lesion by using a balloon angioplasty. In some cases the angioplasty procedure is not successful (or only partially successful), and the surgeon decides to deploy a stent. The coding, billing, and thus reimbursement, concern is between:

1. The surgeon attempting an angioplasty, which fails and then a stent is placed versus
2. The surgeon performs an angioplasty in preparation for stent placement.

Ostensibly with the old guidance reinstated, this issue is not specifically addressed, and thus in the first circumstance above, you can code both the angioplasty and the stent placement. When the second situation is documented as a preparatory step, then the angioplasty is not separately coded and billed.

Note that with the first circumstance, the now rescinded guidance would have not have allowed the angioplasty to be separately coded and billed.

This change is retroactive to October 1, 2007 so that hospitals may need to consider refilling claims that were incorrectly coded under the rescinded policy.

Note: The bundling rules for percutaneous coronary therapeutic services are in CPT and are thus official for all coding and billing. The guidance discussed in this article is for the Medicare program with the NCCI edits and, thus, may not apply to other third-party payers.

EMTALA – The Continuing Saga – Part 1

EMTALA – the Emergency Medical and Labor Act – continues to be refined with new guidance, interpretations, and litigation. At the same time, hospitals continue to have difficulty with certain aspects of EMTALA, including proper clinical care relative to transfers.

The last major update for EMTALA occurred over a period of years, specifically in 2002 and 2003 with new interpretive guidelines in 2004. Since that time, we have had updated guidance addressing a range of issues. In this article we will summarize the changes over the past several years, including some major changes that were finalized in the August 19, 2008 *Federal Register*.

Note: Yes, this is the IPPS update FR entry. ETMALA would appear to deserve a separate FR entry, but EMTALA along with other key regulatory areas are often relegated to add-on status. That is, they are simply part of another larger FR entry.

Brief Background – Due to the technical nature of several issues, a little background is in order.

1. For a hospital to be directly subject to the EMTALA rules and regulations, two conditions must be met:
   a. The hospital must have a provider agreement with Medicare, and
   b. The hospital must have a DED or Dedicated Emergency Department;
2. EMTALA applies to an individual or person who comes to the hospital's DED;
3. EMTALA does NOT apply to a person who is a patient (inpatient or outpatient) of the hospital;
4. ED nursing staff can be qualified to perform the MSE (Medical Screening Examination) in obvious, non-emergency cases;
5. Transfers must be medically necessary;
6. Specialty physicians are to come to the DED when requested as a part of their MSO, Medical Staff Organization, membership.

Alright, this is really a short list of major problem areas for hospitals and their emergency departments. The propriety of transfers has always been a question. In today's healthcare environment there is another question in that the receiving hospital may not accept a transfer. For many hospitals, there is limited ability to provide specialty services so that the patient needs to be transferred to a (generally) larger hospital that can provide specialty services.

Note also that there are many more specialty hospitals that can provide certain types of specialty care. However, these specialty hospitals do not have DEDs. For these specialty hospitals, or hospitals in general that do not have DEDs, does EMTALA apply? CMS's answer to this question becomes convoluted.

Let us first address the question of an individual (note, not a patient) who comes to a hospital that does not have a DED. The hospital must have policies and procedures in place to address these types of situations. The most general policy is to dial 911 for emergency medical personnel to come take care of the patient. First aid would be provided in the interim.

Note: This is exactly the same situation that we have with off-campus provider-based clinics that are not DEDs. Because the individual has entered hospital property (i.e., the off-campus clinic), there is some degree of an EMTALA obligation. The typical policy is to dial 911 and provide first aid.

So let us take the hospital that does not have a DED but does have the capability to provide certain specialty services. What if an individual presents to a general acute care hospital, and they need specialized care that can be provided by a hospital that does not have a DED. Does EMTALA require the hospital with specialty capabilities to accept a transfer?

CMS's answer to this situation is 'yes'. Even though the hospital with specialty services does not have a DED, EMTALA still applies to them relative to transfers.

Now let us change the situation just slightly. Presume that an individual presents to a general acute care hospital with an emergency medical condition. The patient is assessed, and stabilizing treatment is commenced. The patient is admitted as an inpatient. Shortly the physicians determine that this patient needs specialized care beyond the capabilities of the hospital.

In this case, must the hospital with specialized services accept the transfer of the patient? After some consideration on the part of CMS, the answer is 'no'. The basic concept considered is distinguishing between being a patient versus not being a patient. Here is the main division:

- Individual presenting to the hospital is covered by EMTALA,
- A patient (outpatient or inpatient) is covered by the Conditions of Participation (CoPs).

In the case that an individual presents to a hospital with a DED, an emergency medical condition exists that requires specialty services, and the patient is transferred to a hospital having such specialty service. Even if the receiving hospital does not have a DED, EMTALA applies to both the initial hospital and the receiving hospital.

EMTALA obligations cease when the individual becomes a patient. Thus, in the case of the individual that presents to the hospital with an emergency medical condition, the patient is treated and then admitted as an inpatient, EMTALA ceases to apply. When the individual becomes a patient, the CoPs apply, and the transfer process is a normal hospital to hospital transfer. Also, the receiving hospital does not have to honor the transfer.

The ***second major issue*** that CMS addresses in the August 19, 2008 *Federal Register* is that of specialty, on-call physicians. Even though hospitals maintain rosters of specialty physicians, specialty physicians may refuse and/or be unavailable. This has been an on-going issue for years. CMS has not been unsympathetic to this situation, but the EMTALA rules and regulations don't leave hospitals with many options.

CMS has now developed the concept of *community call*. This process allows participating hospitals to develop a formal plan. CMS indicates that the following elements must be a part of the community call plan.

- *The community call plan would include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.*
- *The community call plan would define the specific geographic area to which the plan applies.*
- *The community call plan would be signed by an appropriate representative of each hospital participating in the plan.*
- *The community call plan would ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.*
- *Hospitals participating in the community call plan would engage in an analysis of the specialty on-call needs of the community for which the plan is effective.*
- *The community call plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.*
- *There would be an annual reassessment of the community call plan by the participating hospitals.*

While the process of having a community call plan can certainly be useful, what about hospital that is the only hospital in the community? Critical Access Hospitals (CAHs) already have networking arrangements for transferring patients. However, due to geographic constraints, there are many hospitals that are on their own. Typically, such hospitals have only limited access to specialty physicians.

Community call plans can ease some of the challenges with on-call specialty physicians, but the whole issue of EMTALA on-call requirements will continue to be a challenge.

Note also, in the discussions in the preamble of this FR entry, CMS continues to believe that hospitals have a great deal of control over physicians in the Medical Staff Organizations. Thus, a hospital should be able to demand that specialty physicians take on-call responsibility and actually respond to requests. Hospital administration may have a very different view of the degree of control that is present through the MSO.

Questions from Our Readers

Question: We need some guidance on the correct use of modifier 25. Below are some scenarios.

1. Patient comes to the Wound Clinic (outpatient, provider-based) the first time to see physician to take care of a wound on his leg. The Wound Clinic physician does a full assessment (H&P, reviews old

records if applicable, etc.), and the nursing staff does a complete admission assessment including pictures, etc.). During this first visit the physician also decides to order further labs, x-rays etc., and performs a debridement. He then instructs the patient to come back in a few days, and he will possibly do another debridement and provide the results of the tests he ordered. Would an E&M, based on the hospital specific acuity tool, with a modifier 25 be assigned along with the appropriate debridement CPT code? Or would just the debridement CPT code be assigned?

2. The same patient from above comes back to the Clinic regularly for debridements. During one of the visits the physician suspects a possible infection in the wound. So he does the debridement, calls the patient's PCP to discuss what would be the best antibiotic and then gives the patient a prescription. Would you assign only the debridement CPT code or would you also assign an E&M code with a modifier 25 for the additional workup on the wound?

3. The same patient from above comes to the Clinic for a debridement. The physician also notes that he has lost some weight and orders a Dietary Consult for the patient. Would you assign only the debridement CPT code or would you also assign an E&M code with modifier 25 to account for the additional workup?

The question provided is similar to other questions that we receive in this area. There are really two closely connected issues:

a. Should a separate E/M be coded, and
b. Should the "-25" modifier be used to separate the E/M service from another procedure or medical procedure?

Even beyond these two questions, there are also concerns about documentation and also the choice of the E/M level on both the practitioner side and the hospital, technical component side.

The general answer to this question is a definite 'yes' in all three cases. Note that a physician is performing all the services. A non-physician practitioner such as an NP (Nurse Practitioner) or a PA (physician assistant) would also qualify.[1]

In each of these cases there is a significant, separately identifiable E/M service being provided in connection with a medical or surgical procedure.

[1] We are presuming that any and all state scope of practice and administrative arrangements are being met.

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:
http://www.aaciweb.com/July2008June2009EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2008 Contact 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. Instruct-Online, AHC Media, LLC, Accuro Health, Progressive Business, and the Eli Research Group are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008 and 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 September 16th, "***Researching Coding and Billing Compliance Issues".*** The presentation will run from 9:30 a.m. to 11:00 a.m. EDST.

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 is 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**
- **Chargemaster Coordinator's Handbook** is currently in preparation.

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

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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.

Interventional Radiology, Catheterization Laboratory and Vascular Laboratory a Challenge? Special studies are being provided to assist hospitals in coding, billing and establishing the Charge master. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about preparing for the RAC audits? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.