Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

August 2009 – Volume 21 Number 8

ISSN: 1061-0936

APC/APG Update

The comment period for APCs is rapidly approaching. We discuss some of the ongoing issues for APCs in this Newsletter. There are some new modifiers that will be going into effect through the I/OCE. These involve *never events*.

- "-PA" – Surgical or Invasive procedure on the wrong body part
- "-PB" – Surgical or Invasive procedure on the wrong patient
- "-PC" – Wrong Surgery or Invasive procedure on patient

These are similar to the inpatient two digit codes that go into the remarks on the claim form.

- MX – Wrong Surgery on Patient
- MY – Surgery Wrong Body Part
- MZ – Surgery on Wrong Patient

Note that Medicare will not pay with these new modifiers. Also, any other procedures performed at the same time will not be paid, and the physician/practitioner performing the services will not be paid.

ICD-9 & MS-DRGs - Update

The final *Federal Register* for the MS-DRG update that commences on October 1, 2009 is now (almost) out. The official publication date is set for August 27th. This is almost a month late, which is unusual with CMS because in the past this *Federal Register* is generally out on or about August 1st. luckily, the examination copy of this FR entry was available early in August.

This is a very lengthy FR entry because MS-DRGs as well as the long-term hospital version of DRGs are presented.

We are now moving toward the completed changes for MS-DRGs relative to the recalibration of the MS-DRG weight based upon costs as opposed to charges. This three-year process has highlighted a significant problem in cost reporting for implantable devices. From pages 129 and 130 of the examination copy, we have:

> "*In the FY 2009 IPPS final rule (73 FR 48468), we stated that we expect the revised cost reporting forms that reflect one cost center for "Medical Supplies Charged to Patients" and one cost center for "Implantable Devices Charged to Patients" would not be available until cost reporting periods beginning after the Spring of 2009. At the time the proposed rule was issued, we anticipated that the transmittal to create this new cost center would be issued in June 2009. Because there is approximately a 3-year lag between the availability of cost report data for IPPS and OPPS rate setting purposes in a given fiscal year or calendar year, we stated that we may be able to derive two distinct CCRs, one for medical supplies and one for devices, for use in calculating the FY 2013 IPPS relative weights and the CY 2013 OPPS relative weights."*

Thus the changes to the cost reporting process to alleviate charge compression for both MS-DRGs and APCs has been initiated, but it will take several years for any effect to occur.

Note also, that CMS is working on a complete overhaul of the cost reporting process so that there will be other changes coming as well. While the cost report may not seem important because we have prospective payment systems for both inpatient and outpatient services, there are still significant issues.

Note: Chargemaster coordinators, coding and billing staff, be certain to develop close working relations with cost reporting personnel. They have a wealth of knowledge about what is going on in your hospital and/or hospital system.

The modifications to the ICD-9 coding system were fairly extensive. Activity level with ICD-9 has been fairly high

in recent years even as we are finally moving toward ICD-10 for 2013.

The most notable change is with the E-Codes or external cause codes. This is really an independent subset of ICD-9. Even for those not heavily involved in diagnosis coding, the E-Codes turn out to be very interesting. The number range for the E-Codes has been expanded. Instead of starting with E800, the codes now start with E000. This greatly expands the code set.

With a number of new codes it is almost worthy sitting down and reading through the various changes. For instance:

- E001.1 – Activities Involving Running
- E004.3 – Activities Involving Bungee Jumping

There are also status codes that can be used in conjunction with the typical E-Codes.

Other changes were more typical. A number of additions were made to the V-Codes. This is a code set that describes the patient's reason for encounter.

RBRVS & the MPFS Update

While there are a number of technical changes proposed for the Medicare Physician Fee Schedule, one interesting change is the proposal to drop the consultation codes and use the regular new patient or established patient E/M codes. CMS has already made this change on the hospital technical side with APCs.

Because the consultation codes pay more than the regular clinic visit codes, specialists have long favored their use. If CMS proceeds with this change, there will be a shift in reimbursement from specialists to primary care physicians. The consultation codes have long been a compliance issue due to coding requirements. In order to use the consultation codes, the following must be in place:

- Request for a Consultation,
- Consultant Must Render Advice or Opinion,
- Written Report Back to Requestor,
- Do Not Take Over Care.

Of course the specialist can take over care after the consultation has been completed. Consultation codes are used in both the outpatient and inpatient settings.

The technical changes for the MPFS deal with overall reimbursement levels. Due to pressures from CMS to hold down overall expenditures, recently the RBRVS conversion factor has been going down.

2010 APC Update – Additional Issues

Here is a list of additional issues as found in the July 20, 2009 APC update Federal Register.

- CCRs and RTI Recommendations
- Inpatient-Only Procedures
- Two-Times Rule
- Cost Outliers
- Transitional Pass-Through Items + Devices
- Beneficiary Co-payments
- Drugs, Biologicals and Radiopharmaceuticals
- Electronic Health Records
- Quality Data Reporting
- Expanding HACs (Hospital Acquired Conditions) to OPPS
- Special Hospital Considerations – SCHs and MDHs

On the CCRs and the RTI recommendations, see the comments in this Newsletter for MS-DRGs. The inpatient-only procedure list continues to represent a major problem with APCs. Also, the beneficiary co-payment still are not at the 20% level even after ten years.[1]

RAC Update

We are now starting to see the first of the issues listed at the different RAC websites. Here are seven issues.

- Blood Transfusions, with CPT codes 36430, 36440, 36450, and 36455 (excluding claims with any modifiers) should be billed as one (1) per session, regardless of the number of units transfused on any given date of service.
- Untimed Codes For CPT Codes (excluding modifiers KX, and 59), for which a procedure is not defined by a specific time frame (untimed codes), the provider should enter a one (1) in the units-billed column per date of service.
- IV Hydration Therapy Based on the definition of CPT 90760 (excluding claims modifier-59), the maximum number of units should be one (1) per patient, per date of service. Beginning 1.1.09, code 90760 was replaced with code 96360.
- Bronchoscopy Services CPT Codes 31625, 31628 and 31629 should be billed with a maximum number of units of one (1) per patient, per date of service (excluding claims with modifier 59) and reported with one unit per date of service.
- Once-in-a-Lifetime Procedures By virtue of the description of the CPT code, these codes can be performed only once per patient lifetime.

[1] Technically the 20% is called the coinsurance with the co-payment being the actual dollar amount.

- Pediatric Codes Exceeding Age Parameters Newborn/Pediatric CPT codes being applied/billed for patients who exceed the age limit defined by the CPT code.
- J2505: Injection, Pegfilgrastim, 6 mg By definition, HCPC Code J2505 represents 6 mg per unit. The code should be billed at one (1) unit per patient, per date of service.

Probably the most interesting issue is that of blood transfusions. The guidance in this area has been a little confusing. From Transmittal 495 dated March 4, 2005:

> "Transfusion services codes are billed on a per service basis, and not by the number of units of blood product transfused. For payment, a blood product HCPCS code is required when billing a transfusion service code. A transfusion APC will be paid to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused."

There are circumstances in which there may be two different transfusions on the same date of service. For instance, one transfusion in the morning and another in the evening. Because there are two different encounters, CPT 36430 would be used twice, BUT there would be a modifier on the second such as "-76" or "-77" for a repeat procedure. Note that in the statement of the issue only multiples of 36430 without modifiers will be checked.

OIG Report on Physician Incident-To Billing

The OIG has issued the following report:

"Prevalence and Qualifications of Nonphysicians Who Performed Medicare Services", OIE-09-06-00430 dated August 2009. This report presents the findings for audits conducted on services that were billed by physicians and the services, or some part of the services, were provided by subordinate personnel. This is called *incident-to billing* and this process is allowed only in freestanding settings. In facilities, such as hospitals, physician are generally allowed to code and bill for services which, they, the physicians perform.

Among other things, the OIG found that in 21% of the services, the nonphysician providing services was not qualified. The OIG has made three recommendations.

1. Seek revisions to the "incident to" rule. The rule should require that physicians who do not personally perform the services they bill to Medicare ensure that no persons except: licensed physicians personally perform the services or nonphysicians who have the necessary training, certification, and/or licensure, pursuant to State laws, State regulations, and Medicare regulations personally perform the services under the direct supervision of a licensed physician.

2. Require physicians who bill services to Medicare that they do not personally perform to identify the services on their Medicare claims by using a service code modifier. The modifier would allow CMS to monitor claims to ensure that physicians are billing for services performed by nonphysicians with appropriate qualifications.

3. Take appropriate action to address the claims for services that we detected that:
   - were billed by physicians and performed by nonphysicians that were, by definition, not "incident to" services and
   - were for rehabilitation therapy services performed by nonphysicians who did not have the training of a therapist.

CMS has accepted the first and third recommendations and has deferred on the second as being too cumbersome to implement. Modifiers would be needed for joint services as well as for services provided entirely by the nonphysician personnel.

Note that incident-to billing has long been a point of contention with the OIG. Monitoring and auditing in this area is difficult unless there is substantial documentation relating to the nonphysician providers who are providing services under the direct supervision of the physician or practitioner. Most likely, this whole area will be explored much more fully in the future, and it may even become a RAC issue.

Injections and Surgery

As the RACs gear up we will see many more issues added to their lists. One area of on-going confusion is with injections and infusions in connection with outpatient surgical procedures. CMS has given us rather conflicting guidance in this area.

In Transmittal 1445 to CMS Publication 100-04, Medicare Claims Processing Manual, dated February 8, 2008, CMS has a very interesting statement that was added to §230.2B, which is the Coding and Payment for Drug Administration.

> Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those

> services are separately paid of their payment is packaged.

This statement seems to be very clear! Hospitals are to code and bill all injections and infusions regardless of whether or not they are paid. CMS seems to be stating that for infusions and injections in general, the issue is not coding and billing, the issue is for the claims adjudication process to correctly package or pay separately.

Another source from which to gain information is CMS's National Correct Coding Initiative. This is a very large set, approximately 300,000, or code pairs not to be used together unless there is an appropriate reason and the "-59", separate procedure, modifier is used. From Version 14.3.1, Page I-7 of Chapter I *General Correct Coding Policies For National Correct Coding Initiative Policy For Medical Services* we have:

> Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 90760-90775).

From Page XI-4 of Chapter XI *Medicine Evaluation And Management Services CPT Codes 90000 - 99999 For National Correct Coding Initiative Policy Manual For Medicare Services*, we have:

> Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Note that the injection/infusion codes have not been updated, but these statements seem to indicate that these injections and infusions should not be separately reported for operative procedures.

Where does this leave us? Hospitals need to report charges for unusual injections and infusions in order for the costs to be included in the recalibration of APC weights, but we are not allowed to code these services. Apparently the charges can be reported, but must be without any CPT/HCPCS codes. Otherwise these codes would be paid[2], and this whole area would become a RAC issue. Note that this guidance within the NCCI gives us a partial definition of what is included in the surgical procedures.

[2] While this guidance is in NCCI, there are no edits preventing payment.

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 15th:"**Hospital and Physician Billing for DME**" 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.

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

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FOR UPCOMING ISSUES

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More on Payment System Interfaces

****** ACTIVITIES & EVENTS ******

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: Chris@aaciweb.com.

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned 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. E-Mail: Chris@aaciweb.com.