# 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

Both the APC and MPFS update *Federal Registers* are out. For APCs the date is July 18, 2011, and comments must be submitted August 30th. The MPFS update is dated July 19, 2011, and the deadline for comments is also August 30th. These *Federal Register* entries are out almost a full month relative to previous years.

**Note**: Dr. Abbey's brief comments to the July 18th and July 19th Federal Register entries are available at the AACI website: www.aaciweb.com.

## Physician Supervision – Part 2

As indicated in Part 1 of this article, the whole issue of physician supervision has taken on a life of its own starting in 2008. The July 18, 2011 *Federal Register* entry, specifically Section X – *Proposed Policies for the Supervision of Outpatient Services in Hospitals and CAHs*, must be read with extreme care. See pages 42277-42285.

Read not only for content, but also notice the words and the way in which CMS summarizes what they interpret as previous discussions. For example, from page 42278:

> *"Therefore, in the CY 2009 OPPS/ASC proposed rule and final rule with comment period (73 FR 41518 through 41519 and 73 FR 68702 through 68704, respectively), we clarified and restated the various supervision requirements for outpatient hospital therapeutic and diagnostic services. We clarified that therapeutic services furnished in the hospital and in all PBDs of the hospital, specifically both on-campus and off-campus PBDs, must be provided under the direct supervision of physicians."*

Note the use of the phrase, *clarified and restated*. Fundamentally, it appears that CMS is still maintaining that the changes being made are simply clarifications and not changes. Note also that CMS is now clearly stating relative to supervisory requirements that these requirements are in place for the hospital and in PBDs of the hospital, specifically for on-campus and off-campus PBDs.

Thus when assessing and establishing that there is proper physician supervision taking place, these concerns involve three distinct areas:

1. In the hospital,
2. On the campus of the hospital, and
3. Off-campus from the hospital.

There may also be situations in which the hospital is providing services under arrangements that occur in a nonhospital facility. While the discussions of these services is generally in the context of diagnostic services, at this juncture, therapeutic services under arrangements at nonhospital facilities should also be subject to the physician supervision rules. For example, a hospital may contract for hyperbaric oxygen services as a turn-key operation. The services may be provided at a nonhospital facility. Historically there have been similar situation such as a hospital's providing aquatherapy services at a pool that is not part of the hospital.

**Note**: The whole issue of how to interpret the *under arrangement prohibition* under the provider-base rule (PBR) has never been delineated by CMS. At some point this may become as issue that arises from the physician supervision requirements.

CMS derives most of the supervisory requirements from the Social Security Act (SSA) at 1861(s)(2)(B). This rather brief section indicates that hospitals are paid for services that are incident-to those of a physician. From page 42284:

> *With respect to the issue of application of the payment conditions in § 410.27 to services described by benefit categories other than section 1861(s)(2)(B) of the Act, we are proposing to amend our regulations to clarify our policy. Therapeutic services and supplies described*

*by benefit categories other than the hospital outpatient "incident to" services under section 1861(s)(2)(B) of the Act are nevertheless subject to the conditions of payment in § 410.27 when they are furnished to hospital outpatients and paid under the OPPS or to CAHs under section 1834(g) of the Act.*

Basically what CMS is stating is that the conditions for payment (CfPs), specifically 42 CFR §410.27 can be applied to other services just as they are applied to incident-to services.

Be certain to read through the proposed §410.27 language. This change generally broadens the application of the supervisory requirements for therapeutic services. CMS is certainly making certain that all the bases are covered.

*Additionally, we believe that there is a similar level of clinical risk in the therapeutic hospital outpatient services covered under other benefit categories that are not explicitly defined as "incident to" services. For example, stereotactic radiosurgery (a radiation therapy service under section 1861(s)(4) of the Act) is a high risk and technically demanding surgical procedure. We do not believe that the current requirements under § 410.27 regarding supervision, under arrangement, provider-based, and other aspects of service, were intended to apply only to a subset of hospital outpatient therapeutic services and supplies, or that the agency ever intended to omit large classes of services that are routinely furnished to hospital outpatients from being governed by this regulation.*

Note the rather prolific use of the word *believe*.

*Editor's Note:* See July 18, 2011 (76 FR 42277), November 24, 2010 (75 FR 71998), August 3, 2010 (75 FR 46306), November 20, 2009 (74 FR 60564), July 20, 2009 (74 FR 35358), November 18, 2008 (73 FR 48702), and July 18, 2008 (73 FR 41518) *Federal Registers*.

## Ambiguous Guidance from CMS: Technical Component E/M Coding – Part 2

In the first part of this series, we concluded our discussion with a case study that involved closed fracture care for a simple, nondisplaced fracture of a rib. Because of the minimal nature of care for this condition, some hospitals will not code CPT 21800 and will elect to include such services in their E/M levels. Because there have been no definitive coding guidelines, this lack of consistency has skewed the APC categories in this area.

Another significant challenge for hospitals is to develop the required mapping of resources utilized into the different E/M levels. This directive comes from the April 7, 2000 Federal Register, page 18451:

"*Therefore, each facility should develop a system for mapping the provided services or combination of services furnished to the different levels of effort represented by the codes*."

Hospitals have responded with a variety of different approaches. Typically, there are three approaches:

a. Point System,
b. Narrative System, and
c. Diagnosis Code System.

Point systems are generally simple and count the number of nursing interventions, nursing activity, and other resources used. Narrative systems provide small examples of the types of services that fit into the different E/M levels. In some cases, hybrids of point and narrative systems are used.

Using diagnoses to drive the choice of the E/M level was developed as a part of the pre-cursor system to APCs, namely APGs or Ambulatory Patient Groups. In APGs the E/M levels were generally bundled if there was any other related service provided. Only when an E/M service was provided in an isolated situation was a separate payment made. This involves looking at the presenting diagnosis along with any definitive diagnoses that were made. The presumption is that the level of E/M services correlates to the type and level of diagnoses present for the encounter.

Whatever system is used, hospitals have two major questions:

1. Is our resource mapping appropriate, and
2. Do we obtain standard distributions for the level?

The answer to the first question is one of the great mysteries in this area. Auditors are hard pressed to judge whether a given system is appropriate or not.

At the national level CMS continues to maintain that there are normal distributions when amalgamating hospitals together.

From the July 18, 2011 Federal Register, page 42272:

*In addition, the stable distribution of clinic and emergency department visits reported under the OPPS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect*

*in a system that accurately distinguished among different levels of service based on the associated hospital resources.*

However, CMS is now noting that a shift toward higher levels is occurring. Also from page 42272:

*We note that we have observed a slight shift over time toward higher numbers of level 4 and level 5 visits relative to the lower level visits, when comparing the distributions of Type A emergency department visit levels from CY 2005 claims data to those from CY 2010. We also note that, in aggregate, hospitals' charges for these higher level emergency department visits seem to be trending upward year over year.*

Soon CMS will be talking about "E/M creep". For hospitals these kinds of discussions are not particularly useful. When a given hospital generates the frequency distributions for their ED and provider-based clinic E/M levels, the distributions are far from normal. Let us consider some case studies.

**Case Study 1 – *Small Community Hospital*** – The ED is busy, but more than half of the encounters in the ED appear not as emergencies but as urgent or clinic level care. The community is using the ED as a walk-in clinic.

For Case Study 1, there will be many low-level ED visit codes. The distribution likely will be skewed toward the level 1 and level 2 codes.

**Case Study 2** – ***Metropolitan Hospital*** – Because of an increasing volume of ED encounters, the hospital has established an urgent care clinic to handle the walk-in presentation for relative minor services. The ED itself generally sees only truly emergent cases.

In Case Study 2, the ED most likely is seeing patients at the mid to upper levels. Thus the distributions will be skewed to the higher levels.

What these two little case studies illustrate is that the frequency distribution of cases is influenced, if not controlled, by the actual types of cases that are presenting to the given ED.

So, what does this mean? More importantly, what steps do hospitals need to take in order to be confident that they are compliant?

The immediate issues are:

- Is the resource mapping being used consistently, and
- Does the resource mapping generate correct E/M levels?

Auditors can check for consistent use of the resource mappings. Even here there can be some challenges in that the mappings themselves may be updated or changed depending upon coding conventions and changes in code availability.

For example, in the last few years the insertion of a Foley catheter now has a separate CPT code. Previously, this nursing activity was included in the E/M level. Now it can be separately coded and billed as appropriate.[1]

One of the major issues for the mappings is that services that are otherwise separately codeable and billable should not be included in the resource mappings. This leads us back to the discussion in Part 1 of this article where we discussed closed fracture treatment in situations in which the standard of care is minimal. However, a policy decision must be made.

Another example of this situation is point of service glucose testing, at least in the ED. Glucose testing is a waived laboratory test that can be performed by nursing staff. If there is a way to capture the provision of these services, then it can be billed separately. Often there is no easy way to capture charges, and this activity goes into the E/M level mapping.

The separation of separately codeable and billable services from the E/M levels also raises the question of proper use of the "-25" modifier. Again this is an area where CMS has provided minimal guidance, which was issued very early in the implementation of APCs.

So where does this leave us relative to our resource mappings into the different E/M levels for the ED and provider-based clinics? How can a hospital be assured that they are compliant in this area? Without national E/M coding guidelines, there is no way to assure compliance. You can use internal auditing staff along with external reviews, but the auditors can only judge accuracy and correctness based upon some sort of guidelines.

Here are some action steps that can be taken:

1. Periodic audits of E/M level coding to determine if the resource mappings are being used consistently,
2. Perform an annual review of each of the resource mappings (i.e., ED and clinics) to check for

[1] See the NCCI edit policy manual for coding guidance concerning Foley catheter insertion.

needed changes and faithful utilization of the mappings,

3. On a quarterly basis, develop histograms of the frequency distributions for the different areas in which technical component E/M coding is occurring,
4. At least on an annual basis, check for the frequency and appropriateness of the use of the "-25" modifier,
5. Include a section in the hospital's annual compliance report discussing the activities surrounding the E/M coding and use of the "-25" modifier.

The inclusion of a section in your hospital's annual compliance report is important. Each year you can discuss challenges with the E/M mappings, changes that you have made, audit findings and recommendations, and then also an explanation of how you have made every effort to maintain compliance in the face of almost complete ambiguity.

*Editor's Note: In Part 3 of this article, we will continue the discussion of the "-25" modifier and the way in which the RACs may approach technical component E/M coding and proper use of the "-25" modifier.*

## GAO Improper Payments Report

On July 25, 2011, the Government Accountability Office issued*: IMPROPER PAYMENTS - Reported Medicare Estimates and Key Remediation Strategies*. For compliance personnel including RAC Coordinators and for coding and billing departments for any healthcare provider, this report should be carefully reviewed.

There is no doubt that the federal government is convinced that there are enormous improper payments, mainly overpayments, that are being made. This report indicated $48 billion without considering the Part D drug coverage. Thus, hospitals, clinics, physicians, DME suppliers, home health along with other healthcare providers should anticipate increased scrutiny through audits of various types.

The GAO recommends five strategies:

***Strengthen provider enrollment standards and procedures.*** *Strong standards and procedures can help reduce the risk of enrolling providers intent on defrauding the program. CMS has taken action to implement provisions of the Patient Protection and Affordable Care Act by screening providers by levels of risk and providing more stringent review of high-risk providers, but has yet to implement certain GAO recommendations in this area.*

***Improve prepayment reviews****. Prepayment reviews of claims help ensure that Medicare pays correctly the first time. According to CMS, as of July 1, 2011, CMS has begun applying predictive modeling analysis to claims and plans to expand Medicare prepayment controls. CMS has not implemented GAO's recommendation to improve prepayment reviews.*

***Focus postpayment reviews on vulnerable areas****. Postpayment reviews are critical to identifying payment errors and recouping overpayments. In March 2009, CMS began instituting a national recovery audit contractor (RAC) program to help the agency supplement its postpayment reviews. CMS has also developed information technology to help it better identify claims paid in error, but GAO recently reported that the systems are not being used to the extent originally planned and made several recommendations to address the issues.*

***Improve oversight of contractors****. CMS has taken action to improve oversight of prescription drug plan sponsors' fraud and abuse programs, which addresses GAO's recommendation, but is still developing specific performance statistics.*

***Develop a robust process to address identified vulnerabilities****. Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical. While CMS has begun actions in this area, it has not developed a robust corrective action process for vulnerabilities identified by Medicare RACs as GAO recommended.*

First the GAO recommends strengthening the provider enrollment process. Given the fact that CMS has been making significant changes in this area, further *strengthening* of the process can only mean additional bureaucratic burdens. The various CMS-855 forms, PECOS, and NPIs are already a challenge. Even for a small integrated delivery system, literally there can be dozens of the CMS-855 forms that must be constantly updated. Also, if there is any sort of organizational restructuring and/or growth in the organization, the number and type of CMS-855s will also increase.

Add to this the possible bureaucratic delays in processing CMS-855 forms, and you will realize that there can be significant financial impacts as well.

Predictive modeling analysis is very much like implementing a RAC process, but in this case it is at the front-end of the process, that is, prepayment reviews.

In the October 2010 edition of this Newsletter, we did discuss the new predictive modeling requirements under

the Small Business Jobs Act.[2] This congressional action is now starting to take place as of July 1, 2011.

The GAO seems convinced that CMS's RAC program is not progressing as fast as was anticipated. From the GAO perspective, the RAC program is the only encompassing audit program that is in widespread use. How much more quickly the RACs can move is an interesting question. There are some major, rather subjective issues that have not been commenced. For hospitals, the technical component E/M levels and the use of the "-25" modifier along with enforcing supervision requirements are all yet to be addressed.

Contractor oversight is always an issue, at least from CMS's point of view. We are right in the middle of going to regional MACs (Medicare Administrative Contractors). Changes in this area, particularly a hospital or clinic switching to a new MAC can certainly create difficulties in terms of claims adjudication and local coverage decisions (LCDs). For healthcare providers, there really should not be any differences in the way in which the regional MACs adjudicate claims and issue policy directives. It is sometimes surprising what types of issues are really relegated to the MACs. For instance, the whole issue of active monitoring relative to counting hours of observation has really defaulted to the MACs. Unfortunately, obtaining specific guidance from the MACs can sometimes be difficult.

The fifth strategy involves an area that is of great concern to healthcare providers of all types. For instance, a specific vulnerability has been identified by the RACs, in this case even during the demonstration program, involving short-stay inpatient admissions. Review of records will sometimes indicate that an inpatient admission was not justified, but observation services were justified. For instance see the O'Connor Hospital Ruling that was discussed in the April 2010 edition of this Newsletter, O'Connor Hospital Ruling, 22:4, 19-20.

Different areas where there has been ambiguous guidance have been discussed in this Newsletter. The area of technical component E/M coding is discussed in an article in this edition as an example.

Auditors can only audit and determine correct coding and billing when they have guidelines to follow. If there are no guidelines, then subjective judgments will always creep into the process. Many of the claims that the RACs make concern subjective judgments and interpretation of the CMS rules and regulations.

[2] Predictive Modeling Requirements – Small Business Jobs Act –Medical Reimbursement Newsletter, Oct 2010 22:10, 56-57

## 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/JantoDecember2011EdCal.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 27th "***The Medicare Secondary Payer Program***" 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 book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
http://www.HIPAAMaster.com

Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330



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## ****** 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 physician supervision? Schedule a special provider-based audit to assist your hospital in meeting supervisory requirements. 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.**

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