Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

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Season's Greetings!!

The consultants and staff at Abbey & Abbey, Consultants, Inc., along with our extended family of consultants wish to take this opportunity to extend our warmest wishes for a happy holiday season and a productive and fruitful new year.

APC/APG Update

The updates for both APCs and the MPFS will go into effect on January 1, 2012. Be certain to review carefully and experiment with your newly updated APC grouper/pricer software. As usual, there will be changes that are embedded in the software logic that may not have been overtly addressed through the *Federal Register* updates.

The update for the MPFS has been clouded due to the 27.4% decrease in physician payments. This severe decrease has resulted from the sustainable growth rate formula that has not been implemented for several years. Congress may, or may not, intervene once again.

OIG Work Plan for FY2012 – Part 2

Editor's Note: This is the second part of a two-part article addressing the OIG's Work Plan for FY2012.

The latest OIG work plan pays special attention to home health agencies with several issues. Keep in mind that, for home health providers, there is a relatively new prospective payment system. This prospective payment system is essentially data driven through the use of patient assessment instrument (PAI). For home health, the OASIS or (Patient) Outcome and Assessment Information Set is used. Here is a work plan issue.

Missing or Incorrect Patient Outcome and Assessment Data - ***We will review home health agencies OASIS data to identify payments for episodes for which OASIS data were not submitted or for which the billing code on the claim is inconsistent with OASIS data. OASIS data are electronically submitted to CMS, independent of the home health agency's claim for episode payment. Federal regulations require that HHAs submit OASIS data as a condition for payment. (42 CFR § 484.210(e).) HHAs receive prospective payments based on 60-day episodes of care. The OASIS is a standard set of data items used to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services and includes the billing code for the episode of care.***

Another home health issue involves auditing agencies where there are questionable billing patterns. It would certainly be nice to know exactly what constitutes questionable billing patterns.

Questionable Billing Characteristics of Home Health Services - ***We will review home health claims to identify home health agencies that exhibited questionable billing in 2010. Questionable billing refers to claims that exhibit certain characteristics that may indicate potential fraud. We will identify and review HHAs that had a high percentage of claims that meet at least one of the questionable billing characteristics. Medicare spending has increased 81 percent for HHA services since 2000. The home health benefit was originally intended for short term, post hospital recovery for homebound beneficiaries, but it has been expanded to include other types of homebound beneficiaries. Home health services are authorized by Medicare Part A of the Social Security Act, §§ 1812(a)(3) and 1814(a)(2)(C) and by 42 CFR § 409 subpart E. Services for homebound beneficiaries on a part-time or intermittent basis are authorized in Part B of the Social Security Act, §1832(a)(2)(A), and at 42 CFR § 410.80.***

ABNs (advance beneficiary notices) along with associated notification forms are addressed in the new work plan, although the work plan issue is identified through the use of 'G modifiers'. These are the "-GA", "-GX", "-GY", and "-GZ".

Medicare Payments for Part B Claims with G Modifiers - ***We will review Medicare payments made from 2002 to 2010 for claims on which providers used certain modifier codes indicating that Medicare denial was expected. We will determine the extent to which Medicare paid claims having such modifiers. We will also identify providers and suppliers with atypically high billing related to the modifiers. Providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary. (CMS's Claims Processing Manual.) They may use GX or GY modifiers for items or services that are statutorily excluded. A recent OIG review found that Medicare paid for 72 percent of pressure-reducing support surface claims with GA or GZ modifiers, amounting to $4 million in potentially inappropriate payments.***

The whole ABN issue is an on-going long-term situation. Particularly hospitals continue to have sometimes significant issues because of the potential need to use ABNs or some sort of notice of non-coverage.

There are several physician issues that are new or represent modifications of previous issues. Here are two examples.

Physicians: Impact of Opting Out of Medicare - ***We will review the extent to which physicians are opting out of Medicare and determine whether physicians who have opted out of Medicare are submitting claims to Medicare. We will also examine whether specific areas of the country have seen higher numbers of physicians opting out and its potential impact on beneficiaries. Physicians are permitted to enter into private contracts with Medicare beneficiaries. (Social Security Act, § 1802(b).) As a result of entering into private contracts, physicians must commit that they will not submit a claim to Medicare for any Medicare beneficiary.***

The whole issue of *opt-out physicians and practitioners* appears on the increase. Opt-out physicians, as the name implies, opt-out of the Medicare program. These physicians can still see Medicare patients, but services are provided under private contract. Another complicating factor is that these opt-out physicians can provide urgent and emergent care and bill Medicare directly for these services. Hospitals should anticipate that at least some of these opt-out physicians will request staff privileges that may entail special billing procedures. Because this is a recognized trend, there will be on-going compliance concerns.

For physicians, using various modifiers in connection with the global surgical package (GSP) can become complicated. The GSP has several features including:

- Pre-Operative and Post-Operative Periods,
- Unrelated E/M Services within the GSP,
- Return to Operating Room and the Complications Rule.

Note that under the Medicare Physician Fee Schedule (MPFS), payment percentages are split between the pre-operative, intra-operative and post-operative periods even though actual payments split out only the post-operative period for separate payment.

While the GSP under the MPFS appears as a physician issue, there can be entanglements on the hospital side as well. Similar modifiers may be used in different ways, and even the 3-day payment window can become involved.

Evaluation and Management Services: Use of Modifiers During the Global Surgery Period - ***We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during the global surgery period were in accordance with Medicare requirements. Prior OIG work has shown that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period. (CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 30.***

The MACs (Medicare Administrative Contractors) also conduct audits and associated investigations when there are billing problems and possible incorrect payments.

Contractor Error Rate Reduction Plans - ***We will examine the extent to which Medicare contractors have error rate reduction plans in place and the extent to which the plans have resulted in lower error rates for contractors.***

We will also assess CMS's oversight of the process and the extent to which it affects overall contractor evaluation. Error rate reduction plans describe the corrective actions that contractors plan to take to lower the CERT paid-claims error rate and provider-compliance error rate in their jurisdictions.

This is an interesting issue. How the OIG auditors will investigate and determine what the MACs are identifying and correcting should be quite enlightening. This issue almost seems to fit into the overall thrust that CMS, and presumably the MACs, are not really implementing changes to reduce known improper payments in already identified problem areas.

DRG 3-Day Payment Window – Part 2

This is Part 2 of a two-part article addressing recent changes and interpretations involving the 3-day payment window.

One of the unique features of the 3-Day Payment Window is the *trigger* for application of the rule. The trigger is an entity (facility, organization, service area) that is wholly owned or wholly operated by the admitting hospital.

Editor's Note: The use of the work 'entity' is unfortunate on the part of CMS. A 'provider-based entity' has a specific definition under the provider-based rule (PBR). CMS's use of 'entity' in the 3-day payment window context does not appear to follow the PBR definition.

Any entity that is provider-based (i.e., hospital-based) is by definition both wholly owned and wholly operated by the admitting hospital. There are some possible exceptions:

1. Joint ventures on the campus of the admitting hospital, and
2. RHCs and FQHCs.

As discussed in Part 1 of this article, for Rural Health Clinics and Federally Qualified Health Centers, at least those that are provider-based, CMS has indicated that the 3-day payment window does not apply.

Payment for RHCs and FQHCs is cost-based and is made on the basis of a encounter that bundles various services. The ability to separate professional component and technical component for an encounter is, at best, extremely difficult. Thus, CMS has decided not to try to apply the 3-day payment window for FHCs and FQHCs.

Joint ventures on the admitting hospital's campus also become a potential issue. Ostensibly, if the joint venture is provider-based to the hospital, then the 3-day payment window applies. However, there are situations that do raise questions. One of these is Ambulatory Surgical Centers (ASCs). In theory ASCs have their own provider agreements so that the 3-day payment window may not apply. However, in some cases hospitals do (wholly) own the ASC so that the 3-day window would appear to apply in this situation. Explicit guidance from CMS is needed in this area.

Ownership is a key criterion for the 3-day payment window. While we will not discuss what it means for a hospital to wholly operate an entity that is not owned by the hospital, this could also be an issue of import in some cases.

Now, just how is ownership interpreted by CMS? Generally, CMS is fairly strict in that there must be true ownership by the admitting hospital. Now there is a multitude of ways to organize hospital services. Consider the following case studies.

Case Study 1 – ***Hospital 1 owns Hospital 2*** - Services are provided at Hospital 2 facilities shortly before a patient is admitted to Hospital 1. Does the 3-day payment window for Hospital 1 apply to the services provided at Hospital 2?

The answer to this question is clearly *yes.* What if there was a third hospital? That is, Hospital 1 owns Hospital 2 that in turn owns Hospital 3? The answer remains the same. The Hospital 1 pre-admission window would still apply if services were provided through Hospital 3.

Case Study 2 – ***Hospital System*** - Both Hospital 1 and Hospital 2 are owned by a parent corporation, that is, a hospital system. The hospital system also owns several freestanding physician clinics. Each of the two hospitals also has both provider-based and freestanding clinics.

Services provided by the hospital system owned freestanding clinics would not be subjected to the 3-day payment window for either hospital. Likewise, services at Hospital 1 entities would not be subject to the application of the 3-day window to Hospital 2.

The number of different organizational scenarios is significant. Simply keep in mind that there must be true ownership or, less likely, true operation of the given entity.

The most complicated questions for the 3-day payment window occur with freestanding physician clinics that are either wholly owned or, possibly, wholly operated by the

admitting hospital. Three issues immediately come to mind:

1. Overlap with the MPFS global surgical package,
2. Technical component charges, and
3. Capturing costs relative to the technical component charges.

Case Study 3 – ***Freestanding Physician Clinics – Hospital Charges*** – The Apex Medical Center owns three freestanding physician clinics. Only a 1500 claim is filed due to competitive pressures. Apex has no provider-based clinics. In applying the 3-day payment window, Apex wants to include charges for the technical component of services at the clinics that must be bundled. However, there are no such charges on the hospital chargemaster.

In the circumstances of Case Study 3 Apex will need to establish a fairly complete charge structure for any services provided at the wholly owned clinics. The charges should represent the technical component of services provided even though the professional fees will not be adjusted. Or should the professional fees be adjusted?

In essence, Apex will need to set up a charge structure in the hospital chargemaster for the activities of the clinics. This is really very much like establishing charges for provider-based clinics. For provider-based clinics, the charge structure usually involves taking the full professional charges and splitting them into two components: one for professional charges and one for technical component charges. If split billing is not performed for all patients, then the full professional fee charges to patients will be the same as the sum of the split fee arrangement.

Even if the hospital establishes the technical component charges as described above when applying the 3-day payment window, there will be apparent overcharging. This will occur because the clinic will probably not reduce their (total) professional fee, and then the hospital will also be charging the technical component. The total charges to the patients will be the sum of the full professional fees on the 1500 claim form and the technical component on the UB-04 claim form. Whether this is a violation of the so-called *Medicare Charging Rule* is an interesting question.

Presuming that the charging issue is addressed, then the corollary questions becomes, how are the costs associated with the charges captured and placed on the cost report? At this point, this cost reporting issue is an open question. The costs for these freestanding physician clinics are not otherwise reported. Thus, some sort of artificial approach will be needed. In lieu of formal guidance from CMS, the hospital's outpatient CCR (cost-to-charge ratio) could be used to convert the charges into costs. Obviously, this process is the reverse of the normal process to determine the CCRs.

Another complicating factor for these freestanding physician clinics is that there can be an overlap of the global surgical package (GSP) and the 3-day payment window. Consider Case Study 4.

Case Study 4 – ***Postoperative Care Overlap With 3-Day Payment Window*** – The Apex Medical Center owns several freestanding physician based practices. One of them is surgery clinic. Stephen had outpatient surgery on Monday. The post-operative period is 10-days. He goes to the surgery clinic for a follow-up visit on Friday. Unfortunately on Monday he is admitted to the hospital for a rather severe infection.

When Stephen returned to the clinic for the post-operative care, the surgeon (or group of surgeons) had already been paid through the GSP. There may have been some internal billing using CPT 99024, but there was most likely not a separate billing.[1] While this service is certainly subject to the 3-day payment window, there are immediate operational problems in that there is no charge made. Thus, carving off the technical component of the charge is nonsensical.

In this type of situation, CMS has indicated that the service need not be bundled into the inpatient billing. However, note the following from page 73285 of the October 28, 2011 *Federal Register*.

> ***However, any service that a wholly owned or wholly operated physician practice would bill separately from the global surgical package, such as a separate initial evaluation of a problem by the surgeon to determine the need for surgery or separate diagnostic tests, would continue to be subject to the 3-day payment window policy.*** (76 FR 73285)

Questions from Our Readers

Question: **At our hospital we have several provider-based clinics. Three of the clinics are specialty in nature, specifically dermatology, orthopedics and cardiology. The other clinics are family practice. We are trying to use the same technical component E/M mapping for all of our clinics. Can the specialty clinics have different mappings and how can we know we are in compliance?**

[1] For the purposes of this case study we will not consider transferring post-operative care to another physician or group of physicians.

Different mappings for the specialty clinics will probably be needed. There appears no mandate to use exactly the same mapping for all of the clinics and/or the Emergency Department for that matter. While CMS has long promised national E/M coding guidelines, it appears that will not happen in the near term. Currently CMS, through *Federal Register* discussions, has been asking the AMA to develop special code sets to address the technical component E/M coding.

The three specialties that you have established are quite different relative to clinic services. In dermatology you may well have E/M services along with various treatments. Orthopedics will probably involve many assessments and then post-operative visits. While it is possible that an orthopedic clinic might perform casting, strapping and associated services, more likely these would be performed at the hospital. Cardiology will involve many routine office visits along with routine EKGs and possibly medication management (e.g., Coumadin clinic).

Basically, in developing an E/M mapping, you should first analyze the services that are being performed. While much of the resources utilized will revolve around nursing services and room utilization, be careful to segregate any surgical services or other codeable services from the E/M mapping. In following this general process different E/M mapping will probably result.

Determining whether or not your mappings are in compliance requires that there be specific guidelines. While CMS has discussed certain features of the mappings and even provided some very general guidelines, there is no definitive way in which an auditor can verify compliance.

Consider the general guideline that when you perform a frequency analysis on the different levels of E/M codes, there should be a bell-shaped curve. This means that the level 3 should be most prevalent, levels 2 and 4 the next most prevalent and finally levels 1 and 5 the least prevalent. For specialty clinics this is highly unlikely. For instance, a cardiologist may legitimately bill out a level 4 E/M on the professional side, but the encounters may generally be relatively brief and may involve little ancillary personnel such as nursing. Thus, on the technical side the frequencies of E/M codes may be skewed toward the lower levels.

The bottom line is simply to do your best and then wait to see audit findings either from your MAC or from your RAC once the RACs get involved in this area.

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 2012. 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 CY2011 and planned workshops for CY2012.

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 January 24th ***"3-Day Payment Window"*** 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.

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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 Jane 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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