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

Be certain to carefully review these two Transmittal from CMS concerning APCs and the changes for CY2013.

1. Transmittal 2616 – December 21, 2012 – "*January 2013 Integrated Outpatient Code Editor (I/)CE) Specifications Version 14.0*" to Publication 100-04 Medicare Claims Processing, and
2. Transmittal 2611 – December 14, 2012 – "January 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)" to Publication 100-04 Medicare Claims Processing.

These Transmittals are technical in nature, but they are filled with valuable information that helps us all to understand just how APCs are working and just how the APC grouper logic has been developed. From Transmittal 2616, there are three new, non-pharmaceutical APC categories and two, non-pharmaceutical APCs that have been deleted.

New APCs:

- APC 00059 – Level I Strapping
- APC 00177 – Level I Echocardiogram with Contrast
- APC00178 – Level II Echocardiogram with Contrast

Deleted APCs:

- APC 00086 – Level III Electrophysiological Procedure
- APC 00128 – Echocardiogram with Contrast

Editor's Note: For those of you that have eagle-eyes, note that CMS is using five digits for APC categories instead of the usual four digits. While this appears as a technical change of interest only to computer processing personnel, this increase in digits may be a hint of things to come in the future as APCs becomes more complex.

In Transmittal 2611 there is more discussion about changes in the pricer logic and various coding changes. For instance two major issues discussed are:

- Billing for Intracoronary Stent Placement (§61.5), and
- Partial Hospitalization Billing for Hospitals, Community Mental Health Centers and Critical Access Hospitals.

While there is a brief discussion of the 'sometimes therapy' codes, there is no discussion of the new PT/OT/SLP codes and modifiers. Keep in mind that PT/OT/SLP is not under APCs and thus not a part of OPPS. (See Transmittal 2622, December 21, 2012 for a thorough discussion of the claims-based data collection for outpatient therapy services.)

CMS Year-End Transmittals

In the last two months of each calendar year, CMS seems to issue quite a number of Transmittals. Most of these deal with APCs and the Medicare Physician Fee Schedule (MPFS). However, always be watchful for some unusual updates. The following discussion addresses several of these transmittals.

Transmittals 2611 and 2616 are the update transmittals for APCs, and these are briefly discussed above. In coming issues of this Newsletter we will discuss some of the coding and APC grouping changes that have occurred with the changes to APCs for CY2013.

Transmittal 2622, "*Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services*" to CMS Publication 100-04, Medicare Claims

Process, is a lengthy transmittal. Here is CMS's background statement:

> "*This Change Request implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new nonpayable functional G-codes and 7 new modifiers on selected claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services*."

These new codes and associated modifiers really go back to the mid-1990's when we had FRGs or Functional Related Groups. The FRGs were very much contemporaneous to APGs (Ambulatory Patient Groups). Now, years later, we are seeing the functional assessment concept being implemented on an informational basis.

There is good news in that providers have a grace period to implement these codes. CMS states:

> *However, a testing period will be in effect from January 1, 2013 through June 30, 2013, during which claims without the required G-codes and modifiers will be processed to allow providers to use the new coding requirements in order to assure that their systems work.*

Thus hospital outpatient therapy departments as well as independent therapy clinics will have some time to prepare for the reporting of the functional status.

One of the major operational challenges is who is going to code the functional status and then add the correct modifiers? This process question needs careful attention. In the hospital setting, we have addressed a similar question on a much smaller scale. Namely, who determines if the "-59" modifier, *separate procedure*, should be used on therapy claims.

While professional coding staff could be trained to code these new G-codes from the documentation, more likely the therapy personnel are in a much better position to correctly code the functional status at the time the documentation is being developed.

Note that the current "-GP", "-GO", and "-GN" modifiers (for PT, OT and SLP) will still be used. For hospitals, these modifiers generally are embedded in the chargemaster. Some care will be needed to verify that the new modifiers as coded and then entered into the billing system, will not override the standard G-modifiers that indicate services were provided under a plan of care (POC).

There are many other nuances for coding in this area. Therapy services generally involve multiple visits over weeks and months and then there may be more than one POC that is being followed. Careful study of this transmittal and further guidance from CMS should be anticipated.

Transmittal 443, *"Update to Pub. 100-08, Program Integrity Manual, Chapter 13"* does not appear very exciting. For compliance personnel and coding and billing personnel, the changes that are being made will have a definite impact on the MAC's development of LCDs (Local Coverage Decisions). Here is the key background statement:

> *"To be consistent with Hays v. Sebelius, 589 F.3d 1279 (D.C. Cir. 2009), the Centers for Medicare & Medicaid Services (CMS) is updating the Program Integrity Manual, Chapter 13, Publication 100-08, to state that Medicare Administrative Contractors (MACs) shall no longer use Least Costly Alternative (LCA) provisions within their Local Coverage Determinations (LCDs)."*

Basically the concept of LCA, that is, Least Costly Alternative, will no longer be used in the LCDs developed by the MACs.

There are other wording changes and updating that are also in this transmittal. Compliance personnel along with anyone involved with the RACs (Recovery Audit Contractors) are very much aware of the power of these LCDs for auditing. Also, while the MACs generally try to coordinate these coverage decisions, there can be variability in different part of the country.

Transmittal 2610, "Update to Publication 100—04, Claims Processing Instructions for Chapter 12, Non-Physician Practitioners (NPPs)", basically addresses modifier changes for certain NPPs. These changes involved professional billing on the CMS-1500 claim form and for CAHs (Critical Access Hospitals) using Method II on the UB-04 claim form.

While the policy statement is a little long, a nice summary is provided:

> *"NPP assistant-at-surgery services should be billed with the "AS" modifier only. The health professional shortage area (HPSA) payment modifiers, "QB" and "QU" have been eliminated because they are no longer valid. The "AH" modifier for CPs and, the "AJ" modifier for CSWs have been eliminated because they are no longer necessary for identification purposes. The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85*

percent of what a physician is paid under the Medicare Physician Fee Schedule (MPFS). Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services."

There are no payment changes for the NPPs. The main change is the elimination of the following modifiers:

- "-AH" – Clinical Psychologist,
- "-AJ" – Clinical Social Worker,
- "-QB" – HPSA Rural,
- "-QU" – HPSA Urban.

Be certain to read all of this transmittal with care. The very first statement in the general policy synopsis seems to be contradicted in the actual manual language. For instance, from §20.4.3 we have:

"*Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized."*

Thus, the "-AS" modifier is not the only modifier that can invoke the assistant-at-surgery.

There is also language that indicates that NPPs can be paid for services provided during the Global Surgical Package (GSP). While this certainly includes payment for assistant-at-surgery for approved surgical procedures, the proper application of the GSP for NPPs as well as other physicians (i.e., not the surgeon) can become quite complex.

Transmittal 442, "*Update for Amendments, Corrections and Delayed Entries in Medical Documentation*", provides changes for the Medicare Program Integrity Manual. The changes, actually additional language, are intended for use by the MACs, CERT, RACs and ZPICs. These auditing entities are to follow the standard recordkeeping principles. Entries That contain amendments, corrections or addenda must:

"*1. Clearly and permanently identify any amendment, correction or delayed entry as such, and*
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Not delete but instead clearly identify all orginal content."

This language should be carefully reviewed by compliance personnel and health information management staff.

Transmittal 2613, "*Revised and Clarified Place of Service (POS) Coding Instructions*", updates the Medicare Claims Processing Manual. The POS indicator is used on the CMS-1500 claim. With the proliferation of provider-based clinics, correctly reporting the POS is vital in order to drive the application of the Medicare site-of-service (SOS) differential.

Note: This annual Transmittal is very important. It not only provides all the POS codes, but is also indicates whether the given POS is a facility or non-facility code. That is, whether the SOS reduction in physician payment occurs (facility POS) or does not occur (non-facility POS). For example, Mobile Unit, POS=15, and Urgent Care Facility, POS=20, are both classified as NF, that is, non-facility. Thus, for provider-based mobile clinics or urgent care centers POS=22, Hospital Outpatient should be used on the claims. POS=22 is classified as F for facility, and the SOS reduction would come into play.

The reason for this rather lengthy transmittal is that the OIG has urged CMS to strengthen the education process in this area. Here are two key statements from the background section of the transmittal.

"*This instruction establishes that for all services – with two (2) exceptions -- paid under the MPFS* ***that the POS code to be used by the physician and other supplier shall be assigned as the same setting in which the beneficiary received the face-to-face service****. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of PFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the professional component (PC)/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner shall be the setting in which the beneficiary received the technical component (TC) service.*" (Emphasis Added)

"*There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service*."

Both physician and outpatient hospital coding staff should carefully review this transmittal. The correct POS

is vitally important in order to receive proper payment for physician/practitioner services.

Note: There is also another transmittal, 2598 to the Medicare Claim Processing Manual that addresses the type of service (TOS) on the CMS-1500. The TOS on the 1500 claim form is little utilized by payers for actual payment purposes. For CMS, the TOS is assigned when the claim is adjudicated. Thus, for CMS the TOS is used as an internal classification mechanism.

Transmittal 2574, "*Payment of Global Surgical Split Care in a Method II Critical Access Hospital (CAH) Submitted with Modifier 54 and/or 55"*, updates the Medicare Claims Processing Manual. Ever since Method II billing was established for CAHs, CMS has been issuing special guidance on how to bill for physician and practitioner professional services on the UB-04. The UB-04 claim form was not designed for professional billing, as such. Thus, when CAHs perform complex physician coding that can easily be handled by the CMS-1500 data set, the UB-04 data set is less than adequate.

A basic part of the challenge lies with the fact that the professional services are actually paid through the Medicare Physician Fee Schedule (MPFS). This payment file (and associated logic) is not a normal part of claim processing on the hospital side. Of course, therapy services are paid through the MPFS, so there has been some use of the MPFS.

This particular transmittal discusses what is already a significant problem, even when delimited to physician coding and billing on the CMS-1500 claim form. There are three modifiers of interest:

- "-54" – Intraoperative Care,
- "-55" – Postoperative Care,
- "-56" – Preoperative Care.

These three modifiers provide the means to properly code and bill when a surgery is performed. In MPFS there is a rather complex Global Surgical Package or GSP. When you study the GSP, you will quickly realize that the title should be Global *Surgeon* Package. The rules and regulations are actually based on what the surgeon does or does not get paid as opposed to a global payment for the surgery for which several doctors may be paid.

For instance, if a surgeon is scheduled to perform surgery on a given date of service and the surgeon also performs the pre-surgery H&P on that date, then the surgeon will not be paid for the H&P. However, if a different physician or practitioner performs the H&P, they will be paid separately from the surgery or surgeon's payment.

Note that MPFS does not use the "-56" modifier, as such. This modifier is in the RBRVS (Resource Based Relative Value Scale) information when the preoperative, intraoperative and postoperative percentages are aligned. For instance a given surgery may have the following percentages:

- Preoperative – 10%,
- Intraoperative – 80%, and
- Postoperative – 10%.

Currently, CMS lumps the preoperative and intraoperative percentages together.

Generally, the surgeon is responsible for the postoperative care. That may be for 10 or 90 days depending upon the surgery. Surgical procedures performed through existing body orifices (e.g., colonoscopies) generally have a 0-day follow-up.

Now what if a surgeon asks another physician or practitioner to take over all or part of the post-operative care? At a small hospital such as a CAH, the surgeon may perform an inpatient procedure and then ask a hospitalist to follow the patient while they are in the hospital (i.e., several days). After discharge a primary care physician may be asked to follow the patient. Just how is billing supposed to take place? Who will get paid for what?

Besides the mechanics of billing, for example, the proper use of the "-54" and "-55" modifiers, there are some substantive documentation issues. The surgeon must formally transfer care to the other physician(s) or practitioner(s). This transfer of care must be in writing. What if the surgeon asks the other doctor to be on-call just in case there are any complications? In other words, what constitutes a formal transfer of care?

Transmittal 2606, November 30, 2012, "*Expansion of Medicare Telehealth Services for CY2013*", is an update to the Medicare Claims Processing Manual. The change involved for Telehealth involves some significant coding changes for individual psychotherapy services.

There are now G-codes for services such as alcohol or substance abuse (other than tobacco), annual depression screening, behavioral counseling to prevent sexually transmitted infections, behavioral therapy for cardiovascular disease, and behavioral counseling for obesity. See generally the G-codes in the G0396-G0447 range.

Note: There was a companion Transmittal, namely 164 to the Medicare Benefit Policy Manual issues on November 30, 2012.

Questions from Our Readers

Question: **Our hospital is establishing a satellite radiology operation about 20 miles away from the main hospital. These services are being requested by a group of physicians (family practice and internal medicine) that are in the same building, just across the hallway. Only the technical services are provided, there are no radiologists at the site to interpret the results. Among the tests that are anticipated are CTs that require a contrast injection.. Our questions are:**

a. **Is a notice of two co-payments required for this operation?**
b. **Can the direct physician supervision required for the injection of the contrast be fulfilled by the physicians across the hall?**

There will be no need to issue a notice of two co-payments, because the services provided by the hospital at this satellite operation will not generate two copayments. The notice of two copayments is directed at E/M and surgical services where a single service (e.g., a single E/M service) generates two different copayment amounts in a provider-based setting.

Note: In the above paragraph, there will actually be two copayments involved. At some point a physician, most likely a radiologist, will bill for the interpretation of the radiological services. However, this billing and thus copayment may or may not have anything to do with the hospital as such.

The physician supervision of the contrast injection will require some degree of judgment. First of all, the family practice or internal medicine physicians may not be considered appropriate for supervision of certain radiological procedures. However, in this instance, the supervision is only for the contrast injection.

Second, is the issue of immediate availability and/or location of the supervising physician. CMS has not provided explicit guidance in this area. Note that the supervision being considered is on the diagnostic side, not the therapeutic side. For direct physician supervision of diagnostic tests, the physician must be immediately available and in the office suites. If the specific circumstances are such that the hospital judges that the physicians across the hall meet this requirement, then care should be taken to affirmatively document which physician or physicians met the supervision requirements for dates and/or hours on a given date.

Note: The specific supervisory requirements for physician supervision on the diagnostic side are found in the RBRVS spreadsheet that comprises the MPFS.

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/JantoDecember2013EdCal.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 CY2013.

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 22nd - "***Meeting the Physician Supervision Challenge"*** will run from 9:30 a.m.. to 11:00 a.m. EST.

Dr. Abbey's 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 fourth book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book addresses fee schedule payment systems, and the third in the series addresses prospective payment systems. The fourth and final book in this series addresses cost-based, charged-based and contractual payment systems.

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:
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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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FOR UPCOMING ISSUES

****** 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 Jane 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 Jane Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com