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

You should have your APC Grouper/Pricer software so that you can start experimenting with all the new increased packaging that started this year. Note that this software was generally delayed because of all the significant logic changes that were made to the APC Grouper/Pricer.

While we all experiment and learn, we should also be preparing for the next *Federal Register* cycle for updating APCs for CY2009. We will be discussing some of the ongoing issues in upcoming Newsletters. Workshop participants and clients have requested that we prepare a base set of comments that can then be adapted by the specific person/organization submitting comments. Watch for these basic comments that will be placed out at our website: www.APCNow.com. The proposed update to APCs for CY2009 should be out by May or June with our base comments following shortly.

Updated Infusion/Injection Codes

There are several new injection/infusion codes provided in CPT for CY2008.

90769 – Subcutaneous infusion for therapy or prophylaxis initial; up to one hour including pump set-up and establishment of subcutaneous infusion site(s)
(For infusions of 15 minutes or less, use 90772)

+90770 - each additional hour
(Use 90770 in conjunction with 90769)
(Use 90770 for infusion intervals of greater than 30 minutes)

+90771 - additional pump set-up with establishment of new subcutaneous infusion site(s)
(Use 90771 in conjunction with 90769)
(Use 90769 and 90771 only once per encounter)

+90776 - each additional sequential intravenous push of the same substance/drug provided in a facility
(Do not report 90776 for a push performed within 30 minutes of a reported push of the same substance or drug)
(90776 may be reported by facilities only)

While these new codes are certainly welcome at some level, clearly the complexity of coding and associated billing in the infusion and injection area is rapidly becoming the domain of professional coding staff. Expecting nursing staff to correctly code these services via charge entry driving the coding through the hospital chargemaster has become problematic at best.

For the subcutaneous infusions there is nothing surprising in the logic other than the use of 90769 and 90771 only once per encounter. The APC mapping for these codes is:

90769 → APC=0440 - $114.64 – Level V
90770 → APC=0437 - $ 25.13 – Level II
90771 → APC=0438 - $ 51.22 – Level III

At first glance, the 90776 code for each additional IV push of the same substance appears to be a useful addition in that all of the IV pushes can now be coded. However, reading the parenthetical directions that this code cannot be used within a 30 minute time period tend to destroy its usefulness. Again, if nursing staff are entering charges that then drive the codes, are they going to be able to understand the timing delimitation?

Also note that 90776 is a facility-only code. CPT generally provides codes for physician use. Does this addition herald a move toward developing more facility-only CPT codes?

For APCs, the 90776 code is Status Indicator "N", so there is no additional payment. Thus, all of the efforts to properly use this code almost becomes a futile effort from a payment perspective.

The good news is that the overall payment rates for the injection and infusion codes continue to be quite reasonable for CY2008. While there are some small changes in reimbursement under APCs, the payment rates have not changed dramatically. Be prepared for the injections and infusion to become Status Indicator "Q: in the future; this will herald possible packaging.

Table 1 shows the payment levels for CY2007 versus CY2008.

APC Drug Admin	CY2008 Pay	CY2007 Pay
Level I	**$16.21**	**$14.02**
Level II	**$25.13**	**$25.71**
Level III	**$51.22**	**$52.93**
Level IV	**$105.38**	**$109.25**
Level V	**$114.64**	**$116.62**
Level VI	**$149.34**	**$155.27**

Table 1 – Injection/Infusion Payment Levels

Observation & 3-Day SNF Qualifying Stay

During a recent presentation of our Observation Services webinar/teleconference, the question about whether observation days in the hospital count toward the 3-day SNF qualifying requirement was raised. This question involves an unusually complex payment system interface. Three different payment systems come into play:

- APCs – Observation Services
- DRGs – Inpatient Services
- SNF – Skilled Nursing Consolidate Billing.

As to whether observation services qualify in meeting the 3-day consecutive inpatient days for Medicare to cover SNF services, the current answer is 'no'. Well, at least not currently. We will discuss this answer and the current CMS guidance, but first we will address some corollary issues.

Three additional topics that can come into play are:

1. Billing for observation services in the DRG pre-admission window,
2. POA Coding for conditions in the DRG pre-admission window, and
3. DRG transfer rule.

A full discussion of these three issues is beyond the scope of this article. The DRG pre-admission window is conceptually simple, but proper application can become quite complex. The DRG transfer rule has been greatly expanded in the last several years and potentially reduces payment for hospital moving patient from inpatient to SNF or home health.

Now, back to our original question. Hospitals are placed in a particularly difficult situation in that the physician may admit the patient to the hospital in order for the patient to have a qualifying 3-day stay prior to skilled nursing services. The following situations may involve the same level of care, but result in drastically different coverage for the patient.

- Case 1 A patient is admitted to observation on Monday. Wednesday morning the patient is admitted as an inpatient to the hospital. On Friday morning the patient is discharged to a skilled nursing facility.
- Case 2 – A patient is admitted to the hospital as an inpatient on Monday. On Thursday morning the patient is discharged to a skilled nursing facility.

Under current CMS pronouncements, in Case 1 the patient will not qualify for SNF coverage. In Case 2, the consecutive 3-day inpatient stay, within 30 days of the SNF admission, will be attained.

While there have been discussions about the issue of having observation stays included in the 3-day qualifying stay, currently this is not the case. Consider Transmittal 57, to CMS Publication 100-02, Medicare Benefits Policy, dated November 8, 2006:

> ***Section 1861(i) of the Act requires that a beneficiary be an inpatient of a hospital for not less than 3 consecutive days before discharge from the hospital in order to be eligible for coverage of post-hospital extended care services. Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as inpatient status commences with the calendar day of hospital admission. See 31 Fed. Reg. 10116, 10118-19 (July 27, 1966).***

This language applies to Chapter 8, §20.1.

Now this situation provides another layer of complexity to the whole observation versus inpatient admission process. Physicians, who think that SNF services may be necessary, will be much more likely to admit the patient to inpatient status as opposed to an observation admission.

CMS to Expand RAC Program

While there is the remote possibility that Congress will intervene, CMS is planning to expand the RAC (Recovery Audit Contractors) program to all states. Most likely, this will occur next year or certainly by 2010.

Based on the experience of the three pilot states, New York, Florida and California, hospitals and physicians alike will be significantly impacted. The basic approach in these audits is that overpayments are identified, and future payments will be withheld for recoupment of the overpayments. Then you, the hospital or physician, must fight to get the money back.

The RAC audits are supposed to look for both overpayments and underpayments. This program was mandated by Congress is MMA 2003, Section 306.

Demonstration Project For Use Of Recovery Audit Contractors.

> *(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project—*
>
> > *(1) payment may be made to such a contractor on a contingent basis;*
> > *(2) such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and*
> > *(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.*

Note that the auditing organizations are paid on a contingency basis, that is, a percentage of what is recovered. You may recall that back in 1997, the OIG issued guidance that questioned the use of consultants on a contingency basis, and there were lawsuits filed by the OIG relative to such consultants. For instance, see *United States v. Metzinger*. However, ***apparently***, it is proper for CMS to use consultants on a contingency basis.

Among other considerations, there are five different aspects to the RAC audits:

- Delimited Areas of Consideration
- Data Mining Techniques Using Claims Data
- Actual Clinic/Medical Record Review
- Inconsistent CMS Policy Interpretations
- RAC Issues Are Not New

The contractors chosen to provide services are not currently allowed to look at everything. For instance, the E/M levels on the physician side, and most certainly on the hospital side, are currently out of bounds. However, as time goes on, even the E/M levels will be fair game.

Data mining is still an emerging science. Nonetheless, the contractors use a number of techniques to assess and analyze claims data in looking for aberrations that suggest overpayments (and theoretically, underpayments). While the RAC auditors look at claims data on a large scale, physicians, hospitals and other healthcare providers have been using the same techniques on a much smaller scale.

For example, in a hospital setting, pick a service area and then select a sampling of 30 claims. While the RAC auditors will be looking only[1] at claims data, in the hospital setting we can also look at the itemized statements. Take your 30 case sample and simply go through them to see if there are any inconsistencies, unusual occurrences or something that does not look quite right. Typically, you will start to notice inconsistencies. These inconsistencies may occur because of differing third-party payer requirements.[2]

However, most likely you will recognize other patterns that, when taken to much larger samples, can suggest possible overpayments and/or other aberrations. Another example of this process has been used with DRGs in assessing the relative frequencies of certain pairs, triples and even quadruples of associated DRG categories.

One of the emerging benefits of the RAC auditor activities has been that CMS is being forced to have consistent payment and coverage policies and procedures. While the healthcare provider community

[1] This presumes we are discussing data mining techniques. At a more advanced level, the RAC auditors will consider additional documentation.

[2] Of course, now that we are under the HIPAA Transaction Standard/Standard Code Set rule, there ***should be no differences*** in claims filed to various third-party payers.

has long recognized serious inconsistencies, now that the RAC auditors are claiming overpayments, a clear enunciation of CMS policies and procedures is required to determine if there really were any overpayments.

Again, note that the general process within the RAC audits is that there are assertions of overpayments. The overpayment amounts are recouped, and then the given provider must protest and attempt to reclaim the recoupment. As usual the recoupment process involves withholding future payments for Medicare services.

Note also that none of the issues raised and/or being considered by the RAC auditors are new. We will be discussing a number of these concerns in forthcoming issues of this Newsletter. Virtually everything being considered by the RAC audits has been identified by the OIG and/or by CMS auditing programs.

Editor's Note: We will discuss the RAC program more thoroughly in upcoming issues of this Newsletter.

OIG Concerns about Diagnostic Testing in the ED Continue

The OIG has included a project in the FY2008 OIG Work Plan involving ED services. This is an instance of the OIG's more general concern about too much diagnostic testing in the ED. On page 6 of the Work Plan we have:

> **Payments for Diagnostic X-Rays in Hospital Emergency Departments**
>
> *We [OIG] will review a sample of Medicare Part B paid claims and medical records for diagnostic x-rays performed in hospital emergency departments to determine the appropriateness of payments. Radiology services furnished by a physician are reimbursed by the Medicare Physician Fee Schedule provided the conditions for payment for radiology services at 42 CFR § 415.102 (a) and 42 CFR § 120 are met. The Medicare Payment Advisory Commission (MedPAC), in its March 2005 testimony before Congress, reported concerns regarding the increasing cost of imaging services for Medicare beneficiaries and potential overuse of diagnostic imaging services. In 2004, approximately 4.7 million diagnostic x-rays were performed in Medicare-certified hospitals with emergency departments, a 9.6-percent increase since 2001. Medicare spent approximately $48.3 million for these services in 2004. We will determine the appropriateness of payments for diagnostic x-rays and interpretations. (OEI; 00-00-00000; expected issue date: FY 2009; new start)*

While the OIG continues to be concerned about medically unnecessary testing exhibited by high volumes of diagnostic testing in the ED, this whole issue has a long history and includes congressional intervention to some degree.

Though hospitals should be addressing this issue, the more ominous question is whether or not this will be an area in which RAC audits become the norm. Hospitals are generally at the mercy of the physicians when it comes to performing diagnostic tests for ED patients. If the physician orders the test, the hospital will perform the test even if the purpose is to rule-out a condition as opposed to having diagnostic conditions that require the test.

Thus, this is a very sensitive issue for hospitals. Hospitals may have little direct control concerning the level and frequency of tests in this area.

Questions from Our Readers

Question: What we will get paid if we have a patient that comes in through the ED and is then *admitted* to Observation for *less* than 8 hours? I know we will *not* get the new Composite APC payment. Will we get the APC 604 ($53) payment? - Would we still get paid for the ED level charge in this situation? Would we get paid for the Ancillary services?

There are several different facets involved in this question. First of all, hospitals must make a policy decision as to whether they are going to code and bill for observation services that are less than eight hours in duration. Presuming that all the other requirements for observation are achieved, (i.e., physicians' order, medical necessity, nursing assessment, periodic monitoring, etc.), billing for less than eight hours of observation does not appear to be precluded by CMS.

Note: The eight hour requirement for observation services under Medicare appears to be a payment issue, not a billing issue. In other words if you don't have at least eight units of G0378, then APCs will make no payment for observation services.

Now if you do provide an observation nursing assessment, that is, HCPCS G0379 and there are less than eight hours of G0378, then you will indeed be paid for APC 0604. Note that this is the answer to the tricky question, 'When do you get paid for G0379?'. Normally, when G0379 is used there are more than eight hours of observation services, and the payment for G0379 is packaged into the composite APC 8003.

To answer the question about payment for other services such as the ED E/M level and associated ancillary charges, simply take a sample case and run it through the APC Grouper/Pricer. Payment should be made separately for these other services. The bottom-line is that if you provide less than eight hours of observation, your payment will be limited to about $54.00.

Question: We are looking at the new venous access procedure codes, CPT 36591 – 36593. We have patients who have routine blood work drawn from their port, mostly cancer patients. I would like to use the new code 36591 plus the code for lab test. Or would a code from the outpatient E & M area be better, such as 99211 – 99213?

Interestingly enough, this question has several parts. First of all, the 36591 maps to APC 0624 with a $36.00 payment. By any standard, this appears to be pretty good payment! Of course, this APC is Status Indicator "Q" so that packaging is a real possibility, but 36591 is not on Table 10.

The way the question is phrased, drawing the blood through the venous access device appears to be an isolated service provided in connection with a laboratory test or tests. Thus, this service will probably be paid separately.

Note: As always, run some sample cases through your APC Grouper/Pricer to verify whether packaging will occur under different types of service situations.

Now, the question concerning the use of a low-level technical component E/M level in lieu of 36951 becomes moot given the actual service provided. The more interesting question is whether or not you can justify the use of an E/M level along with the 36951. While using both would be unusual, it is possible that circumstances might justify using both.

The questions surrounding E/M technical component for nursing services include:

- Documentation of nursing services
- Medical necessity of nursing services
- Services being incident-to those of physician or practitioner

If circumstances are present by which each of these issues is properly addressed, then due consideration can be given to using a low-level E/M along with the 36591 and the associated tests. However, such circumstances are going to be relatively rare. Also, with the relatively high payment rate for 36591, some degree of evaluation and management by the nurse performing the draw would reasonably be presumed.

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/Sept2007June2008EdCal.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 and the Eli Research are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008. This calendar is updated frequently as presentations are scheduled. Note that most of these sponsors can also provide these sessions in CD/DVD format. Thus, if you are not able to participate at the scheduled time, you can still obtain the information and listen at your leisure.

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 next webinar is on March 11, 2008, "**Mastering Injections and Infusions**".

Dr. Abbey has completed his seventh book, "***Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance***." HCPro is the publisher. See CSmith@aaciweb.com for information.

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**
- **Compliance For Coding, Billing & Reimbursement: *A Systematic Approach To Developing a Comprehensive Program***

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.