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 now have your chargemaster and associated coding and billing processes modified to handle the new cardiovascular interventional radiology codes. This involves diagnostic coronary catheterizations and subinguinal vascular catheterizations. Also, you should perform reimbursement analyses for how the APC grouper handles the new codes relative to payments.

This is also a good time to investigate any APC outlier payment that you are receiving. Make certain that you don't have unusual charge structures driving improper cost outlier payments.

Observation and 'Active Monitoring'

The proper coding and billing for observation services along with meeting documentation and compliance demands has taken on a life of its own over the past decade.

One of the CMS requirements is any time that a patient is removed from the observation bed for some diagnostic or therapeutic service, the time out of the bed is to be subtracted from the hours reported for observation.

This same directive indicates that if the services, therapeutic or diagnostic, are performed at the bedside, then the time must be subtracted if the service involves 'active monitoring'. Of course, CMS does not further define what is meant by 'active monitoring'.

Thus, hospitals are placed in a position where policies and procedures must be developed without explicit guidance from CMS. There are really two issues:

- Time Units for Timing Consideration, and
- The Meaning of 'Active Monitoring'.

There are some hints provided in the Medicare Claims Processing Manual in Chapter 4, §290.2.2:

> *Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour).*

The timing issue appears to involve recording the start and stop times relative to the interruption that requires active monitoring. Because observation is billed by the hour, some thought can be given to using different time units such a 5-minute time unit or a ½ hour time unit. However, using minutes as the time unit is certainly safe.

For the 'active monitoring', two brief examples are provided. One is for a colonoscopy and the other chemotherapy. Clearly, for procedures such as a colonoscopy, which rarely would be performed at the bedside, there is constant monitoring by qualified medical personnel.

For chemotherapy, nursing staff is generally immediately available and also in direct line of sight of the patient. This is quite common for infusion centers where nursing staff start and stop chemotherapy and other services and are in constant line of sight of patients. Thus, there is active monitoring at least through directly observing the patient.

CMS also discusses, in Q&A #9974, infusions and injections. Here is the CMS language:

> *The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of*

drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

This language really leaves the question up in the air. Now CMS is using the phrase *significant active monitoring*. How is this different from just *active monitoring?*

The CMS statement does appear to suggest that routine hydration and routine infusions do not require active monitoring. Thus, these services can be billed concurrently along with observation.

Another aspect to this issue involves the on-going development of physician supervision rules. For observation services we now have the concept of non-surgical extended duration services. This includes infusions, injections and observation. It does not include chemotherapy and blood transfusions. If a nurse is starting an IV, then direct physician supervision is required, but once the IV and associated hydration or infusion have been successfully started only general supervision is required.

Case Study 1 – *Hydration with IV Injection* – An elderly observation patient is being hydrated over four hours and is provided with an IV push of a drug during the hydration.

The case study is very simple, but it does provide the need for making a determination as to what active monitoring means. As with many compliance issues in which CMS does not provide definitive guidance, decisions must be made.

Case Study 2 – *Titration of Morphine* – A nurse has been instructed to provide morphine as an analgesic for an elderly patient currently in observation. The nurse provides the first push and remains with the patient for 10 minutes. The nurse returns in 15 minutes and provides a second push and then remains with the patient for 10 minutes. A final push is provided 15 minutes later and the nurse remains with the patient for another 10 minutes.

In Case Study 2 the nurse has been at the patient's bedside for a total of 30 minutes with 30 minutes intervening time. The question is whether there is 30 minutes of active monitoring or 1 hour of active monitoring. Maybe the fact that an IV is being used means that the total time for any hydration, which includes the IV pushes, should be subtracted from the observation time.

We will consider two approaches.

Approach 1 – The conservative approach, from a compliance perspective, is simply to designate that any hydration, infusions, injections and the like require active monitoring, and there should be no concurrent billing with the observation hours.

Approach 2 – A more liberal approach is to adopt a policy that active monitoring means that a nurse or other qualified medical person is at the patient's bedside for more than five minutes. In the cases where the time period is five minutes or more the actual start and stop time are documented and the time subtracted from the observation hours.

If you take a conservative approach, be certain to consider telemetry observation. If a patient is in an observation bed and telemetry is being provided, then there is a nurse or other qualified medical person constantly monitoring the patient's heart rhythm.

Bottom-Line: Hospitals must develop a policy and procedure defining what is meant by the phrase *active monitoring*. From this policy statement, the appropriate billing for injections and infusions can be implemented.

Editor's Note: No matter what approach you take, someplace down the road, CMS will determine what *active monitoring* should have meant and will then *clarify*, not *change*, the meaning. Most likely the retroactive interpretation will be applied to find any possible overpayment situations.

CAHs, CRNAs & Method II Payment

Through Transmittal 2137 to the Medicare Claims Processing Manual, CMS is in the process of updating the coding, billing and reimbursement process for CRNAs at Critical Access Hospitals. This Transmittal was published January 21, 2011 and is effective July 5, 2011.

Note that the directives in this Transmittal constitute a significant change for CRNA Method II reimbursement for CAHs that have not elected the pass-through exemption. In some cases, CAHs that are using a pass-through exemption may need to consider and analyze reimbursement differences in going to Method II under

the new payment calculations. As usual, note that the Method II methodology applies to outpatient services.

The CRNA services provided at CAHs can be coded, billed and reimbursed in one of several ways. While not as complicated, the billing for CRNAs at prospective payment system hospitals also depends on organizational structuring. Basically, CRNAs may be providing anesthesia services under the direction of an MDA (MD Anesthesiologist) or they may be providing services independently, that is, not medically directed.

CAHs face an operational challenge with anesthesia services. While there are the typical operative procedures that require anesthesia, there are also urgent or emergency situations that require anesthesia services. Thus, CAHs tend to contract for anesthesia services. In rural, less populated areas these services will be provided by contracted CRNAs. The contracting is often accomplished with a group of CRNAs. In some limited instances, MDAs may also be available.

With the given that CAHs often contract and pay for anesthesia services, regardless of utilization, using cost-based reimbursement is attractive. If the costs are covered (i.e., the contracted amount), then at least the CAH is not losing money.

As the interest in Method II billing and reimbursement increases, CAHs need to carefully consider the most advantageous way to bill and be paid for anesthesia services. Obviously, the proper approach will depend on utilization and cost-benefit analysis.

- CRNAs and MDAs Bill Independently – As with other hospitals, the CRNAs and MDAs can bill independently on the CMS-1500 claim form. The usual rules relative to reporting base units, time units and then appropriate modifiers for directed or non-medically directed anesthesia services must be used.
- CAH Elects Pass-Through Anesthesia Payment – This is the cost-based approach. Both technical component anesthesia and professional component anesthesia are paid on a cost or pass-through basis. Coding and billing are as follows:
    - Type of Bill – 85X
    - Technical Component – RC=037X with no codes. Billing depends on the chargemaster setup.
    - Professional Component – RC=0964 with CPT codes from the range 00100-01999 using 15-minute anesthesia time units.
- CAH Elects Method II – No Pass-Through Exemption – Payment is generally made through a special payment arrangement based on base units (see Anesthesia CPT codes 00100-01999) and 15-minute time units that are then multiplied times an annually adjusted conversion factor. Coding and billing become more complicated.
    - Type of Bill – 85X
    - Technical Component – RC=037X with no codes. Billing depends on the chargemaster setup. Cost-based reimbursement applies.
    - Professional Component – RC=0964 with the anesthesia CPT codes, base units and time units. If there is medical direction, then the "-QZ" must be used, and payment is reduced to 50% of the allowable amount. If there is no medical direction, then 100% of the allowable amount is paid.

Where does the 115% payment come into the picture? If Method II is being used with the CRNAs' reassigning Medicare payment to the hospital, then the application of the 1.15 multiplier occurs at the very end of the process.

For instance, if we have a case in which the CRNA is not medically directed and there are 3 base units and 4 time units, then the total is 7 units. This is multiplied time the current conversion factor.[1] The deductible (if any) and the coinsurance are subtracted and then this amount is multiplied by 1.15.

If we use the Iowa conversion factor of $19.82 and assume that the deductible amount has been met, then we would have:

(3+4)*$19.82 =$138.74

80% of $138.74 = $110.99 (Taking out the 20% coinsurance)

1.15 * $110.99 = $127.64

Note: CMS has honed down the process of counting units so that it is simply the actual anesthesia time (i.e., start time to end time) divided by 15 and then appropriately rounded.

CAHs and Telemedicine Credentialing

On May 26, 2010 CMS issued a Federal Register entry, CMS-3227-P, addressing proposed changes to the CAH process for credentialing telemedicine providers. The comment period for this FR entry has long since come and gone. There has been no indication as to when the final rule will be published.

[1] For CY2011, the national conversion factor is $21.0515. This amount is geographically adjusted, generally on a state level.

Currently, CMS-3227-F, that is, the final *Federal Register* entry is listed as 'pending'. Hopefully, we will receive the final rule before the end of the first quarter of 2011.

This update is particularly crucial for CAHs that use telemedicine with larger hospitals and/or specialty groups of physicians. Until a change is made, CAHs are required to credential any and every provider that will provide services through telemedicine services. In most circumstances this is not feasible particularly if there is a group of specialty physicians, anyone of whom, can provide services.

The Chargemaster Corner – CPT 95992

Chargemaster coordinators should note, that if your physical therapists have not already informed you, CPT 95992 is available for the canalith services. Over the past several years there has been some controversy with CMS as to how these services should be coded and reimbursed. Starting in 2011 physical therapists as well as ENT physicians, performing the canalith services should use 95992. Previously PTs were instructed to use CPT 97112, neuromuscular reeducation. This is a time-unit based code.

When updating the chargemaster, be certain to set the maximum number of units for 95992 to just '1'. 95992 is a 'per day' service. PTs performing this service may report more than one unit because of the previous coding using 97112.

Note that a part of the controversy over this service has to do with CMS's presumption that this is just a part of an E/M service provided by physicians. Obviously, the PTs performing this type of service do not otherwise provide and E/M service.

Note also that untimed codes versus timed codes continue to interest the RACs. For PT/OT the reporting of the proper number of 15-minute time units has been an ongoing challenge.

Adjudication and the "-GZ" Modifier

The "-GZ" modifier is used by healthcare providers when a given line-item on the claim required that an ABN (Advance Beneficiary Notice) should have been obtained, but was not obtained. Basically, the service or item involved on the line-item did not meet medical necessity requirements.

The "-GZ" modifier is one of several ABN related modifiers.

- "-GA" – Waiver of Liability Statement Issued
- "-GY" – Item or Service Statutorily excluded or does not meet the definition of Medicare Benefits
- "-GZ" – Item or service expected to be denied as not reasonable and necessary
- "-GX" – Notice of Liability Issued, Voluntary Under Payer Policy
- "-GL" - Medically unnecessary upgrade provided instead of non-graded item, no charge, no advance beneficiary notice

In the past the adjudication procedure was to process the claim regardless of any ABN modifiers. After the standard adjudication was completed, the system could then look at any modifiers and payments could be correctly made. In theory, if a hospital used the "-GZ" modifier, the claim might still make it through the adjudication process.

Here is the new language from Transmittal 366 to CMS Publication 100-08, the Medicare Program Integrity Manual:

> *Effective for dates of service on and after July 1, 2011, all MACs, CERT, RACs, PSCs and ZPICs shall automatically deny claim line(s) items submitted with a GZ modifier. Contractors shall not perform complex medical review on claim line(s) items submitted with the GZ modifier. The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review. See Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1. under paragraph F "GZ Modifier" for codes and the MSN to be used when automatically denying claim line(s) items submitted with a GZ modifier.*

Clearly, CMS intends that the "-GZ" modifier will force nonpayment, and no reviews of such line-items are allowed.

Questions from Our Readers

Question: Can 'provider-based' and 'hospital-based' be used interchangeably?

The Provider-Based Rule (PBR) is found at 42 CFR §413.65. This CFR section does define the phrase, *main provider* as:

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

This definition depends upon the meaning of the word *provider*. While the Condition for Payment (CfPs, found at 42 CFR §424) do use the word *provider* and distinguishes this from the word *supplier*, the best source is the Social Security Act (SSA) itself. Here are the SSA definitions:

- *§1861(d) The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.*
- *§1861(u) The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.*

Typically, the word *provider* carries the connotation of having a provider agreement with the Medicare program. Hospitals and the others mentioned in the definition have provider agreements whereas physicians, who are suppliers may participate in the Medicare program, do not have provider agreements, per se.

Thus, in terms of the PBR, a main provider may be a hospital or, in theory, any other provider as defined above. For instance, just as hospitals have provider-based clinics, a skilled nursing facility (SNF) could just as well have a provider-based clinic.

The answer to the question of using *provider-based* and *hospital-based* interchangeably is answered through the definitions. The term *hospital-based* is a specific instance of the more general term *provider-based*. In technical terminology, *hospital-based* is an instantiation of *provider-based*.

Editor's Note: The definition of terms relative to Medicare payment and the establishment of provider-based status is extremely confusing. Under the PBR the fundamental terms used are *facilities* and *organizations*. Neither of these terms is defined in the PBR itself. The term *entity* in the PBR has a special meaning. Recently, CMS has started using the phrase *provider-based department* or PBD. Thus, as you read the various rules and regulations, constantly check for the context of the explicit phraseology being used.

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 March 22nd "***Physician Supervision and Auditing Provider-Based Status"*** 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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****** 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.

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