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 a good idea of the changes being made to APCs. Probably the biggest change is the move that CMS is making toward significantly increased packaging. The increased packaging for CY2008 is just the beginning of this trend. We will continue to discuss some of the APC related changes in this Newsletter and expand on additional issues in the future.

New CPT, HCPCS & Modifiers

As usual, there are many changes in the CPT and HCPCS coding systems. We will look briefly at a few of the changes.

For physician coding staff, be certain to review all the new Category II codes for performance measurement.

There are also some new Category III codes including a new sequence for 64-lead ECGs.These are 0178T, 0179T and 0180T that are set up essentially the same way the regular ECG codes are sequenced.

There is a new subsection at the end of the CPT codes, "Medication Therapy Management Services". There are three codes:

99605 – Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient

99606	initial 15 minutes, established patient
99607	each additional 15 minutes

CPT 99607 can be used with either 99605 or 99606. While we can all read the descriptions for these codes, the exact circumstances under which they can or might be used is not clear. The Medicare program does not appear to recognize these codes. Presumably, these codes could be used for medication management clinics. We will have to wait for further guidance.

CPT 99174, Ocular photoscreening with interpretation and report, bilateral, is new and represents the old Category III code, 0065T.

For HCPCS be certain to note:

- A9569-A9579 - Generally for nuclear medicine services.
- C2634-C2699 – For brachytherapy sources
- C9352-C9355 – Special implantable devices coded by length
- C9728 – Placement of interstitial device(s)
- G3780-G8484 – This is a long list of codes for physician use.
- J7347-J7349 – These codes are not for drugs but for dermal substitute tissues, nonhuman origin
- S9152 – Speech therapy, re-evaluation (non-Medicare)

Editor's Note: The discussion of new/revised codes and the new/revised modifiers will be continued in the February issue of this Newsletter.

APCs for ASCs – Part 2

Editor's Note: CMS is completely altering the ASC (Ambulatory Surgical Center) payment system. There are two Federal Register entries of interest:

- *August 2, 2007 Federal Register – Final For Payment* **Process**
- *November 27, 2007 Federal Register – Final For Payment* **Rates**

In the first article we discussed that ASCs are going to a hybrid payment system based on a combination of APCs and RBRVS. Also, the ASC listing of surgeries that is paid through the ASC payment process has been greatly expanded to include office-based procedures, that is, procedures that can be safely provided in a physician's office.

From the physician's perspective, this new payment process may provide some incentive for physicians to provide more of these office-based procedures in the ASC setting.

For ASC services, physicians are paid the same way they are paid for outpatient services in the hospital and provider-based settings. The physicians report the correct place-of-service (POS) that for facility settings invokes a payment reduction. This is the site-of-service (SOS) differential under the Medicare physician payment system. The actual calculation of the reduction can be found in the RBRVS (Resource Based Relative Value System). In the first part of this article, an actual calculation was shown.

Particularly, if the physician has ownership in the ASC,[1] then additional reimbursement can be obtained by performing office-based procedures at the ASC. The overall increase in payment is not as much as with outpatient surgical procedures at the hospital, but the increased ASC profitability may, to some degree, accrue to the physician owner. Thus, as with hospital provider-based situations, there may be incentive for the physicians to perform for office-based procedures in the ASC setting versus the physician's clinic setting.

Another feature of APCs that does translate to the ASCs is the inpatient-only list. Generally, the surgeries on this list should not be a problem for ASCs because the more complicated, outpatient surgical procedures are not even on the approved ASC list. However, there is always the possibility that a planned ASC surgery will evolve into a surgery not on the ASC list and actually may be on the inpatient-only list.

CMS is quite explicit in circumstances of this type. The inpatient-only procedure is considered non-covered, and that the Medicare beneficiary is liable for payment. We have the following from the November 27, 2007 *Federal Register*:

> "***Consistent with the current OPPS payment policy that prohibits facility payments to the hospital for noncovered services (such as those surgical procedures on the OPPS inpatient list) and makes the beneficiary liable for those charges, this proposed policy would make beneficiaries responsible for the ASC charges for noncovered services furnished to them in ASCs."*** (72 FR 66850)

CMS addressed another issue involving the relationship of hospitals and ASCs. Because ASCs generally receive only 65% of the APC payment that is received by hospital outpatient departments, a hospital could contract with the ASC to provide services. This is an ***under arrangements*** contract in which the hospital will bill (i.e., receive 100% payment) while the ASC (i.e., lower cost) will provide the services.

As might be imagined, CMS does not consider this type of arrangement to be appropriate. Again from the November 27, 2007 *Federal Register*, we have:

> "***With regard to the potential for ASCs to provide "incident to" services under arrangements with HOPDs, in the proposed rule, we noted that the provider-based rules set forth at § 413.65 do not apply to ASCs. In addition, our longstanding policy codified at § 416.30(f) for ASCs operated by hospitals requires that "the ASC participates and is paid only as an ASC, without the option of converting to or being paid as a hospital outpatient department, unless CMS determines there is good cause to do otherwise." In the proposed rule, we indicated that we did not believe good cause exists such that a Medicare-certified ASC would be able to provide "incident to" services under arrangement to hospital outpatients under § 410.27."*** (72 FR 66818)

There are a number of concepts in play with this CMS statement. You must understand the provider-based rule (PBR) found at 42 §413.65, the concept of "incident-to" which is used in two very different ways in the Social Security Act (SSA), and also 42 CFR §410.27 and 42 CFR §411.15.

CMS to Expand RAC Program

The Medicare Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (DHHS) to demonstrate the use of RACs 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 Part B of Title XVIII of the Social Security Act).

The Revenue Audit Contractor Program has been in a pilot phase over the past three years for Florida, New York and California. Based upon the recovery progress with the pilot programs, CMS is now moving to institute the RAC Program to all states. While the mandate is by 2010, CMS appears to have a 2009 target in sight.

You can keep up to date on the RAC program by monitoring the CMS website:

[1] We will make no attempt in this article to address any Stark issues involving physician ownership.

http://www.cms.hhs.gov/RAC/.

The contractors chosen, generally consulting firms of one form or another, concentrate their efforts based upon three phases.

- Phase 1 – DRG Reviews
- Phase 2 – Overpayment Identified by Data Mining
- Phase 3 – Part B Requiring Medical Records

These audits address hospital, physician and DME. Note that both overpayments and underpayments are to be identified. Obviously, recoupment is for overpayments.

Most of the issues being addressed are well-known to the healthcare provider community. Medicare auditors as well as the OIG have identified numerous issues, all of which must be considered by compliance personnel. All of these activities and associated issues involve coding, billing and reimbursement.

Here is a very brief listing of some common issues:

- DRGs – Upcoding Pneumonia
- DRGs – 079, 416, 468, 475, 477, 483[2]
- One-Day Stays
- Chest Pain Admissions versus Observation
- Medical Back Problems – Inpatient versus Outpatient
- Three-Day Stays Prior to SNF Admission
- Elective Procedures – Inpatient versus Outpatient
- Units of Service – Injections, Drugs, Therapy
- Transfer Cases and Inpatient Discharge Status
- Joint Replacements – Inpatient Rehabilitation versus SNF

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

Pain Management on the OIG's Work Plan

On page 12 of the FY2008 OIG Work Plan, we have the following issue:

"***Medicare Payments for Interventional Pain Management Procedures We will review Medicare payments for interventional pain management procedures. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will pay for services only if they are medically necessary. Interventional pain management procedures consist of minimally invasive procedures, such as needle placement of drugs in targeted areas, ablation of targeted nerves, and some surgical techniques. Many clinicians believe that these procedures are useful in diagnosing and treating chronic, localized pain that does not respond well to other treatments. Interventional pain management is a relatively new and growing medical specialty. In 2005, Medicare paid nearly $2 billion for these procedures. We will determine the appropriateness of Medicare payments for interventional pain management procedures and assess the oversight of these procedures."***

This issue, and associated investigation, is in the physician section of the work plan. However, hospitals as well as physicians need to take a very close look at this overall issue.

Pain management clinics at hospitals are definitely growing in number and level of services. These clinics are generally provider-based clinics so that all of the issues surrounding the provider-based rule (PBR), technical component E/M coding, professional component E/M coding, injections coding, pharmaceutical charges and the like come into play.

Hospital compliance personnel should make a point of reviewing the organizational structuring of pain management services. This review should include:

- ✓ Meeting any PBR criteria
- ✓ Proper technical component E/M coding, that is, a proper mapping of resources utilized
- ✓ Proper professional component E/M coding based on documentation
- ✓ Proper reporting of the place of service on the physician 1500 claim form
- ✓ Proper coding of procedures performed (both physician and hospital)
- ✓ Proper reporting of units and correct coding of multiple procedures
- ✓ Correct coding of pharmaceutical items provided
- ✓ Documentation supporting medical necessity from both the physician and nursing staff as appropriate
- ✓ Frequency of services and re-assessment
- ✓ General service patterns and growth in services

The physicians providing these services typically will use a consultation code for the initial assessment and then regular E/M visit codes for reassessments. As discussed in the 'Questions from Our Readers' section of this Newsletter, recent changes in the technical component coding for E/M services cause the hospital to use regular E/M levels in lieu of the consultation codes.

[2] These are DRG numbers under the old MS-DRGs.

Questions from Our Readers

Question: Is CMS really doing away with the consultation E/M codes? What do we need to do?

Yes, for ***APC purposes*** the consultation E/M codes (99241-99245) are not recognized starting in CY2008. We have the following from the November 27, 2007 *Federal Register*, page 66795:

> "*For CY 2008, we are also finalizing our proposal, without modification, to change the status of the consultation codes so that these codes are no longer recognized for payment under the OPPS."* (72 FR 66795)

You can also verify this by looking at Addendum B. This addendum lists all the CPT/HPCS codes and the way these codes map into APCs. The consultation E/M codes are now listed as Status Indicator="B", that is, not recognized under APCs.

The fact that CMS is no longer recognizing these codes for hospital outpatient services has a number of implications.

First, these codes are still fully available on the professional side. Thus, physicians certainly will continue to use this series of codes based upon meeting the consultation code criteria (e.g., consultation requested, report back to requesting physician, etc.). This includes the so-called 'reverse consultation' in which a primary care physician performs a pre-surgery H&P at the request of the surgeon.

Second, for hospitals that have provider-based clinics, there can be some definite challenges.

> Case Study 1 – Apex Medical Center Pain Management Clinic – The Apex Medical Center has established a Pain Management Clinic. Several MD anesthesiologists provide assessments and series of injections. Patients are referred by community physicians. During the initial assessment, the MDAs code and bill a consultation. On the hospital side, a consultation code is also used. However, there is a different mapping of resources utilized into the given E/M level. Thus, the MDA's E/M level may differ from the hospital's technical component E/M level.

Adjusting the coding system for this specific case is not unduly difficult. The hospital will need to start using either the new or established E/M levels depending on whether the patient is new or established ***to the hospital***.

A patient is new to a physician using a three-year rule as defined in the CPT Manual. For hospitals, CMS has indicated that a patient is new only if the patient does not have a medical record number. From the April 7, 2000 *Federal Register*, page 18451:

> "*(The meaning of "new" and "established" pertain to whether or not the patient already has a hospital medical record number.)"* (65 FR 18451)

Note that this key definition is only a parenthetical comment! The process for determining the E/M level will need to be adjusted to use the regular office visit E/M levels versus the consultation codes.

> Case Study 2 – Integrated Delivery System Provider-Based Network – An IDS has about two dozen different provided-based clinics in the hospital, on the campus and several off campus. Because of all the variability in E/M coding and the number of different people involved in E/M coding, the IDS decided to use the same E/M level for the technical component as that used by the physician providing the services.

The IDS has a major challenge for technical component E/M coding. Because the consultations codes have been dropped by CMS for technical component coding, either the new patient or established patient codes will need to be used. Also, the IDS will really need to establish a more sophisticated mapping of resources utilized into the new and established E/M levels. Everyone that codes and/or enters changes will need to be trained or retrained.

Editor's Note: In a future Newsletter we will address some additional complications created by the CMS changes in the E/M coding area for CY2008.

Question: We had a situation in which a patient presented on the morning of Day 1 with a laceration that was repaired in our ED. The afternoon of Day 2 the patient was directly admitted to observation services with chest pains. The patient was observed and discharged home on Day 4. We filed two separate claims, but the observation payment was basically denied even though the services were for chest pain.

While the specific rules for separately payable observation services have changed for CY2008, the same basic grouping processes are still in place. If you read the CMS language for observation services very closely, you will find, "…and no "T" status procedure reported on the day before or the day of observation services." With observation services and SI="T" surgical procedures there is a limited global period including the day before and day or days of observation services.

In your case, the Medicare adjudication software picked up the fact that there was a surgical procedure the day

before the observation services. Even though this surgical service is totally unrelated to the observation services, CMS insists that the observation service payment be bundled into the surgical procedure.

While we continue to convince CMS that this process is totally incorrect, CMS insists on this process in order to never pay for observation services in connection with surgical procedures.

Editor's Note: All of our readers are encouraged to comment to CMS through the Federal Register process for the next APC update. If you have never commented before, this issue would be a good starting point.

Question: Why has CMS made the change to start paying for certain services through the new composite APCs, 8002 and 8003?

The reason that CMS has decided to make this change is not clear. In the August 2, 2007 *Federal Register* (i.e., the ***proposed*** changes for APCs), CMS indicated their intention to bundle all observation services into codes such as the level 5 ED visits. The anticipated change was that there would be a modest increase in payment for CPT 99285 so that there would be little increase in the bundled payment for observation services.

CMS dramatically changed their approach in the November 27, 2007 *Federal Register*.[3] The final changes involved the development of the two new composite APCs, 8002 and 8003, which pay for observation services, without regard to diagnostic conditions or tests. If the services are provided with a high level ED admission, high level clinic or direct admission to observation services, payment is made.

This means that the Medicare program will be paying much more for observation than they have in the past. For example, prior to CY2008, the direct admission of a patient (for other than one of three special conditions) resulted in an overall payment of about $50.00. This was the payment for the nursing assessment (for G0379). This year, these same cases will pay about $350.00. The payment for G0379 will be bundled into the composite 8002 APC.

Undoubtedly, CMS will note a significant increase in payment for observation services. This situation may cause CMS to again rethink payment for observation services. Thus, watch for further changes that will probably be proposed in the APC update *Federal Registers* later this year for CY2009.

[3] This change from the proposed to the final rule is so dramatic, that the potential of CMS violating the ***not a logical outgrowth*** language in MMA 2003 could be considered.

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/current.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 February 12, 2008, "**Observation Services".**

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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FOR UPCOMING ISSUES

****** 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 the CMS Form 855? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.