Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

January 2009 – Volume 21 Number 1

ISSN: 1061-0936

Happy New Year!!

The consultants and staff at Abbey & Abbey, Consultants, Inc., along with our extended family of consultants wish to take this opportunity to wish you a wonderful and productive new year.

APC/APG Update

You should now have your new APC grouper. This is a time for experimentation to see exactly what changes CMS really made to the APC payment system. Be particularly fastidious to monitor the way in which APC claims are being adjudicated.

APC Packaging – CVIR Impact

Consider the following two vascular catheterization services and the associated coding.

Case 1 - Using a right femoral approach, a catheter is advanced into the aorta, and an arch aortogram, thoracic aortogram and an abdominal aortogram with bilateral runoffs are performed. The catheter is manipulated into the left iliac where an atherectomy on a lesion is successfully performed. All catheters are removed, and an angioseal device is place.

Assume the coding is:[1]

36200 ← Code Will Be Bundled Non-Selective
75650-59 – Arch Aortogram
75605 – Thoracic Aortogram
75630 – Aortogram with Bilateral Runoffs
36246-LT – Catheter Placement
35492-LT – Atherectomy Surgical Component
75992-LT – Atherectomy Radiological Component

The table shows the grouping for 2006-2009.

CPT	2006 SI→APC	2007 SI→APC	2008 SI→APC	2009 SI→APC
75650	S→0280	S→0280	N	N
75605	S→0280	S→0280	N	N
75630	S→0280	S→0280	N	N
36246	N	N	N	N
35492	T→0081	T→0081	T→0082	T→0082
75992	S→0279	S→0668	N	N

Case 2 - Through a right femoral puncture a catheter is manipulated into the aorta and an aortogram with bilateral runoffs is performed. A stenosis is found in the left iliac artery. The catheter is withdrawn to the aortic bifurcation and then manipulated into the left iliac artery. An angioplasty is performed, but the procedure fails to address the stenosis. Through a separate left femoral artery puncture, the catheter is manipulated to the left iliac and a stent is successfully placed. All catheters are removed, and angioseal devices are placed.

Assume the coding is:

36200 ← Code Will Be Bundled – Non Selective
75630 – Aortogram with Bilateral Runoffs
36246-LT – Catheter Placement
35472-LT – Angioplasty Surgical Component
75962-LT – Angioplasty Radiological Component
36140-59-LT – New Puncture with Catheter Placement
37205-LT – Stent Surgical Component
75960-LT – Stent Radiological Component

CPT	2006 SI→APC	2007 SI→APC	2008 SI→APC	2009 SI→APC
75630	S→0280	S→0280	N	N
36246	N	N	N	N
35473	T→0081	T→0081	T→0083	T→0083
75962	S→0668	S→0668	N	N
36140	N	N	N	N
37205	T→0229	T→0229	T→0229	T→0229
75960	S→0668	S→0668	N	N

[1] This is **not** intended as a coding exercise, only as an example of the bundling impact under APCs.

Note that the major bundling impact occurred in going from 2007 to 2008. Two different types of packaging were implemented.

i. Bundling of diagnostic procedures into therapeutic procedures, and
ii. Bundling of the radiological component into the surgical component.

The second type of packaging represents a double whammy in the sense that the radiological component are normally Status Indicator "S" for which there is no discounting. Now that the radiological portion is bundled, it is being bundled into the surgical component. Discounting will occur because surgeries are typically Status Indicator "T".

Note that if the diagnostic tests are separate from the therapeutic services (i.e., different date of service), they will both be paid separately. For Case 2 for CY2009, here are the payments:

- 75630 – SI=Q2, $1,954.38
- 35473 – SI=T, $3,194.51
- 37205 – SI=T, $6,093.99

The diagnostic angiography is bundled through the Q2 Status Indicator, so that this case, as coded, will pay:

$6,093.99 + 0.5 * $3,194.51 = $7,691.25.

If the diagnostic angiography is performed separately, then it will pay $1,954.38. Thus, there is a very real incentive to unbundle the diagnostic services from the therapeutic services. Also, note that the payment for Case 2 for CY2008 was $7,084.62. There was almost a 10% increase in payment for CY2009.

Note: See the December 2008 edition of this Newsletter, pages 67-68 for a discussion of the 'episode-of-care' concept mentioned by CMS for possible future consideration. Quite possibly, in the future, even if the diagnostic and therapeutic services are separated in time, they may be considered a single episode of care, and thus should be grouped together.

Technical Component E/M Coding – What To Do

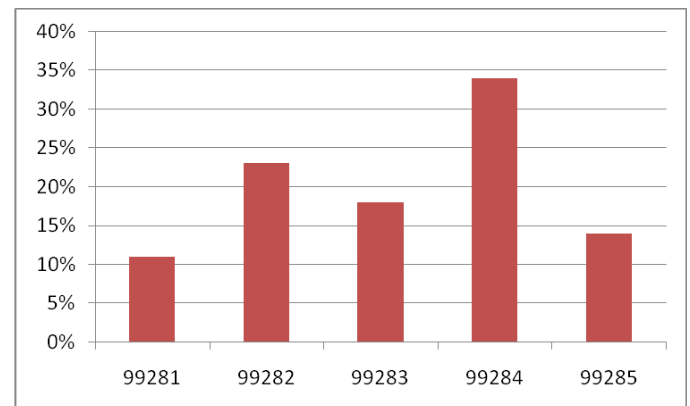
On pages 62 and 63 in the November issues of this Newsletter, we discussed the changes for E/M coding under APCs. There is no national guidance on the horizon, and CMS has changed the definition of what constitutes a 'new' patient versus an established patient.

While hospitals can make adjustments in their procedures to accommodate the revised definition of 'new', there is a major compliance gap in determining whether or not your hospital is properly coding and billing for E/M levels. Additionally, the use of the "-25" modifier is intertwined into these compliance concerns.

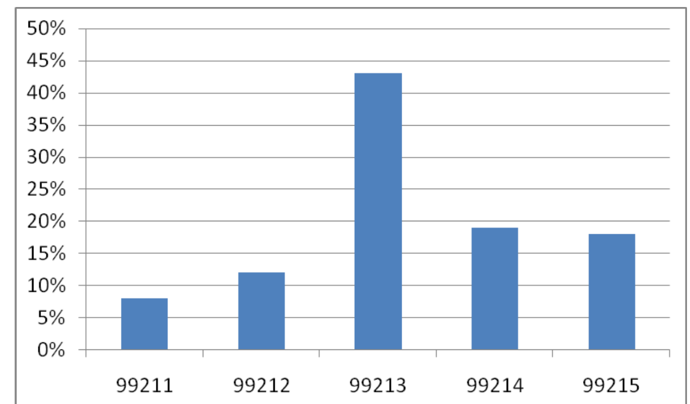
For compliance officers, the concern is how to verify that the current E/M level assignment processes are appropriate, that is, not elevating the assignment by which overpayment may be asserted. Without national guidelines, there is no way to be completely certain that your processes are appropriate and acceptable.

CMS has enunciated eleven principles that tend to be idealist and not always practical. One of the principles is that if you do a frequency analysis of the E/M levels, a normal or bell-shaped curve should result. CMS has found that at the national level, by amalgamating all E/M codes, there is a national bell-shaped curve.

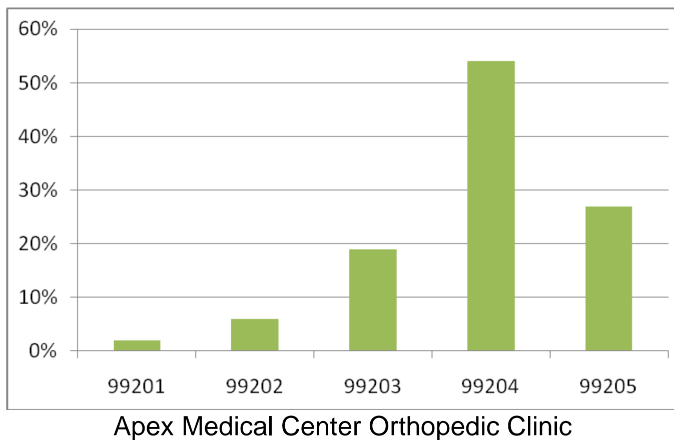
Let us visit the fictitious Apex Medical Center that, among other provider-based operations, has an Emergency Department, the Apex Family Practice Clinic and an Orthopedic Specialty Clinic. The following three graphs illustrate the percentage frequency distribution of E/M codes over the period of six months.



Apex Medical Center ED



Apex Medical Center Family Practice



Apex Medical Center Orthopedic Clinic

If you were looking at these E/M distributions from a compliance perspective, what questions would you ask? Do you think these are appropriate? Is there the distinct possibility that the E/M selection processes need to be carefully reviewed?

Now there are two main concerns:

1. The E/M assignment system itself, and
2. The types of patients presenting to the given service area.

For Apex, there are three different mappings being used: one for the ED, another for the family practice operation and a third for the orthopedic specialty clinic. Each of these is a point system that has been designed specifically for the operations at each of the clinics.

The ED distribution is a bimodal distribution. For a given ED this may be quite correct. Either the patients presenting are not very ill, or they really do have some problems.

The family practice distribution comes the closest to a bell-shaped curve with a slight skew to the higher levels. Again, is this an indication of a problem with the E/M level selection process?

The orthopedic clinic is heavily skewed to the higher level E/M codes. However, this is for new patients. New patients probably do require more thorough examinations so that this distribution may be appropriate.

These distributions generally do not fulfill CMS's principle of generating a bell-shaped curve. However, it is quite possible that a careful analysis of the types of patients presenting and the resources being consumed by E/M services are correctly represented by the E/M distributions.

From a compliance perspective you are really very much on your own. CMS is unlikely to issue any national guidance in this area in the coming years. As a result, it is up to you to assess and document your technical component E/M level assignment systems. You must be prepared to defend your hospital from any allegation of upcoding the E/M levels and thus receiving overpayments.

Bottom-Line: You should annually review your mapping systems when the new codes sets come out at the beginning of each year. Be certain that there are no services that are separately codeable and billable included in the E/M level assignment. At least every two years a careful analysis through frequency analyses and an assessment of patient presentations should be made to be reasonably assured that the E/M levels are appropriate and there are no possible overpayment situations.

HCPCS for CY2009

The HCPCS books are out! It is strange that the printed version, that is, commercial versions of the HCPCS books, seem to come out fairly late. The actual file from CMS is generally available several months before the beginning of the year.

You should be certain to obtain both:

1. The CMS HCPCS file, and
2. A printed copy of the HCPCS manual.

Note that the CMS HCPCS file is updated quarterly. You will need to download the update quarterly files and look for changes, particularly additions. Also, the CMS file allows you to sort the HCPCS codes in order to look for new and/or modifier HCPCS codes and modifiers. You will need to study the MS Excel file in order to become accustomed to all of the data that is present.

While we can manipulate the CMS file, the commercial versions of the HCPCS manual provide additional information generally through an extensive set of annotations. For instance, the status indicators for APCs and the payment indicators for ASCs are typically provided.

Here are the basic statistics for the new entries:

Modifiers – 6	A-Codes – 3
C-Codes – 7	D-Codes – 4
E-Codes – 11	***G-Codes – 74***
J-Codes – 15	L-Codes – 8
Q-Codes – 15	S-Codes - 2

Depending on the type of healthcare services your organization provides, some of these will be of interest while others will not. Thus, you will need to thumb through the manual or sort out the new entries from the

MS Excel spreadsheet. Here are few interesting changes.

The number of HCPCS modifiers continues to expand. Two new modifiers include:

"-JC" - Skin Substitute Used As A Graft
"-JD" - Skin Substitute Not Used As A Graft

There are quite a few new G-Codes. Most of these relate to various types of patient assessments. For instance, here are two examples:

G8512 - Pain Severity Quantified; Pain Present
G8541 - No Documentation of a Current Functional Outcome Assessment

Additional G-codes involve a range of services including home sleep tests (HSTs), ECGs in connection with Medicare initial preventative physical examination, Telehealth consultations, group psychotherapy, bone fracture treatment and surgical pathology. Be certain to look through the new G-codes because these codes may apply across healthcare providers. The new Q-Codes address skin substitutes and allografts.

Questions from Our Readers

Question: At our hospital we are receiving many more requests for physical therapy services on a cash basis or self-pay basis. Our hospital charges are relatively high so that we are not at all competitive with others that would provide the physical therapy services on a cash basis. Can we set up a separate, lower fee schedule for these cash-paying patients?

While the simple answer to this question is 'yes', proceed with due consideration. As a general rule, you should not charge Medicare beneficiaries more than you charge other patients. If you have a preferential fee schedule that is lower than that charged to Medicare beneficiaries, then you have, in some sense, violated this rule.

The concern lies with the OIG's ability to exclude you from the Medicare program if you charge a Medicare beneficiary significantly in excess of your usual charges.[2] While the OIG has issued some guidance in this area, there have been no specific definitions developed to guide hospitals in setting charges.

Note: See the September 15, 2003 *Federal Register* in which the OIG issued a proposed rule discussing what the CFR entry means. However, the OIG never issued a final rule.

Basically, you can set up a preferential fee structure for cash customers or self-pay patients. As long as the frequency of these charges is not too great relative to Medicare patients, then you should have no problem.

A slightly different alternative is to establish an internal contract for cash paying or self-pay patients in which you charge a given percentage of your usual charges. This is very much like establishing a discounted fee schedule with a private third-party payer.

However, you approach this general issue, do so with care and be watchful for any guidance. This is a significant compliance area as well as a patient relations area.

Question: When a surgical patient returns to our surgical provider-based clinic, we have been charging an E/M level for the hospital, but no E/M level for the physician because of the post-operative period. Is this correct? Where can I find Medicare guidance for APCs and the post-operative period?

On the professional side, that is the physician billing side, the Medicare program has established an extensive and well-defined global surgical package or GSP. There is a 1-day pre-operative period and then either a 0-day, 10-day or 90-day post-operative period. When the physician is paid for the surgery, this includes for any services related to the surgery by the surgeon during the pre-operative, intra-operative or post-operative periods. There are even modifiers in CPT that delineate these periods. See the "-54", "-55" and "-56" modifiers.

When CMS implemented APCs, the entire basis for grouping cases was based on the concept of an *encounter,* and more specifically the grouping process is performed based on a single date of service. CMS did not address any sort of surgical package concept.

Two exceptional cases were addressed including more than one ED or clinic encounter on the same date of service and then an extended encounter for observation services in which there might be three dates of service involved in the overall encounter.

Dr. Abbey did ask CMS to craft a global surgical package definition for APCs in his comments to the August 9, 2003 *Federal Register*.[3] The intent of the question was to have guidance as to what was or was not included in such a package and also to have explicit guidance in the use of non-use of the "-25" modifier.

---

[2] See 42 CFR §1001.701.

[3] If you would like a copy of these comments contact Dr. Abbey at Duane@aaciweb.com.

CMS did respond to this question.[4] From page 66793 of the November 1, 2002 Federal Register (67 FR 66793):

"**Comment**: *One commenter asked that we craft a surgical global package for facilities to provide guidance for facility billing of surgical procedures and visits.*
Response: *The current APC structure and coding edits already do this. Payment for surgical procedures includes payment for all services related to the procedure (for example, postoperative care, preoperative valuation). Facilities may bill for visits in addition to surgical procedures when the visit is a separately identifiable service unrelated to the procedure. In such cases, the facilities attest to this by appending the –25 modifier to the line item for the visit."*

This response is somewhat disconcerting in that it is difficult to interpret. CMS indicates that there is no need for a GSP because the APC structure and grouping process (i.e., the edits) takes care of any necessary bundling. Of course, the grouping process is totally based on the concept of an encounter. Thus, this answer seems to indicate that there is no pre-operative period and no post-operative period outside of the date of service for the encounter.

Obviously for the given date of service and thus the encounter for a surgical procedure will include any and all pre-operative and post-operative services associated with the surgery on that given data of service. The "-25" modifier is to be used only if there is some separate, significantly identifiable E/M service in addition to the surgery itself on that date of service.

Thus, if a hospital has a provider-based surgical clinic, a patient may present on Day 1 and the surgeon determines that surgery is indicated. On Day 4 the surgery is performed, and then on Day 15 the patient returns to the clinic for post-operative services.

The hospital will bill three separate encounters. An E/M for the Day 1 encounter, surgical code(s) for the Day 4 encounter and an E/M for the Day 15 encounter. The physician (presuming a 90-day post-operative period) will bill an E/M for the Day 1 encounter, surgical code(s) for the surgery on Day 4, but for the post-operative encounter, the physician has already been paid through the GSP. Some surgeons do code the 99024 to indicate a no-charge post-operative visit. This is generally performed for tracking purposes.

[4] CMS does not indicate to whom they are responding. Because of the use of the word 'craft', it appears that this is a response to Dr. Abbey's question.

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/JantoDecember2009EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2009Contact 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. Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Accuro Health, Progressive Business, and the Eli Research Group are all sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2009.

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 webinar scheduled for February 10th, "***Conducting Your Own RAC Audits***". The presentation will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's eighth book, "***Compliance for Coding Billing & Reimbursement: a Systematic Approach to Developing a Comprehensive Program***" is now available. This is the 2nd Edition published by CRC Press. ISBN=978156327681. There is a 20% discount for clients of AACI. See CSmith@aaciweb.com for information.

Also, Dr. Abbey has completed his ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro.

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**
- **Introduction to Payment Systems** is currently in preparation.

A 20% discount is available from HCPro for clients of Abbey & Abbey, Consultants.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
http://www.HIPAAMaster.com

Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

EDITORIAL STAFF

Duane C. Abbey, Ph.D., CFP - Managing Editor

Mary Abbey, M.S., MPNLP - Managing Editor

Penny Reed, RHIA, ARM, MBA - Contributing Editor

Linda Jackson, LPN, CPC, CCS - Contributing Editor

Contact Chris Smith for subscription information at 515-232-6420.

INSIDE THIS ISSUE

APC Update
APC Issues – CVIR Bundling
APC Issues – Technical E/M Coding
Questions from Our Readers
HCPCS for CY2009

FOR UPCOMING ISSUES

More on RAC Audits and Issues
More on Coding, Billing Compliance
More on Payment System Interfaces
More on Observation Services
More on the CY2009 APC Update

© 2009 Abbey & Abbey, Consultants, Inc. Abbey & Abbey, Consultants, Inc., publishes this newsletter twelve times per year. Electronic subscription is available at no cost. Subscription inquiries should be sent to Abbey & Abbey, Consultants, Inc., Administrative Services, P.O. Box 2330, Ames, IA 50010-2330. The sources for information for this Newsletter are considered to be reliable. Abbey & Abbey, Consultants, Inc., assumes no legal responsibility for the use or misuse of the information contained in this Newsletter. CPT® Codes © 2008-2009 by American Medical Association.

****** 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.

Worried about the RAC Audits? Special audits and studies are being provided to assist hospitals 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.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried about maintaining coding billing and reimbursement compliance? Contact Mary Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling.