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 productive and fruitful new year.

APC/APG Update

At this point you should have made the necessary changes to the chargemaster and coding processes to accommodate the CPT/HCPCS changes. The major changes are in the coronary cardiac catheterizations and the sub-inguinal vascular catheterizations. Depending on how the coding is accomplished, there may be a distinct impact on the chargemaster.

Be certain to carefully track how the APC grouper and I/OCE (Integrated Outpatient Code Editor) adjudicate and then pay you for the services under the new code sets.

Financial Assistance and Hospital Charge Limitations

The Affordable Care Act[1], which contains thousands of pages, has hundreds of provisions, some of which involve coding, billing and reimbursement compliance issues. Among the various changes are changes for ***tax-exempt hospitals*** relative charge structures for individuals qualifying for financial assistance. While the legislation's intent is reasonably clear, the actual wording and associated guidance is awkward. See Section 9007 with a slight modification at Section 10903.

The first issue concerns the hospital's financial assistance policies. While the legislation really does not define what is or should be contained in a financial assistance policy, the imposition of charge limitations is driven off the existence of such a policy.

Many hospitals, if not most, have financial assistance policies that generally are means tested either through income and/or through assets. Sometimes these programs will have a graduated scale to determine payment as a percentage of charges. Payment in this case refers to the amount that the hospital will accept as payment-in-full for the services.

These financial assistance programs typically are established for uninsured or underinsured individuals that do not have the financial resources to pay appropriately for medical services.

The way the ACA language has been interpreted, the trigger for charge limitations is based on whether or not the patient qualifies for (any) financial assistance. Thus, the status of a tiered financial assistance program will need careful review in light of these changes.

The basic idea of the legislation is that if a qualifying patient receives services, then the charges made to that individual should not be higher than charges to other patients, particularly those with health insurance coverage. Most hospitals have a single charge structure implemented through the hospital's chargemaster. Fundamentally, all patients are charged using the same process to arrive at an amount for the same item or service. The charges for item or service are developed through the chargemaster that has a single set of charges for each line-item.[2]

At issue is not the amount charged. The real issue is what the hospital will accept as payment-in-full. The individual with health insurance may be under a contract that the hospital has with the insurer. The contract may specify that the payment made will be discounted in some way from the full charges. The basic idea of the

[1] ACA is used as an acronym for Patient Protection and Affordable Care. Act, Public Law 11-148.

[2] This is an oversimplification because some hospitals do have multiple fee schedules in areas such as the laboratory and possibly other areas.

ACA provision is that the uninsured individual should not be disadvantaged by not being under a contract of some sort.

Interestingly, the additional guidance for this legislative language indicates that the 'gross charges' or 'chargemaster' charges cannot be made to the individual qualifying for financial assistance. Here is the statement from page 82 of JCX-18-10 as issued by the Joint Commission on Taxation.[3]

> *Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility's financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care. A hospital facility may not use gross charges (i.e., "chargemaster" rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.*

The point of confusion is differentiating 'charges' from 'payment rates'. The guidance indicates that there is a test with three options:

- The best negotiated commercial rate,
- The average of the three best negotiated commercial rates, or
- The Medicare rates.

Hospitals typically have dozens if not hundreds of negotiated contracts. These contracts are often quite different and may be based on different types of payment systems including fee schedules, prospective payment, and/or percentage of charges payment among other combinations. Thus, there is no easy way to determine a 'best' or 'the three best' negotiated commercial rates. Any given contract may pay more or less than another contract for a given service and/or line-item in the chargemaster. For any given service or line-item in the chargemaster, one contract may be higher in one instance and then lower than another contract in another instance.[4]

Even the use of the term 'rate' is a bit misleading because it implies a discrete payment for a particular service or item. At best 'rate' seems to imply some sort of percentage payment based on the charges. In many instances the charges made through the chargemaster for various items do not receive separate payment so there is no applicability of the concept of a 'rate'. ***The fundamental problem is that the chargemasters are disaggregated relative to separate payment.*** Thus, the concept of a payment rate is difficult to apply.

Hospital charges for a service and/or associated items are developed through the hospital's chargemaster at a detailed level. Chargemasters are developed according to sometimes very different philosophies and approaches. For instance, take a common surgical procedure such as cataract surgery, CPT=66984.

Given a group of 10 patient, Medicare or otherwise, all of whom receive the same cataract surgical service, the actual charges made probably will vary. If the use of the surgical suite is based on time, then one patient may take only 30 minutes while another make take an hour. Different charges for the use of the surgical suite will thus be developed. Also, the exact amount of various supplies and drugs may vary as will the charge for the specific type of IOL (Intraocular Lens). The way the chargemaster is established and the way in which services are provided will have a direct effect on the final charges developed.

Note that in the discussion concerning charge development for the cataract surgery, the hospital is following the Medicare directives that all patients are charged the same, based upon consistently charging which, in turn, is based on the cost of resources utilized.

This has been a very difficult issue for the OIG that has the ability to exclude providers from the Medicare program for inappropriate charging.[5]

Because of the directive to reduce the charges for the patients qualifying for financial assistance, hospitals will be charging these individuals less than that charged to Medicare beneficiaries. This immediately raises questions about overcharging Medicare patients.

Setting aside all of these definitional and charging process concepts, tax-exempt hospitals are still required to meet the law. So how are you going to determine the 'best negotiated rate' or the three 'best negotiated rates'?

Determining these best negotiated rate or rates will require significant analysis. With the given that hospitals have various types of contracts, comparing these

[3] The full title of this March 21, 2010 document is, *Technical Explanation Of The Revenue Provisions Of The "Reconciliation Act Of 2010," As Amended, In Combination With The "Patient Protection And Affordable Care Act"*

[4] If you have the ability to calculate general realization rates per contract, then this may be a way to determine what is the best discounted payment rate.

[5] For instance, see the September 15, 2003 Federal Register (68 FR 53939).

contracts relative to payment rates (i.e., the one that has the best discounted rate) is extremely difficult.

Most hospitals have a number of simple contracts that are termed ‘percentage-of-charges’ contracts. The given third-party payer establishes a contract whereby payment is a percentage of charges. The percentage may vary and is typically in the 95% to 80% range. Comparing these contracts is straightforward. If only these types of contracts were considered, then determining the best ro three best contracts would be easy.

Other contracts vary considerably and may pay quite differently for inpatient services versus outpatient services. There may be various carve-outs for services such as labor and delivery. One contract may discount heavily for outpatient services but, relatively, pay more for inpatient services. Thus comparing the discounting for these contracts would require development of complex models using average frequencies of various types of services.

A more general approach that may work for most hospitals is to calculate the realization rate for each of the third-party payers with whom the hospital has contracts. The term is being used as the total payments received divided by the total charges made for the given contract. This type of information should be obtainable from the billing system with the assumption of proper parameterization.

By simple comparison of realization rates, the best or three best negotiated rates can be determined.

If the best rate or rates approach is not used, then the default is simply to reduce the charges to what the Medicare program would pay. To use this approach you would have to calculate the actual payment amount using all of the Medicare coverage and adjudication rules. While this is not infeasible, calculating the actual payment under a system such as Ambulatory Payment Classifications is not straightforward and would need the use of the APC grouper and I/OCE (Integrated Outpatient Code Editor).

Another approach would involve simply picking a discount rate that is more than reasonably below any of the hospital’s negotiated rates. Depending on the given hospital’s charge structure, this could be in the 50% to 60% range.

Hospital compliance and auditing personnel should carefully study the language and then look for a way to assure reasonable compliance. Note that this is only one of many issues from ACA.

Condition Code 44 – Correcting Errors

While CMS continues to refine guidance on observation services and while we wait for the final outcome in the O’Connor Hospital case[6], hospitals must continue to deal with the challenges for observation. One question frequently asked is:

> If a physician admits a patient as an inpatient but before discharge indicates that the admission should have been for observation (i.e., an error was made), does the Utilization Review Committee need to be contacted and then Condition Code 44 used?

The basic question is, if the request for changing from inpatient to outpatient is made by someone other than at the request of the UR Committee, does Condition Code 44 still need to appear on the claim and thus have the involvement of the UR Committee?

Of course there are degrees of relevancy. If a physician comes to hospital registration personnel four hours after an inpatient admission and indicates that a clerical error has occurred and that the services should be classified as outpatient, then apparently a clerical error is being corrected and the use of Condition Code 44 seems inappropriate.

However, if after two days of inpatient services, the physician indicates that outpatient status was really intended, then viewing this as a clerical error becomes more difficult. Perhaps in this type of case the UR Committee should be involved and Condition Code 44 utilized.

As with many compliance issues, there are some very fine lines that must be recognized. CMS does give us some guidance at the Q&A level. Consider Q&A #9972.

> ***Question # 9972 - May a hospital change a patient's status using Condition Code 44 when a physician changes the patient's status without utilization review (UR) committee involvement?***
>
> ***Answer -*** No, the policy for changing a patient's status using Condition Code 44 requires that the determination to change a patient's status be made by the UR committee with physician concurrence. *The hospital may not change a patient's status from inpatient to outpatient without UR committee involvement.* The conditions for the use of Condition Code 44 require physician concurrence with the UR committee decision. For Condition Code 44 decisions, in accordance with 42 CFR 482.30(d)(1),

[6] See the April, 2010 edition of this Newsletter, pages 19-20, Volume 22, Number 4 for an associated article.

one physician member of the UR committee may make the determination for the committee that the inpatient admission is not medically necessary. This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use, who is the physician responsible for the care of the patient. For more information, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.3.2 (When an Inpatient Admission May Be Changed to Outpatient Status).

Now this Q&A answers the question that if Condition Code 44 is used, then the UR Committee must be involved. It does not seem to address the question of changing the status without using Condition Code 44.[7]

Thus, you will need to make a policy decision in this area. Two approaches that hospitals may take are at the opposite ends of the compliance risk scale.

Approach 1 – ***Aggressive*** – If the request for the change in status originates from the physician's indicating that an error has been made and there has been no involvement from UR (i.e., they have not questioned the inpatient admission), then change the status but do not use Condition Code 44.

Approach 2 – ***Conservative*** – When a request is made to change the status, even if only a clerical error, refer immediately to UR, follow the conventional process, and use Condition Code 44.

Obviously, the second approach is the safest. You may want to establish a policy and associate procedure that lies someplace in-between these two extremes. For instance, if there is truly just a clerical error, then correct the error without going through the formal process. Everything should still be documented. If there is a substantive error, that is, the physician made a change in their thinking about the case, then go through the formal UR Committee and use Condition Code 44.

Keep in mind that all of these machinations are for the Medicare program. CMS has a much more restrictive definition of Condition Code 44 than do other third party payers[8]. Thus, for many commercial insurers with whom you have contracts, the process of changing an inpatient admission to outpatient observation may occur days, if not weeks, after the fact. For private third-party payers the motivation for changing to observation is that they, the insurance company, will pay less for the observation than for the inpatient admission.

Questions from Our Readers

Question: We had a Medicare patient who was admitted for pneumonia on Thursday. On Monday this same patient had an outpatient procedure performed, namely, a screening colonoscopy. There were no abnormal findings from the colonoscopy. Under the 3-Day Pre-Admission Window, do we have to bundle the charges for the colonoscopy into the inpatient billing? We also had another case in which a patient had a colonoscopy with removal or polyps in the morning and was admitted later that day after an automobile accident that caused multiple fractures. Because the colonoscopy was not related we don't have to bundle the therapeutic colonoscopy into the inpatient billing. Right?

The 3-Day Pre-Admission Window has a number of intricacies that must be carefully studied. Yes, the screening colonoscopy, which is diagnostic in this case, must be bundled for billing purposes into the inpatient claim. All diagnostic tests the day of and in the three dates of service preceding the inpatient admission must be bundled.

The second question is a little more involved. Interestingly enough there is a distinction between the three dates of service preceding the admission and the date of the admission. While both of these time periods are in the window and actually constitute the window, there is more inclusive bundling for any services provided on the date of admission, that is, the time period leading to the admission.

This distinction can be found in the Memorandum issued by CMS on August 9, 2010.[9] Here are the two key paragraphs that distinguish the time periods between the three dates prior to admission and the time period on the date of admission up to the point of being admitted.

> ***In accordance with section 1886(a)(4) of the Act, outpatient nondiagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission. In accordance with section 102 of Pub. L. 111-***

[7] This, of course, is an interpretation.

[8] It is interesting that CMS does not accept the official definition form the National Uniform Billing Committee (NUBC), which, according to HIPAA , is the code set maintainer and is responsible for issuing guidance on the use of the code set.

[9] This language was essentially repeated in the Preamble to the August 16, 2010 *Federal Register* that updated IPPS for FFY2011. Note that there has not yet been any formal language in the relations addressing this issue.

192, for services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay.

Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission). Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010 effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

While the distinction between these two time periods is subtle, the language used by CMS does make the distinction.

Thus, we can answer the second question by indicating that even though the therapeutic colonoscopy is unrelated to the reason for the inpatient admission, this service must still be bundled into the inpatient billing. This results from the first quoted statement in that ***all services*** (diagnostic and therapeutic – related or not) must be bundled if provided on the same date as the admission.

Editor's Note: The whole issue of the 3-Day Pre-Admission Window should be followed with extreme care by hospitals. The current situation is an example of less than precise guidance being provided by CMS. In time this issue will also be addressed by the RACs. Be prepared for the RACs to disagree with policy decisions on the part of hospitals.

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 February 22nd "***RAC Denials – Medical Necessity & Physician Documentation***" 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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