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 hope for you to have a productive and fruitful new year

APC/APG Update

The two APC transmittals with update information for CY2012 are:

1. R2376CP – January 2012 Update for OPPS, and
2. R2370CP – January 2012 I/OCE Version 13.0 Update.

These are the standard update transmittals for APCs that seem to become longer each year.

The update for OPPS includes information on:

- Policy and Billing Instructions for Condition Code 44
- Cardiac Resynchronization Therapy
- Payment Window for Outpatient Services Treated as Inpatient Services
- Use of Modifiers for Discontinued Services

This update also addresses other topics such as pass-through items, including contrast agents, biologicals as implantable devices, therapeutic radiopharmaceuticals, and several NCDs (National Coverage Decisions) among other topics.

The update for the I/OCE is more technical in nature and is 43 pages long. Here you will find the new and changed APCs, new and changed CPT and HCPCS codes, and new modifiers that relate to processing through the I/OCE. Also, the OPPS pricer logic is updated in this transmittal. Keep in mind that to answer certain coding and billing questions, the only real way is to see how the APC grouping takes place within the I/OCE.

State Operations Manual - Update

CMS publication 100-07, State Operations Provider Certification, is sometimes overlooked by coding, billing and reimbursement personnel. However this manual can prove extremely useful, particularly relative to maintaining compliance. CMS issued several transmittals toward the end of 2012 providing updated language and interpretations.

Editor's Note: In the February issue of this Newsletter, we will look at some of the SOM updates for CAHs.

As with other CMS manuals, the State Operations Manual (SOM) is updated through periodic transmittals. Late in 2011 CMS issued three transmittals:

- R72SOM – 11-18-2011,
- R74SOM – 12-02-2011, and
- R77SOM – 12-22-2011.

Note that the implementation date of for transmittals to the SOM go into effect at the same time the transmittal is issued. Because the information in the SOM represents interpretations of already existing rules and regulations, there is no need for any lead time for implementation.

We will briefly review three areas:

- Rehabilitation Services,
- Respiratory Therapy Services, and
- Infusions, Injections and Blood Transfusions.

Rehabilitation services are addressed at 42 CFR §482.56(b):

Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

Rehabilitation services refer to physical therapy, occupational therapy, speech language pathology and audiology. This statement from the CFR seems reasonably straightforward, that is, there must be orders from a qualified practitioner who is authorized by medical staff to order such services.

Here is part of the interpretive guidelines for §482.56(b):

Rehabilitation services must be ordered by a qualified and licensed practitioner who is responsible for the care of the patient. ***The practitioner must have medical staff privileges to write orders for these services.*** *Privileges must be granted in a manner consistent with the State's scope of practice law, as well as with hospital policies and procedures governing rehabilitation services developed by the medical staff and approved by the governing body. Practitioners who may be granted privileges to order rehabilitation services include physicians, and may also, in accordance with hospital policy, be extended to Nurse Practitioners, Physicians' Assistants, and Clinical Nurse Specialists as long as they meet the parameters of this requirement.*

The guidelines go on to list the specific practitioners who have the authority to order services. The sentence that is highlighted seems innocent enough, the physician or practitioner ordering the services must have medical staff privileges. However, if you give this some thought, this requirement puts hospital PT, OT and ST services at a disadvantage when competing with independent physical therapy and rehabilitation providers.

If the hospital is to provide these services, then the physician or practitioner ordering the services must be on the medical staff. In turn, this generally means that the ordering physician or practitioner must be credentialed through the medical staff organization (MSO). Also, there may be different levels of MSO staff privileges. How should this be addressed?

The actual survey procedures for §482.56(b) are reasonably straightforward:

Review the medical staff policies and procedures for rehabilitation services privileging. Do they identify the types of eligible practitioners and their qualification criteria?

Review medical records of patients receiving rehabilitation services. Determine who wrote the orders for the rehabilitation services. Determine if the practitioner is responsible for the care of the patient and privileged to write orders for rehabilitation services. Verify the practitioner meets hospital medical staff policies and procedures as well as State law for ordering rehabilitation services.

Also for §482.56(b)(1):

Review a sample of patient medical records who received rehabilitation services. Determine whether the rehabilitation service orders are legible, complete, dated, timed, authenticated, and meet all other medical record requirements specified at §482.24.

Note that CMS is now routinely including the time of the order along with the date.

Transmittal R72SOM then significantly updates the therapy plan of care (POC).

Establishment of the plan: —The plan must be established before treatment begins by one of the following: (1) A physician. (2) A nurse practitioner, a clinical nurse specialist or a physician assistant. (3) The physical therapist furnishing the physical therapy services. (4) A speech-language pathologist furnishing the speech-language pathology services. (5) An occupational therapist furnishing the occupational therapy services.

Content of the plan: —The plan: (1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and (2) Indicates the diagnosis and anticipated goals.

Changes in the plan: —Any changes

The survey procedures for §482.56(b)(2) now include:

Review medical records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented.

Review employee personnel files to verify the rehabilitation service providers (i.e., physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists) have the necessary education, experience, training, and documented competencies to provide rehabilitation services.

Ask the hospital what national standards of rehabilitation practice provide the basis for its rehabilitation services. Is there supporting documentation?

Note that PTs, OTs and STs also need to go through the credentialing process. Typically this can be done through the MSO.

This transmittal then provides new information concerning respiratory therapy services. Again, the ordering physician/practitioner must have hospital privileges to order services. For RT, this is not as much of a challenge as it is with PT/OT/ST. Generally hospital RT staff would not provide services outside of the hospital setting. There is no independent practice of respiratory therapy, at least not at this time.

Survey procedures for §482.57(b)(3) now includes:

Review the medical staff policies and procedures for respiratory care services privileging. Do they identify the types of eligible practitioners and their qualification criteria?

Review the medical records of patients receiving respiratory care services. Determine who wrote the orders for the respiratory care services. Does this individual hold privileges to order respiratory care services and is he/she responsible for the care of the patient?

Verify the practitioner writing respiratory care service orders meets hospital medical staff policies and procedures and State law requirements for ordering respiratory services.

Transmittal R72SOM also addresses intravenous (IV) medications and blood transfusions. Nurses who generally provide IV medication and perform blood transfusions must be appropriately qualified. The interpretive guidelines call for the nurse's competencies to be documented in the nurse's record. Also, the content of the training:

"...must be based on nationally recognized standards for intravenous medication administration and blood transfusion and must address at least the following: fluid and electrolyte balance; venipuncture techniques, including both demonstration, and supervised practice; and, for blood transfusion training: blood components; blood administration procedures based on hospital policy, State law, and nationally recognized standards of practice; requirements for patient monitoring, including frequency and documentation of monitoring; the process for verification of the right blood product for the right patient; and identification and treatment of transfusion reactions."

There is also a new, rather extensive section concerning drug administration errors, adverse drug reactions, and incompatibilities.

Transmittal R77SOM significantly extends directives for drug administration. While a complete discussion of the newly expanded language is beyond the scope of this article, we will look at two issues:

1. Minimum information in the order, and
2. Standing orders.

In accordance with standard practice, all practitioner orders for the administration of drugs and biological must include at least the following:

- *Name of the patient;*
- *Age and weight of the patients, or other dose calculation requirements, where applicable;*
- *Date and time of the order;*
- *Drug name;*
- *Dose, frequency, and route;*
- *Exact strength or concentration, when applicable;*
- *Quantity and/or duration, when applicable;*
- *Specific instructions for use, when applicable; and*
- *Name of the prescriber.*

For those of you have ever audited drug administration, this provides a nice checklist. Note that the time of the order along with the date is needed. How time should be applied to surgery documentation in which injections and infusions are provided is an interesting question. Often the documentation will list the drugs, route of administration, individual administering the drugs, etc. Sometimes finding the actual prescriber (e.g., surgeon versus anesthesiologist) can be interesting. At the very least, compliance personnel can use the above listing as a means of developing policies and procedures in this area.

Other issues addressed include:

- Personnel authorized to administer medications,
- Safe practices for medical administration,
- Timing of medication administration
- Medications not eligible for schedule dosing times
- Medication eligible for schedule dosing times
- Time-critical schedule medications
- Non-time-critical schedule medications
- Missed or late administration of medications

Standing orders for medication administration is a sensitive area. Here is the newly added language for standing orders.

*"**Hospitals may adopt policies and procedures that permit the use of standing orders to address well- defined clinical scenarios involving medication administration.** The policies and procedures must address the process by which a standing order is developed; approved; monitored; initiated by authorized staff; and subsequently*

authenticated by physicians or practitioners responsible for the care of the patient."

*"**The specific criteria for a nurse or other authorized personnel to initiate the execution of a particular standing order must be clearly identified in the protocol for the order, i.e., the specific clinical situations, patient conditions or diagnoses in which initiating the order would be appropriate.** Policies and procedures must address the education of the medical, nursing, and other applicable professional staff on the conditions and criteria for using standing orders and the individual staff responsibilities associated with their initiation and execution. An order that has been initiated for a specific patient must be added to the patient's medical record at the time of initiation, or as soon as possible thereafter. Likewise, standing order policies and procedures must specify the process whereby the physician or other practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders after the fact, …"*

The policies and procedures must also establish a process for monitoring and evaluating the use of standing orders, including proper adherence to the order's protocol. There must also be a process for the identification and timely completion of any requisite updates, corrections, modifications, or revisions.

The State Operations Manual is ever expanding. Coding, billing and associated compliance personnel should carefully study the interpretations and auditing guidelines that are addressed.

ZPICs and PSCs

As the compliance efforts for both Medicare and Medicaid continue to expand, healthcare compliance personnel can be faced with increasing challenges. The ZPICs (Zone Program Integrity Contractors) were developed after the consolidation of the Medicare Administrative Contractors (MACs). Basically the ZPICs are replacing the PSCs (Program Safeguard Contractors). There are seven zones with various contractors.

One of the more important aspects for the ZPICs is that they tend to go beyond overpayment issues on into actual fraud investigations. Thus, a RAC will typically look for overpayments, and only when something is really wrong will the RAC refer for possible fraud investigation.

This means that if your healthcare provider receives a request for records from a ZPIC, then care should be taken to work through your compliance office and also legal counsel. With the RACs you probably have standard procedures to respond, analyze and investigate. Because the RAC issues are almost always claims of overpayments, actual allegations of fraud will not be carefully considered.

The ZPICs are included in Chapter 4 of the Medicare Program Integrity Manual. If you have never browsed through this chapter then you should put it on your to-do list. Note that statistical extrapolation is a tool that is fully available to the ZPICs as it is with other governmental auditing programs.

One of the issues that arises with all of the different governmental auditing programs (e.g., MACs. OIG, and DOJ) is that there could be some sort of overlap between the programs. Particularly if statistical extrapolation is used on a large universe of cases, then that universe of cases will need to be off-limits to other auditing entities. At least the claims should be off-limits for the specific issue or issues that caused the extrapolation process to be used.

Also, because the ZPICs will likely be involved in more complex cases and that may involve possible fraud, there will probably be more appeals at least to the ALJ (Administrative Law Judge) level. Because these cases address more serious issues, involvement of legal counsel should be considered early in the process of addressing issues that are raised by the ZPICs.

ALJ hearings seem to be on the increase. Also, there appears to be more direct participation by audit contractors to actively participate in the ALJ hearings. This active participation can also allow the audit contractors to introduce new arguments and justifications at the time of the ALJ hearing.

One way to detect possible ZPIC activity is with pre-payment activities. If you are detecting delays in payment for certain service areas or for particular types of claims, then there may be some sort of pre-payment review taking place. Also, the ZPICs do not have the same constraints as do the RACs. ZPICs can go back in time, particularly with post-payment audits much as do the OIG and DOJ.

Small providers such as individual physicians and clinics should be particularly wary. Small healthcare providers of all types have typically not been bothered by all these government audit programs. Great care should be taken by small providers because any sort of significant recoupment could easily put a small provider out of business.

Medicare Odds & Ends

In Transmittal R2376CP CMS indicates that the new guidance in the 2012 CPT manual concerning non-continuous intravenous pushes ***will not be followed***. For 2012 CPT updated the coding guidance for injections and infusion. Included in the updated guidance is reference to situations in which an IV push might be provided late in the evening, and then another push is provided after midnight. The new CPT instructions would allow coding two initial services (i.e., CPT 96374). While not explicit in this updated guidance, this would appear to apply to IV infusions as well.

Note that there is a series of new HCPCS codes for 2012 in the general area of behavioral counseling. See the G0442-G0451 sequence. This sequence includes alcohol misuse, obesity, and sexually transmitted infections. Right in the middle of this sequence is G0448 that is for insertion of a cardioverter-defibrillator system.

There is some updated information on use or non-use of Condition Code 44 along with a slight clarification on the 3-day payment window. For Condition Code 44 note the following language:

> *If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.*

CMS is also indicating that if there is an inpatient admission that is not medically necessary, that is, not covered by Part A, the 3-day payment window does not apply. Obviously, if there is no inpatient coverage, it is difficult to bundle outpatient services into something that does not exist.

Also CMS has revised the language relative to modifiers "-73" and "-74" in the context of reduced services, that is, modifier "-52". The language changes mainly involve the phrase *partially reduced or cancelled*. CMS is making very clear that the "-73" and "-74" are used with procedures involving anesthesia. This additional language does allow for more accurate use of the modifiers.

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/JantoDecember2012EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2012. 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 CY2012.

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 7th "***CMS-855, Medicare Enrollment & the Revalidation Process"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's 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 third book in a series of books on payment systems. The first book is:
"***Healthcare Payment Systems: An Introduction***". The second book addresses fee schedule payment systems and the third in the series addresses prospective payment systems. The fourth, and final, book in this series addresses cost-based, charged-based and contractual payment systems.

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.

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

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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 Jane Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned about maintaining coding billing and reimbursement compliance? Contact Jane Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com