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

Both the APC proposed update for CY2010 and the RBRVS update for next year are out. The Examination Copies are available from the CMS website. The APC update is 1,277 pages long, at least in the Examination Copy version. The actual *Federal Register* is due out July 20th. We will start discussing issues in the 2010 APC update in this Newsletter.

The update to the MPFS (Medicare Physician Fee Schedule) will officially be published in the July 13th *Federal Register*. Note that the update will have a separate correction section as well. Be certain to look for any changes involving non-physician practitioners.

2010 APC Update – Physician Supervision

CMS is proposing to make significant changes in the area of physician supervision rules and related issues involving the Provider-Based Rule (PBR) found at 42 CFR §413.65. Here are some of the key points starting with all-important definitional changes.

PBD – Provider-Based Department – CMS has suddenly starting using the phrase *provider-based department*. Since terminology and definitions are all-important, just what does this phrase mean? The PBR uses the two words: *facility* or *organization*. How does this relate to a department?

Note: CMS had never defined facility or organization.

In The Hospital – With CMS's recent change to require direct physician supervision in on-campus provider-based clinics as opposed to treating these situations as if they were in the hospital (i.e., physician supervision presumed because physician close by), a definition of what is actually *in the hospital* is required. This concept has been discussed over the years with the PBR. Also, you may see the phrase, "within the four-walls of the hospital".

From page 476 of the Examination Copy of the 2010 APC update, CMS's proposed definition is as follows:

> ***We also are proposing to define "in the hospital" in new paragraph §410.27(g) to mean areas in the main building(s) of a hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital or CAH; and for which the hospital or CAH bills the services furnished under the hospital's or CAH's CCN.***

While this definition seems reasonable at first reading, actually applying this definition in practice will be extremely difficult. Hospitals have many different physical and organizational structures. Hospitals that have anything unusual will, most likely, need to seek a determination from their FI or RO (Regional Office) as to what is considered in the hospital.

Non-Physician Practitioners – Over the past year there has been significant discussion that non-physician practitioners such as physician assistants, nurse practitioners and clinical nurse specialist cannot provide the direct physician supervision requirements for off-campus and on-campus, but out of hospital, services.

Fortunately, CMS is changing this situation although the Social Security Act is not being changed. From page 475 of the Examination Copy of the 2010 APC update, CMS is proposing:

> ***In summary, for CY 2010, we are proposing that nonphysician practitioners, defined for the purpose of §410.27 of the regulations as clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves within their State scope of practice and hospital-granted privileges, provided that they meet all additional requirements, including any***

collaboration or supervision requirements as specified in §§410.71, 410.74, 410.75, 410.76, and 410.77.

This change will come as a very welcome relief for hospitals that have provider-based clinics.

Note that while CMS is proposing to allow non-physician practitioners to supervise in most situations, they will not be able to supervise cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) or pulmonary rehabilitation (PR).

Diagnostic Supervision – CMS separates the physician supervision rule between diagnostic and therapeutic. Generally the diagnostic supervision rules follow the different levels required under MPFS (Medicare Physician Fee Schedule). They are listed right in the RBRVS spreadsheet. Therapeutic supervision rules generally relate back to hospital directive and the provider-based rule.

CMS does discuss some changes in the diagnostic area, mainly with under arrangement situations in which a hospital may have services provided by another organization such as an IDTF (Independent Diagnostic Testing Facility).

Bottom-Line - All hospital that have any sort of provider-based operations, which are almost all hospitals, should carefully review these proposed changes and make comments either to support the changes or to request more detail in the changes. One area that CMS mentions, but does not seem to address, is the issue of in-hospital departments that have provider-based status. These PBDs seem to be subject to the various requirements for on-campus provider-based clinics, but they are in the hospital. This is a fundamental question that has never really been answered throughout the development of the PBR. For instance, do these in-hospital departments need to be included in either attestations and/or formal approval as provider-based?

2010 APC Update – Pulmonary Rehabilitation

Several years ago CMS had the LCDs (Local Coverage Decisions) for pulmonary rehabilitation programs (PRPs) withdrawn. These are very nice programs involving assessments of various types, exercise sessions, training and counseling and the like. Under the LCD directions various codes could be used. Different providers such as Respiratory Therapists, Physician Therapist and nurses could provide services, and the hospital would be reimbursed for a variety of services.

For 2010 CMS is bringing back, in some sense, the PRP concept. However, the whole process has been significantly reduced in scope and certainly reduced for payment purposes. The PRPs will now be reimbursed much more like cardiac rehabilitation.[1]

Basically, there will be a new HCPCS, GXX30 that will be for pulmonary rehabilitation, including aerobic exercise with monitoring per session, per day. As with cardiac rehabilitation, the session will have to last at least 60 minutes. Only one session per day will be allowed.

Payment for this new code under APCs would be set at $15.00. There is no discussion of the other services typically provided such as various RT tests and associated assessments by nursing staff typically using CPT=99211. CMS seems to be taking the stance that the $15.00 per individual per session is the only payment that will result. Obviously, for larger groups there will be requirements as to staff to patient ratio although this is not discussed.

CMS is also formalizing intensive cardiac rehabilitation (ICR) in relation to the regular cardiac rehabilitation (CR). Two new HCPCS are proposed, GXX28 and GXX29, both of which will map to APC=0095, Cardiac Rehabilitation, with a payment of approximately $39.00. As with PRPs this is a per session per day approach.

CMS is also indicating that direct physician supervision is required for PR, CR and ICR. This supervision cannot be provided by non-physician practitioners.

Bottom-Line: Many hospitals have developed Pulmonary Rehabilitation Programs that provide very valuable services. Reimbursement for these programs has been reasonable using a wide range of codes and different teams of providers. With this change in approach, PRPs will receive quite minimal reimbursement. There are a number of questions surrounding coding and billing relative to this new G-code. As appropriate, hospitals should express their concerns about this change and the propriety of reimbursement relative to the costs of providing such services particularly with direct physician supervision being required.

2010 APC Update – Observation Services

There are no major changes for observation services. Also, for the first time in several years, there are no long discussions of start and stop times.

One change that CMS has proposed is to rephrase the description of G0379 to 'Direct referral for hospital

[1] Many hospitals would maintain that reimbursement in this area is well below costs incurred.

observation care.' CMS has become sensitive to the phrase 'observation status' that is used in the CMS manuals. Given that CMS views observation more as a 'bed' rather than a 'status', this change in terminology is consistent with the CMS approach in this area.

2010 APC Update – Drug Administration

Remain calm! There are no new major changes for injections, infusions and chemotherapy. However, CMS is planning to make significant changes in the mappings of the various CPT codes. Starting on page 390 of the examination copy, Table 33 gives the new mappings.

This means that you should run a quick analysis of the potential financial impact. While a particular mix of services is needed for analysis, indications are that reimbursement in this area will decline. Be particularly careful with chemotherapy operations. Any changes can result in major reimbursement shifts.

2010 APC Update – E/M Coding

As no surprise, CMS has very little to say about the long-awaited national guidelines for technical component E/M coding. There appears to be nothing on the horizon. Moreover, we do not have any sort of a proposed system to which to comment on possible improvements.

At some length CMS does discuss concerns about Type A versus Type B EM visits and the associated payment rates. There are also indications that CMS continues to plan to implement guidelines and encourages hospitals to make comments.

CMS made the decision in 2000 to implement APCs with the provision that the E/M codes would be paid in addition to other services using the "-25" modifier. At that time, CMS indicated that national guidelines for technical component E/M coding would be forthcoming shortly. Also, specific guidance on the use and nonuse of the "-25" modifier would be provided.

Now, ten years later, we are still waiting. Very general E/M mapping guidelines have been discussed. There were two Program Memorandums, one in 2000 and one in 2001, on the use of the "-25" modifier, but nothing else. Additionally, CMS has made no movement to develop and/or define any sort of surgical package, so that packaging surrounding surgical services continues to be confined to the date of service for the surgery.

Currently, hospitals have no way to verify that E/M coding levels are correct and/or that the "-25" modifier is being used correctly. This situation creates significant compliance concerns, particularly with the RACs gearing up to address multiple issues, which, theoretically, could include the propriety of E/M levels and the proper use of the "-25" modifier.

Bottom-Line: Hospitals should comment to CMS that national guidelines must be developed immediately. Also, detailed guidance on the use and nonuse of the "-25" modifier should be developed and implemented. Also, if CMS does not issue such guidelines quickly, then CMS should exempt E/M coding and "-25" modifier utilization from the RACs and other regulatory agencies such as the Department of Justice and the Office of the Inspector General.

RAC Concerns

Currently the RACs appear to be in preparation for full activities starting this summer and then probably accelerating this fall. There are many concerns and many operational issues that are yet to be fully addressed.

One of the concerns for hospitals and associated healthcare providers involves finding overpayments for one healthcare provider that then affects other healthcare providers. Let us take a simple example.

> Case Study – The Apex Medical Center's RAC has been auditing cases surrounding inpatient stays for knee replacements. A statistical study has indicated that the vast majority of knee replacement cases involve exactly a 3-day stay before the patient is moved to skilled nursing for full recovery. The RAC is now asserting that many of these 3-day stays could easily have been only 2-day stays.

For the hospital, the amount of potential overpayment will result from the DRG Transfer Rule and possible reductions in the DRG payments. Overall, these overpayments will be relatively minimal.

However, for the associated SNF to which the patients were moved for final recovery, there is potentially an enormous impact. Also, the physicians who provided services in the hospital and the SNF may be affected.

For coverage of the SNF services, there must be a 3-day qualifying hospital stay. If the 3-day stay in the hospital is determined to be medically unnecessary and that only 2 days were needed, then the entire stay at the SNF suddenly will not be covered and the whole stay will result in an overpayment.

To a lesser extent, the physicians involved may find that the hospital visit on the third day is an overpayment as well as the visits to the SNF during the recovery period.

At issue is whether an entity such as a SNF can be held accountable for the actions (or inactions) of another healthcare provider. In this case, the hospital, presumably at the orders of a physician, kept the patient for three days when only two were necessary. The SNF has no control over this type of issue. The SNF must assume that the hospital and the physician acted properly.

Thus, the question is whether or not the SNF should be held accountable for such overpayment situations. Only time will tell how this situation will play out. However, from the perspective of a RAC, the potential overpayments to the SNF will be very attractive. If you were a RAC would you want to capture these overpayments? Remember, as a RAC, you are receiving a percentage contingency fee based on the overall overpayment amounts.

APCs, Encounters & Packaging

APCs are now in their eleventh year. This means that various compliance issues will now start becoming more evident. With the full implementation of the RACs, there will be more issues than ever surrounding APCs.

In order to better understand APCs, the basic architecture of this system must be fully understood and appreciated. In some cases APCs borrowed from APGs (Ambulatory Patient Groups), but in other instances a very different approach is used. In this article we will discuss one of the fundamental underpinnings of APCs and relate that to bundling under APCs which is called packaging.

APCS are an encounter driven payment system. This is very easy to state and appears to be innocuous. However, there are some deeper implications in this statement than appear at first glance.

Obviously, what we need is a very precise definition of what constitutes an outpatient *encounter*. Only recently has CMS provided a definition of this all-important term. In Transmittal 82, February 8, 2008, CMS gives the following definition:

> ***A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.***

Basically, this states that an encounter involves a patient's coming to a physician or hospital, receiving services, and then leaving. This definition is vastly different from APGs in which an encounter is defined to be all services provided in a moving 3-day window, that is, the *window-of-service*. For such a window, if a surgical service is provided today, then any related services the day before or the day after would be grouped into the surgery itself.

Given the lack of specificity in CMS's definition, we can turn to the APC grouper itself to see how the grouping process takes place. The APC grouper is an integral part of the Outpatient Code Editor (OCE) or now the Integrated OCE, I/OCE. The grouper contains all of the packaging routines, discounting, Correct Coding Initiative edits and the like.

The way the grouper is programmed, the grouping is based on a date-of-service. Thus, operationally the concept of an encounter equates to a date of service, that is, a single day. There are exceptions to this date-of-service equivalence.

1. Observation services may span up to three date of service although the entire observation stay is considered an encounter.
2. Patients may visit different provider-based clinics on a given date-of-service, or there may be two or more ED visits on a given date of service. Each of these visits is considered a separate encounter. CMS has provided the "-27" modifier and the "G0" condition code to separate the encounters for grouping purposes.

Let us take the ED in which there are two separate visits to further illustrate just what it means to state the APCs are encounter driven. We could do the same thing for multiple provider-based clinic visits.

> Case Study 1 – A patient presents to the Apex Medical Center's ED at 9:00 a.m. and complains of abdominal pain. The patient is examined, a prescription is provided. AT 4:00 p.m. the same patient presents with the same symptom. An examination is performed, and an ENT specialist is called to perform an esophagoscopy. Nothing is found, and the patient is given an additional prescription and sent home.

Obviously, these two visits are related because they are for exactly the same symptom (i.e., diagnosis codes). Back in 2001, CMS was queried about this type of situation.[2] The suggestion made was that for related visits to the ED on the same date of service, that the APC grouper should consider them together (i.e. group them as a single encounter). CMS's response was quite specific that these were separate encounters, separate

[2] See Dr. Abbey's comments to the August 24, 2001 *Federal Register* and comments to the August 9, 2002 *Federal Register*.

resources were being consumed, and that APCs would pay them separately.[3]

This response made it clear that the concept of an *encounter* is all important. The APC grouper groups an encounter without any consideration of other encounters. There is no packaging or discounting across encounters.

Let us consider a second case study that further illustrates this concept.

Case Study 2 – A patient present to the Catheterization Laboratory where, through a left femoral puncture the catheter is advanced into the aorta, and an aortogram with lower extremity bilateral runoffs is performed. Stenoses in the right leg are noted. An arterial puncture device is placed and the patient is discharged.

The next day the patient returns to the hospital. This time through a right femoral puncture the stenoses are treated by balloon angioplasty and stent placement.

The APC grouper will recognize these two services as different encounters because they occur on different dates of service. Even though these two encounters are related, each encounter will be grouped and paid separately. (The diagnostic procedure alone in this case pays approximately $1,800.00)

If we change this case so that both the diagnostic and therapeutic services are provided on the same day, then there is a single encounter. Now the APC grouper will package the diagnostic services into the payment for the therapeutic services. (Yes, $1,800.00 is bundled!)

Clearly, the concept and definition for an *encounter* is all-important for APCs. Generally an encounter is equated to a date-of-service. However, as we have discussed there can be exceptions to the date-of-service approach.

Bottom-Line: For APCs the grouper determines when there has been an encounter and performs all grouping relative to that encounter. All of the packaging, discounting, consideration of the "-25" modifier, pre-surgery and post-surgery services, and the like will all occur relative to the given encounter or date of service. However, if there are two different encounters, even if related, the APC grouper will group them separately with no consideration for any relatedness.

Editor's Note: If you would a copy of either of Dr. Abbey's comments, please e-mail us at Duane@aaciweb.com, and we will send you a copy.

[3] See November 1, 2002 *Federal Register*, page 66793.

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 August 11th:"***E/M Coding***" 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's ninth book, "***The Chargemaster Coordinator's Handbook***" available from HCPro. His tenth book, "***Introduction to Healthcare Payment Systems***" is available from Taylor & Francis.

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 available from Francis & Taylor.

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

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