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

The proposed changes for both APCs and MPFS were made available through examination copy on July 6, 2012.

- APCs – Proposed OPPS Update – 687 pages with official publication on July 30, 2012.
- MPFS – Proposed Physician Fee Schedule Update – 765 pages with official publication on July 30, 2012.

The Home Health PPS update was also issued in examination format on July 6th as well. The HHA update is much shorter, only 186 page. The official publication for Home Health will be on July 13th.

In the August issue of this Newsletter, we will discuss the key points for APCs along with suggested comments that can be made to CMS. We are now entering our fourteenth year with APCs so that this PPS should be settling down to some extent.

Clinical Documentation versus Payment Documentation

As the RACs continue to expand their audits and extend the number and type of issues being addressed, there are increasing demands for certain types of documentation. While hospitals and other healthcare providers can address assertions of overpayments by developing additional information and arguments on a retrospective basis, clearly a process for developing certain information and arguments on a prospective basis is really necessary.

Documentation standards have generally addressed clinical documentation for justifying the provision of services. Clinical documentation is developed primarily for the continuity and possible transfer of care. Thus, clinical documentation is generally used by healthcare providers of various types. Of course there are requirements concerning dating, documenting the time and author of documentation. These are generally mechanical requirements as opposed to substantive clinical documentation requirements.

A greater concentration on justifying services is now emerging. The clinical documentation must now also justify the provision of services. Auditors reviewing the documentation must make definitive judgments as to whether various medical necessity issues are properly addressed.

There are three rather generalized issues:

1. Medical necessity for providing the service,
2. Medical necessity for the specific type and level of service, and
3. Medical necessity for the location of the service.

Case Study 1 – ***Coronary Stent Placement*** – Sam, a retired rancher in Anywhere, USA, has been having some cardiac problems. Sam's physician has concluded that Sam may need bypass surgery, or at least, extensive cardiac catheterization services. Sam is admitted to the hospital in the evening. The next morning, a heart catheterization is performed and a single drug-eluting stent is placed. Sam recovers quickly and is discharged from the hospital the same afternoon.

While we do not have all of the documentation, a RAC would probably question two issues:

a. The need for a hospital admission, and
b. The use of a drug-eluting stent versus a bare metal stent.

There could even be a question about the use of a stent versus a simple balloon angioplasty or possibly an atherectomy. However, we will not address this possible area of contention.

Prospectively, the physician had to make a decision about whether Sam's condition justified a hospital admission versus remaining an outpatient. This same argument could arise in the context of observation

services as well. That is, did Sam even need to stay at the hospital overnight before the catheterization procedure?

Certainly the physician involved had reason to have Sam stay overnight in the hospital. But was the physician's assessment and reasoning documented in the record? Will the record also substantiate an inpatient admission versus an observation admission versus no admission?

One of the keywords that physicians must use is the word ***because***. When the physician writes the order for inpatient admission or observation, the physician must tell us why this service must be provided. Often the physician is making a considered decision, but the actual assessments and decision making process will not be fully documented.

Today, documentation must meet three general criteria:

- Clear,
- Concise, and
- ***Convincing***.

As the work of the RACs becomes even more pervasive, the need for convincing documentation is becoming more important. Three general concerns are:

- Medical necessity for providing the service,
- Medical necessity for the level and type of service, and
- Medical necessity for the site of service.

Particularly with cardiovascular services and orthopedic services, CMS and the RACs will push for explicit justification of a given service and then the proper site of service (i.e., inpatient vs. outpatient). Thus hospitals will need to increasingly work with physicians in these areas, among other areas, to enhance documentation so that any reviewer or auditor will be convinced that the services were necessary, the specific level of service is appropriate, and the location of the service is proper.

Developing this additional payment documentation will require significant reorientation and hospitals will need to work extensively through their medical staff organizations. Note also that care must be taken to study and meet any clinical requirements from the various CMS National Coverage Decisions (NCDs). For instance, in the cardiovascular area we have:

- 20.4 – NCD for Implantable Automatic Defibrillators
- 20.7 – NCD for Percutaneous Transluminal Angioplasty
- 20.8 – NCD for Cardiac Pacemakers[1]

Bottom-Line: While CMS maintains that only the usual clinical documentation is required when providing and justifying services, the work and demands made by the RACs seems to indicate that more documentation is needed to justify coverage and payment. Thus we appear headed toward enhanced clinical documentation that can be characterized as payment documentation.

Prepayment Audits: Inpatient versus Outpatient

The implementation of CMS's Recovery Audit Prepayment Review demonstration is imminent. While this prepayment process was scheduled to start January 1, 2012, there have been delays. This is one of several special demonstrations. Two other projects include:

- Prior Authorization for Certain Medical Equipment, and
- Part A to Part B Rebilling.[2]

For the prepayment demonstration the geographic coverage involves:

- Seven states with high populations of fraud and error prone providers (FL, CA, MI, TX, NY, LA, IL), and
- Four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO).

Two areas of concern are with cardiovascular services and orthopedic services. As with other demonstrations, if there are significant recoveries, then these prepayment audits will be expanded to all states.

> **Note**: This prepayment audit program is not related to the predictive modeling process as required under SBJA 2010. See related article in the October, 2010 edition of this Newsletter, Vol. 22, Number 10, pages 56-57.

Care should be taken to follow the results and problems that are encountered with this demonstration project. Whenever claims are being reviewed before payment is made, there is a high probability that payments will be delayed. Both cardiovascular and orthopedic services are high volume, high dollar claims so that there could be significant cash flow concerns.

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[1] See CMS Publication 100-3, Medicare Benefits Policy Manual.

[2] Note that this rebilling concept is also present in the ongoing O'Connor Hospital Ruling.

Physician-Only Services
Limitations on Non-Physician Practitioners

For non-physician practitioners, such as, nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs), state scope-of-practice rules generally delimit the range of services that can be provided by these individuals. For the most part the Medicare rules and regulations defer to these state scope-of-practice limitations so that Medicare covers and pays for any such allowed services.

Coverage for these NPPs (Non-Physician Practitioners) comes from the Medicare Benefit Policy Manual, Chapter 15, §§190, 200 and 210. Here is the language for NPs in §200.

> ***Types of NP Services That May Be Covered***
> *State law or regulation governing an NP's scope of practice in the State in which the services are performed applies. Consider developing a list of covered services based on the State scope of practice. Examples of the types of services that NP's may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.*

The directive to establish a listing is to the Medicare Administrative Contractors (MACs). The general directive seems to indicate that NPPs can perform any services allowed by state scope-of-practice rules. While not explicit, the NPP would also have to possess the personal skills for performing particular services. Because NPPs, as with physicians, are specializing, there are even advanced services that are within their personal capabilities.

Note that this discussion is in the context in which the given NPP would be directly billing the Medicare program. If the NPP services are billed by a supervising physician on an incident-to basis, there appears no restriction on what the NPP can perform.

National Government Services has recently issued guidance that delimits services that these NPPs can perform and then bill directly to the Medicare program.[3] In this case the orthopedic area is addressed.

Generally speaking, NGS has indicated:

- NPPs can perform minor surgeries, but
- Cannot perform major surgeries.

The definitions of minor and major are from the MPFS (Medicare Physician Fee Schedule). Interestingly enough, NGS uses the 10-day post-operative period for minor and the 90-day post-operative period for major. There is no mention of the 0-day post-operative procedures, which are generally for endoscopic procedures through already existing body orifices.

This effectively means that surgical codes classified as major surgeries are *physician-only* codes.[4] Only

Now the NGS guidance goes on to list exceptions for the major surgeries, that is, major surgeries that NPPs can perform and then bill directly. While this listing is too long to replicate here, most of the surgeries involve closed fracture or dislocation treatment without manipulation. Thus if there is any manipulation involved, then the NPPs cannot bill directly. The NPP services could certainly be billed as incident-to.

> **Case Study 2** – ***Freestanding Orthopedic Clinic*** – A very nice orthopedic clinic has been established. There are three orthopedic surgeons along with five specially trained PAs and NPs in the orthopedic area. The three physicians are often at the hospital and/or otherwise out of the clinic. The PAs and NPs are fully capable of assessing and reducing fractures including manipulation. One of the marketing policies for the clinic is that patients are always treated on the same day they present and/or are referred.

For the clinic in Case Study 2, this delimitation on what NPPs can personally perform and then directly bill will cause significant consternation. At least for Medicare beneficiaries, if there is a fracture reduction that requires manipulation, then the NPP will have to provide the service under the direct supervision of one of the orthopedic surgeons. This means that one of the surgeons will have to be at the clinic and be immediately available whenever such services are provided.

While the propriety of the MACs delimiting what services NPPs can perform and separately bill can be questioned, there is also the question of the specific rules from Medicare that substantiate the designation of physician-only codes.

Bottom-Line: Non-physician practitioners should anticipate that there will be further delineations and

[3] See NGS website, Part B News Article – 05/21/2012.

[4] Note that this discussion is in the context of the Medicare program and does not necessarily apply to other private third-party payers.

listings of physician-only codes. While this current guidance is in the orthopedic area, in time other areas will probably be addressed as well.

Questions from our Readers

Editor's Note: Questions from our readers are encouraged. Those asking questions are kept anonymous. Also, suggested answers should be assessed

Question: As a Chargemaster Coordinator, what is the current status on billing for conscious sedation?

There is no simple answer to this question. While the Medicare program discusses conscious sedation to some extent, there is very little guidance from private third-party payers. Be certain to check for any contractual obligations. Even with Medicare the guidance is less than crystal clear.

The history for conscious sedation has a rather tortuous path over the last decade. Here are some basic facts that govern the answer to this question.

1. Conscious sedation is considered as anesthesia for billing purposes. Thus, Revenue Code 0370 can be used for technical component anesthesia.[5]
2. There are two main CPT codes, 99141 and 99142, for conscious sedation, which under APCs are Status Indicator 'N", so that there is no separate payment.
3. Revenue Code 0370 does not require CPT or HCPCS codes. Thus, this is a Revenue Code without CPT or HCPCS codes.
4. Starting in CY2005, CPT has included the bulls-eye notation, Θ, for certain endoscopy and catheterization codes that indicates that conscious sedation is an inherit part and should not be reported separately.
5. For all other procedures in which conscious sedation is used, the services may be reported separately, ostensibly with the proper CPT code at least for Medicare which uses the codes.

Conscious sedation was discussed in a Q&A issued by CMS, ID=4896, dated June 2, 2005 and (apparently) updated on June 9, 2005. In this document CMS indicates that when conscious sedation should not be reported separately (as per CPT), then the charges for conscious sedation should be bundled into the associated procedure(s).

However, questions about separately charging and separately reporting have persisted. Some rather surprising guidance comes from a series of Q&As issued by CMS concerning the 'not reporting separately' question relative to injections and infusions. In Q&A #6 in this document (issued February 2006) CMS indicates that not reporting separately, or equivalently, not billing separately, means one of two things:

- The charges are bundled into the associated procedure(s) and there is no separate line-item charging, **OR**
- Charges can be reported separately but there should be no CPT or HCPCS codes reported.

This, of course, completely changes the picture for chargemaster coordinators. This guidance also seems to imply that CMS's issue in this area is a payment issue (i.e., with no codes there is no possibility of inadvertent payment) rather than a billing or charging issue.

With our focus delimited to just Medicare, there are several different approaches that can be used by chargemaster coordinators.

Bundle All Conscious Sedation Charges – This is a straightforward approach in which conscious sedation is not charged separately under any circumstances.

Bundle Only Conscious Sedation Charges with the Bull-Eye Notation – In this approach there is no separate charge made for conscious sedation with the CPT denoted codes with the bulls-eye notation. Conscious sedation under Revenue Code 370 is made for all other conscious sedation services.

Separately Charge for Conscious Sedation in All Cases – Using the guidance from CMS that states no CPT or HCPCS codes are to be used, a separate charge for conscious sedation under Revenue Code 0370 appears acceptable.[6] Of course, no CPT or HCPCS codes should appear.

If there is to be any sort of bundling, partial or total, then chargemaster coordinators must be extremely careful to take what would be the normal technical component anesthesia charges and average them into the associated procedures. Given the fact that cost for conscious sedation services are time dependent (namely the time that the nurse spends in administering and monitoring the patient relative to the conscious sedation), determining average charges to be bundled is not a trivial process.

[5] See Transmittal 442, dated January 21, 2005, to the CMS Claims Processing Manual.

[6] This statement depends on how the rather minimal guidance from CMS is interpreted.

Separately charging for conscious sedation creates consistent charging patterns for this service. The charges are often based on time units that then better reflect the overall resource utilization.

Now the above discussion relates to the Medicare program. When we move away from Medicare, there is very little general guidance for conscious sedation billing. With the presumption that other third-party payers recognize conscious sedation as a form of anesthesia, then the use of Revenue Code 0370 becomes appropriate for all third-party payers. Of course, there may be contractual delimitations in some cases. Also, some private third-party payers may pay based on the conscious sedation CPT codes so that these codes will need to be placed in the chargemaster for these payers.

Another related issue is what to do with the pharmacy items (typically Versed and Fentanyl) used for conscious sedation. If you are bundling, is it still appropriate to separately charge for the drugs?

Note: The above discussion presumes that any sort of solution is at the charging level. A more elegant solution to this whole situation is to handle the bundling at the claims level. For instance, the line-item(s) for conscious sedation can be placed in the chargemaster under Revenue Code 0370 most likely without CPT/HCPCS codes. Charges can then be accrued for all third-party payers including Medicare. When the billing system generates the claim, the billing system can be programmed to take the conscious sedation charges and bundle them into the associated procedure(s) when there are special third-party payer requirements to do so. Otherwise, the conscious sedation charges flow over to the claim form as a separate line-item under Revenue Code 0370.

Bottom-Line: Even in an area as delimited as conscious sedation, there are significant chargemaster issues relative to properly reporting conscious sedation charges. What guidance there is comes from the Medicare program. How private third-party payers address conscious sedation must be determined from contractual arrangements and associated coding and billing guidance.

References:

1. *Medical Reimbursement Newsletter*, "Integral-Part Concept – Part 3", December, 2005, Pages 69-71.
2. *Medical Reimbursement Newsletter, "*Conscious Sedation Bundling", July 2005, Pages 38-39.
3. *Medical Reimbursement Newsletter*, "Conscious Sedation – Coding, Billing & Compliance**",** March, 2005, Pages 16-17.

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 August 7th ***"Auditing Provider-Based Operations for Compliance"*** 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 fourth 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.

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INSIDE THIS ISSUE

FOR UPCOMING ISSUES

Affordable Care Act Issues
More on RAC Audits and Issues
Chargemaster Pricing Issues
More on Coding, Billing Compliance
More on Payment System Interfaces

****** 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.

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