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 update to APCs for CY2010 should be out shortly. Watch for this *Federal Register* entry as well as the MPFS update that should be out about the same time. Note the separate article for the quarterly APC update, which contained some interesting directives.

'Incident-To' Strikes Again

The phrase, 'incident-to', is used in two very distinctly different ways within the Social Security Act (SSA). For payment for hospital outpatient services, we have at §1861(s)(2)(B):

> "…hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;"

This section, among other things, states that hospitals are paid for services and items that are provided incident-to physician's services. Basically, if a hospital on the outpatient side is to be paid for services and items, then there must be some sort of incident-to physician services.

Note that the SSA does not use a phrase such as, 'physician or qualified nonphysician practitioner'. This phraseology has become quite standard with the Medicare program and pronouncements from CMS. In many instances, qualified nonphysician practitioners such as Nurse Practitioners, Physician Assistants or Clinical Nurse Specialists can and do stand in the stead of physicians.

A properly credentialed NP can literally establish an independent practice, see patients, provide services, and write prescriptions just like physicians. They must obtain billing privileges with Medicare through the CMS-855 process and obtain an NPI (National Provider Identifier). Physician supervision, other than that which may be required at the state level, is generally through a collaborative agreement and certainly is often quite indirect.

Of course, such an NP or group of NPs will be establishing a freestanding clinic and will be billing only on the CMS-1500 claim form and will receive 85% of what physician would be paid through MPFS (Medicare Physician Fee Schedule).

What happens if we move the NP to a provider-based clinic, for our purposes a hospital-based clinic?[1] Can the NP be the provider of services in the hospital-based clinic? Before we address this question, we need to review some recent clarifying guidance from CMS.

In analyzing compliance in connection with provider-based clinics we must divide the clinics based on their relative location, namely:

- In the hospital,
- On the campus, but outside the hospital, and
- Off-campus.

WIth the issuance of the April 7, 2000 *Federal Register*, CMS clearly stated that direct physician supervision was required for off-campus clinics. However, for clinics on hospital premises, that is, in the hospital or on the campus, such physician supervision was presumed because there would be a physician nearby.

Through Transmittals 82 and 101 to Publication 100-02, Medicare Benefit Policy Manual, and further discussed in the July 18, 2008 and November 18, 2008 *Federal Registers* CMS is now stating that provider-based clinics that are on the hospital's campus, but outside the actual hospital building, also require direct physician supervision.

[1] Note that Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) also have provider agreements with Medicare and could, in theory, have provider-based clinics.

If we take these two concepts, namely payment only for incident-to services and the fact that nonphysician practitioners are not physicians, we arrive at a rather convoluted conclusion. Nonphysician practitioners cannot meet the supervision requirement for off-campus or on-campus, out of the hospital, provider-based clinics. For instance, if a nonphysician practitioner such as a Nurse Practitioner (NP) is providing services without a physician's being on the premises and immediately available, then the supervision requirement is not met, and the hospital cannot be paid for the services.

Of course the NP can encounter patients, assess the patients, provide services, write prescriptions and bill professionally. However, because the direct supervision by a physician is missing, the incident-to requirement is not met, and the hospital cannot be paid.

Let us look at two case studies that illustrate how strange this whole situation has become.

Case 1 – Wound Care Center – The Apex Medical Center (AMC) has a very nice small wound care center in a separate building across the parking lot from the hospital itself. There are two NPs who, along with support staff, provide a variety of specialized wound care services. There is a medical director who is at the clinic once a week.

Under the recent changes in interpretation of the Medicare rules, the hospital cannot be paid the technical component for services because there is no physician supervision. Of course, for the limited period of time that the medical director is present at the clinic, technical component payment can be made.

Case 2 – Wound Care Plus Additional Services – AMC has established a provider based clinic in a separate building on the campus. Wound care, pain management and radiation oncology services are provided in the clinic. There is a common reception area and common clerical support staff. The medical director for wound care is present on Wednesday; the MDAs (MD Anesthesiologists) are present in the afternoons. The radiation oncologist is generally in the clinic although there are trips to the main hospital where the radiation oncology services are actually provided.

There are two main issues in Case 2:

1. Can a physician of a different specialty provide the necessary direct physician supervision?
2. Is there a physician present at all times that services are provided in this clinic?

The answer to the first question appears to be 'yes'. However, a careful reading of Transmittals 82 and 101 will indicate some ambiguities. In this case, CMS's guidance seems to morph over time.

Presuming that any physician can meet the direct supervision requirement, the next issue is to determine if there is a physician present at all times when services are provided to Medicare patients. This issue rapidly becomes a documentation issue involving when physicians are or are not present.

Note that you will need to carefully analyze any and all provider-based operations that are on-campus but outside the hospital itself. For instance, some hospitals have infusions centers that have limited times in which physicians are present. Note also that the question of when an operation is inside the hospital is not trivial. A clinic may be attached to the hospital but not considered to be inside the hospital itself.[2] In some cases a specific determination from your FI may be necessary to determine when an operation is truly inside the hospital.

Now a reasonable question is whether or not we can bill as a freestanding clinic when the physician supervision requirement is not met and then as a provider-based clinic when the physician supervision requirement is met. This raises a significant number of issues that require careful consideration.

Certainly, the NPs in our case studies can, and most likely will, file professional claim forms for their services. If the clinic is freestanding, then POS=11 is used, and the RBRVS site-of-service differential is not applied. If the clinic is provider- based, then POS=22, and the site-of-service differential is applied. The main challenge with switching back and forth is that when the clinic is provider-based, then the costs of the clinic go onto the cost report. If the clinic could also be considered freestanding part of the time, then the costs for that time will have to be removed from the cost report.

Thus, to even consider switching back and forth will take some real thought. Additionally, approval for this process should be obtained from your FI. The provider-based rule itself does address a situation of this type.

Bottom-Line: The recent changes in interpretation of the provider-based rules throw the whole process of correctly billing for provider-based clinics on the campus into limbo. Hospitals will need to carefully assess all such operations with great care and make changes accordingly. If there are circumstances in which the physician supervision requirement is not met, non-physician practitioners (PAs, NPs, and CNSs) can still provide services and bill professionally. However, the hospital cannot be paid for the facility component. While

[2] This is the so-called 'four-walls' concept of being inside the hospital.

some consideration can be given to billing POS=11 for freestanding when the physician supervision requirement is not met, this will require very careful analysis and consideration.

APC Update – Transmittal 1702

On March 13, 2009 CMS issued Transmittal 1702 to Publication 100-04, Medicare Claims Processing Manual. This is an off-quarter update for APCs that contains important billing directives. The following gives a brief synopsis of the some of the main items. Be certain to read this transmittal with care. These types of changes are somewhat unusual outside the annual APC update.

Blood Storage and Processing – See Revenue Code 0392 that is now available. There donnot appear to be any changes in coding and billing for blood and blood products other than the availability of this new revenue code.

Medical and Surgical Supplies – CMS is now telling us, other than Status Indicator "H" and "N" items, that are supplies should not be billed with HCPCS codes. This comes as no surprise! Early in the implementation of APCs hospitals encountered claims denials when using various A-codes for supply items. These A-codes were generally for supply items that are payable under other payment systems such as for skilled nursing or home health.

Thus, chargemaster coordinators have typically removed the HCPCS codes from the chargemaster for various supply items. Given that APCs packages all such supply items, logically these codes should not appear on the claim forms because of possible claims adjudication errors.

Note that this guidance further reinforces the difference between:

- Separately Billing, and
- Separately Charging.

What CMS is directing is that the supply items can either be bundled into the associated, separately payable services, or they can be separately charged. This simply means that there is a line-item in the chargemaster for the given supply item. However, these supply items should not be separately billed; this means that there should be no HCPCS code reported. Thus, you can separately charge (i.e., line item in chargemaster), but you cannot separately bill (i.e., HCPCS code associated with the line-item).

This means that chargemaster coordinators have the option of removing various supply items from the chargemaster without affecting reimbursement, at least under APCs. However, great care should be taken so that appropriate charges for the supply items are included in associated line items. Also, hospital departments are very sensitive to possible reduction in revenue generation.

Editor's Note: Our Supply Categorization Position Paper is being updated with this additional guidance and will go to Version 11.0. If you would like a copy, please e-mail Duane@aaciweb.com for a copy.

Bilateral Procedures – If more than one set of bilateral procedures is billed on a given date of service, then use modifier "-76", repeat procedure.

Drugs, Biologicals and Radiopharmaceuticals – Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Also, the I/OCE is supposed to recognize all the HCPCS drug codes, not just those with the lowest dosage.

Correct Reporting of Units for Drugs - Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Coverage Determinations – The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

RACs Update

As the RACs get organized, there are indications that medical-necessity audits will probably not start until 2010. There was a similar delay with the Demonstration Program. However, keep in mind that the start date is October 1, 2007 and the RACs can look-back three years. Thus, when the medical necessity audits do begin, the RACs most likely will address the older claims first to make certain they have notmissed anything.

The medical necessity audits are subjective and thus can generate the need to appeal. Also, CMS guidance continues to change, particularly with the issuance of *clarifying* guidance. If CMS issues clarifying guidance, this is not considered a change in policy so that the MMA Section 912 prohibition against retroactively applying changed policy does not apply. You should anticipate that even though you met what was understood to be CMS's guidance several years ago, the situation may now be significantly different, and there could now be overpayment situations.

RACs – What Happened to the Underpayments?

The main objective of the Medicare RAC program is to identify and correct *improper payments*. Logically, this means *both* overpayments and underpayments. However, according to the CMS January 2009 "**Update to the Evaluation of the 3-Year Demonstration**", the underpayments amounted to only 3.67% of all the improper payments identified and addressed by the RACs. Why is this percentage so low? Are the RACs really looking for underpayments?

The RACs are paid on a percentage basis or contingency basis for finding improper payments. Thus, in theory, the incentive to find underpayments is the same as for finding overpayments. However, as we will explore, the whole Medicare RAC program has really been constructed and organized in order to find overpayments, not underpayments. This fact is certainly obvious with the 3.67% figure from the CMS report.

Healthcare consulting firms have worked for years to assist every type of healthcare provider to identify circumstances in which payments under a variety of payment systems can be increased. Sometimes the word *optimize* is used. The OIG has frowned on using the word *maximize* because this suggests that consultants, particularly on a contingency basis, are incentivized to find underpayments where none may actually exist. Interestingly enough, it appears that the RACs can be incentivized on a contingency basis to find overpayments that may not actually exist. At the very least, overpayments may be claimed by the RACs on a subjective basis such as questioning medical necessity.

There are many different types of audits, such as, probe audits, baseline audits, pre-payment audits, and the list certainly can go on.

For healthcare providers audits can be classified as:

- Prospective Audits,
- Concurrent Audits, and
- Retrospective Audits.

Prospective audits address the systematic process of providing services, documenting services and then coding and billing for services. The emphasis is on the systematic process and associated subprocesses throughout the reimbursement cycle.[3]

Concurrent audits look at the systematic processes and then also look at samplings of current claims. Generally, current claims are in the 90 to 180 day range and may or may not be paid. The purpose of such audits is to identify weaknesses in the systematic process by analyzing the current end products, namely the claims. If possible, reimbursement also is audited. A real advantage with current claims is that the claims can be corrected and refiled if errors or omissions are identified.

Retrospective audits look back in time and consider only paid claims. Often the claims are so old that there is no opportunity to correct and refile the claim. If there is an overpayment found, then a repayment is appropriate. On rare occasions underpayments may be identified. In general, these underpayments are lost.

Auditors of all types have been using these types of audits for many years. For instance, the OIG or DOJ may decide to investigate a particular issue. In some cases they have gone back as far as seven years in conducting retrospective audits. The prospective and concurrent audits are generally used by consultants assisting healthcare providers in reimbursement enhancement. Consultants also routinely conduct retrospective audits looking for possible errors.

[3] We could use the phrase 'revenue cycle', but we are focusing on generating claims for which reimbursement is made.

The RACs use data mining to identify possible problem areas. Automated reviews are retrospective reviews of paid claims. The automated reviews look for identified and potential aberrations in coding and billing by various healthcare providers.

The complex reviews actually do look at the supporting documentation. However, the main intent of these reviews is again on a retrospective basis looking for specific issues such as medical necessity for hospital admissions. Typically, the intent of a complex review is to verify that the documentation justifies the provisions of service and also justifies the coding and associated claim that was filed. Also the RACs look for weaknesses in the documentation relative to identified or potential overpayment problems.

Have you ever heard of a RAC checking the documentation because of possible under-coding issues?

The RACs can and will use other types of audits. For instance, the RACs can request a limited number of records, usually 10, in order to determine if a suspected problem area really is a problem.[4] This is a type of probe audit. However, do not confuse this type of small audits with probe audits that are conducted as part of the extrapolation process. These probe audits will be for 30 or more cases depending upon the size of the universe being considered.

The RACs are allowed to review current claims, but it is unlikely that this would include unpaid claims. Current claims in this case generally refer to the fact that you could refile the claims if the RAC found and substantiated an overpayment. Note that the time period for refiling claims is a rather convoluted algorithm found at 42 CFR §424 which is the Conditions for Payment (CfP) section of the Code of Federal Regulations.

Bottom-Line: If you have any hope that the RACs will find significant amounts of underpayments, most likely, this will never occur. The RAC auditing processes are geared to address paid claims, generally on a retrospective audit basis. While some underpayments may be found, underpayments are generally identified through either prospective audits and/or concurrent audits. These are the types of audits that consultants have used for years to assist healthcare providers in receiving proper payments. Evidently CMS has established the whole RAC program to find overpayments as opposed to underpayments.

[4] These small probe audits are not included in the medical record limitation for complex reviews.

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 July 14th:"***Auditing Hospital Provider-Based Operations***" 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.

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

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FOR UPCOMING ISSUES

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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.

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned 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. E-Mail: Chris@aaciweb.com.