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 (Ambulatory Payment Classifications) and MPFS (Medicare Physician Fee Schedule) should be appearing shortly through the *Federal Register* process. Be watching for these FR entries so that you can review and comment as to the proposed changes.

The July 1st update to APCs is close at hand. Be certain to review the following two transmittals:

a. Transmittal 1980, Publication 100-04, Medicare Claims Processing Manual, June 4, 2010, and
b. Transmittal 128, Publication 100-02, Medicare Benefit Policy Manual, May 28, 2010.

Both of these are titled, "July 2010 Update of the Hospital Outpatient Prospective Payment System. ***Be certain to read them carefully!*** There is a related article on physician supervision in this Newsletter.

There are a number of other transmittals that are of importance. For instance, Transmittal 124 to Publication 100-02, Medicare Benefit Policy Manual was issued on May 7, 2010. This transmittal discusses pulmonary rehabilitation services, and there will be an article in the July issue of this Newsletter.

Physician Supervision – A Little More Guidance

The July 2010 update to the Hospital Outpatient Payment System (OPPS) comes from Transmittals 128 and 1980. Both of these transmittals include additional language pertaining to the physician supervision requirements that have been changing over the last two years.

First, on the diagnostic side, CMS has not really changed the supervisory requirements. These requirements are embedded in the Medicare Physician Fee Schedule (PFS) as a special indicator. However, with CMS' allowing non-physician practitioners to meet the supervisory requirements on the therapeutic side, does this mean that the non-physician practitioners can meet the supervisory requirements on the diagnostic side?

From Transmittal 128 that updates §20.4.4 of the Medicare Benefit Policy Manual,

> *Thus, while physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives only require physician supervision included in any collaboration or supervision requirements particular to that type of practitioner when they personally perform a diagnostic test, these practitioners are not permitted to function as supervisory "physicians" for the purposes of other hospital staff performing diagnostic tests.*

In other words, these non-physician practitioners can perform the diagnostic tests, but they can't supervise others to perform the tests that require special supervision as delineated in the MPFS.

There is a significant update to §20.5.2:

> *Immediate availability requires the immediate physical presence of the physician or nonphysician practitioner. CMS has not specifically defined the word "immediate" in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician or nonphysician practitioner is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician or nonphysician practitioner may not be so physically far away on-campus from the location where hospital/CAH outpatient services are being furnished that he or she could not intervene right away.*

Instead of defining 'immediate', CMS chooses to discuss what is not immediate. Fairly obviously, if the physician or non-physician practitioner is performing a service that cannot be interrupted, then the

immediately available test would fail. The second concept for on-campus might be disconcerting in some cases because certain hospitals have geographically large campuses. So what does 'intervene right away' mean?

The supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized therapeutic equipment, and while in such cases CMS does not expect the supervisory physician or nonphysician practitioner to operate this equipment instead of a technician, CMS does expect the physician or nonphysician practitioner to be knowledgeable about the therapeutic service and clinically appropriate to furnish the service.

This is a most interesting paragraph! With discussion of technicians operating specialized equipment, this statement is likely in response to concerns about radiation therapy and related services. These therapeutic services are performed by specially trained technicians after extensive planning and preparatory work is made by the physicians involved. The actual provision of the services generally does not involve the physician. Thus, the main function of a supervisory physician or non-physician practitioner would seem to involve possible emergency situations that are related to circumstances other than the radiation therapy.

While this guidance from CMS must be carefully interpreted, it would seem to say that the supervisory physician or non-physician practitioner would need to have the ability to operate the equipment, that is, to provide the service. This interpretation is delimiting.

Case Study 1 – ***Medical Oncology Clinic*** – At the Apex Medical Center, there is a clinic building on the campus across the parking lot (100 yards) from the main hospital in which radiation oncology services are provided. There is a single radiation oncologist that typically sees patients in the clinic while radiation services are provided by the technicians.

The question then becomes, must the radiation oncologist serve as the supervising physician for the therapeutic services provided by the radiation technicians? Most likely, the physician can leave the clinic on a moment's notice, but what about the dash across the parking lot?

The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician or nonphysician practitioner and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician or nonphysician practitioner would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner. In summary, the supervisory physician or nonphysician practitioner must be clinically appropriate to supervise the service or procedure.

This paragraph does not add a great deal of substance. While the supervising physician or practitioner must be able to take over any procedure, other physicians certainly can be consulted.

Direct supervision is the minimum standard for supervision of all Medicare hospital outpatient therapeutic services. Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. ***For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate****.*

The last highlighted statement moves the entire burden of proof from statements in the CMS regulations over to the hospital. All of a sudden it is the hospital that must prove that not only was supervision provided, but that also the supervision was at the appropriate level, including possible personal supervision.

Presuming that a hospital can unravel exactly what these regulations entail, an overarching issue is how hospitals are to document and/or otherwise be able to verify that proper physician supervision was available and/or took place if necessary. From a compliance perspective, if an auditor requests that physician supervision be verified, what kind of documentation is necessary?

Case Study 2 – ***Infusion Center*** – The Apex Medical Center has a nice Infusion Center in a two story building that is attached to the hospital by a skywalk. On the second floor there are multiple clinic offices for several oncology physicians and a nurse practitioner. On the bottom floor, various services are provided

including chemotherapy, infusions, and injection services and blood transfusions.

The immediate question for the hospital concerns meeting the supervisory requirements including the latest guidance. If there is an immediately available oncologist, either physician or nurse practitioner, in the building, then the supervision requirements for a qualified physician or practitioner are met. But, what if the oncology staff is elsewhere (e.g., at a conference, at lunch, making rounds, etc.)? How is the hospital going to document who was available and able to fulfill the supervisory requirement?

Previous discussions of these supervisory requirements indicated that if there were a qualified physician or practitioner anywhere on the campus who was immediately available, then the supervision requirement was met. This new language appears to narrow those who can qualify both by qualifications and by proximity. Additionally, the burden of proof appears to reside totally with the hospital that must be able to document who was available, their approximate proximity and their qualifications to take over provision of a given service.

Transmittal 1875 – E/M Coding – Part 1

Editor's Note: This transmittal is entitled, "Revisions to Consultation Services Payment Policy", BUT there is a great deal more in this transmittal. ***Anyone performing physician coding should thoroughly study this transmittal.***

CMS has dropped the use consultation codes for both hospitals and physicians. Inpatient consultations and inpatient follow-up consultation are still available for telehealth using two series of Level II HCPCS codes, in this case G-Codes.

Discontinuing the use of the consultation codes on the hospital outpatient technical side has a limited impact that depends on the mappings of resources to code levels. These mapping do not include inpatient consultations, so that the main mapping for hospitals consists the five levels of outpatient consultations to the five levels of either new patients (CPT 99201-99205) or established patients (CPT 99211-99215). For hospitals, CPT 99211 has no special connotation relative to just nursing services; this code is simply the first level in the established patient series.

For physicians, the discontinuation of the consultation codes is much more difficult. For physician clinics, for hospital-based provider-based clinics and for hospital owned and operated freestanding clinics there are challenges in mapping the CPT consultation codes over into the outpatient visit or inpatient visit codes on the professional side.

Transmittal 1875 in updating Chapter 12, § 30.6.10 gives the following guidance:

> *In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "-AI", Principal Physician of Record, in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.*

Because physicians will continue to use the consultation codes for third-party payers other than Medicare, the natural process is to map the consultation codes into the office visit or hospital visit codes. Let us consider the initial inpatient consultation codes.

There are five levels of inpatient consultation codes. Here are the first two levels with the following three primary documentation criteria:

- 99251 – Level 1 Inpatient Consultation
  - Problem-Focused History
  - Problem Focused Examination
  - Straightforward Medical Decision Making
- 99252 – Level 2 Inpatient Consultation
  - Expanded Problem Focused History
  - Expanded Problem Focused Examination
  - Straightforward Medical Decision Making

Now these two services should map into the initial inpatient visits, but consider just the firs level:

- 99221 – Level Initial Hospital Visit
  - Detailed/Comprehensive History
  - Detailed/Comprehensive Examination
  - Straightforward/Low Complexity Medical Decision Making

Can either 99251 or 99252 map into 99221?

Editor's Note: To be continued next month.

May 5, 2010 *Federal Register*

CMS has issued an interesting, although difficult to read, *Federal Register* entry concerning changes in provider and supplier enrollment and ordering and referring suppliers. For anyone involved in the CMS-855 forms

and/or filing of claims for DME and home health services, this FR entry is required reading.

First, this is an Interim *Final Rule with Comment Period*, referred to as IFC. This means that there is a comment period that ends on July 6, 2010, but the rules actually go into effect regardless of comments from the public. At a later time CMS will address the comments holding out the possibility that further changes could be made.

Second, when you study this FR entry, you should have your copy of the Patient Protection and Affordable Care Act (PPAC) or at least Subtitle E – Medicare, Medicaid and CHIP Program Integrity Provisions. The main sections addressed are §§ 6405 and 6406. Note that § 6404 has changed the filing period for Medicare claims to one year after the date of service.

Third, be certain to note the implementation dates of different changes. Some have been implemented as of January 1, 2010; some go into effect July 1, 2010 and others January 1, 2011.

Fourth, note the changes in terminology. 42 CFR § 424, the Condition for Payment (CfPs), has long created confusion between the terms 'provider' and 'supplier'. Hospitals and skilled nursing homes are providers because they have provider agreements with the Medicare program. Almost everyone else, including physicians, are suppliers. However, this CMS language is not consistent with the HIPAA TSC (Transaction Standard, Standard Code Set) Rule as found in the Implementation Guides. For the standard transactions, the terms 'ordering provider' and 'referring provider' are used in a more general context.

There is also the introduction of the phrase, 'eligible professional' that can refer to a physician and other qualified non-physician practitioners. This terminology has been adjusted relative to ordering and referring capabilities. While terminology may seem somewhat trite, compare this to the EMTALA rules that reference 'qualified medical person'.

The three main issues addressed by this FR entry are:

- Inclusion of the National Provider Identifier (NPI) on all Medicare and Medicaid Enrollment Applications and Claims
- Ordering and Referring Covered Items and Services for Medicare Beneficiaries
- Requirements for Physicians, Other Suppliers, and Providers to Maintain and Provide Access to Documentation on Referrals to Programs at High Risk of Waste and Abuse

Now the requirements for using NPIs for Medicare and Medicaid enrollment should come as no surprise. The second major issue comes from § 6405 of the PPAC and involves reporting NPIs on claims relative to ordering and referring physicians. The actual language in PPAC for this section involves DME and home health. HOWEVER, § 6405(c) allows the Secretary to extend this claim requirement to other items and services. Thus, hospitals and other providers should prepare for including the NPIs for ordering and referring physicians and other eligible professionals. For DME and HHA this provision goes into effect on July 1st.

The third issue involved documentation requirements. Technically, the requirements in this area went into effect on January 1st. Obviously, we are now receiving the official changed language. The basic idea is that a provider or supplier who furnishes:

- DMEPOS,
- Home Health,
- Laboratory,
- Imaging, or
- Specialist Services

must maintain documentation for a period of 7 years. This documentation must include the NPI of the ordering physician. Access to the documentation must be granted for the 7 years. Note that this NPI information may not be in the patient's medical record, but may be in the billing and claims documentation.

Editor's Note: As you read and study the various section of the PPAC note how many times significant latitude is afforded to the Secretary in promulgation of additional rules and determination of coverage of rules.

CMS Guidance on UB-04 - Update

In Transmittal 1973 to Publication 100-04, issued on May 21, 2010, CMS modifies some of the language in the manual. While there are really no substantive changes, what CMS is doing is coming into better conformance with the HIPAA TSC. For *some* of the form locators (FLs), the following language is inserted:

> *Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via NUBC's Official UB-04 Data Specification Manual.*

In theory, the NUBC is the official code set maintainer for many of the cost sets used on the UB-04. Thus, the NUBC is the only source for official guidance on the use of these code sets. A good example of how this process is violated is with Condition Code 44 relative to changing the status of a patient from inpatient to outpatient. The NUBC definition is much less stringent than the requirements made by CMS for the use of this particular code.

DRG Pre-Admission Rule

The DRG Pre-Admission Rule, sometimes inappropriately referred to as the 72-Hour Rule, has suddenly come onto CMS's radar screen. This is an area that may be included in the various RAC (Recovery Audit Contractor) audit issues. Additionally, Congress may review this area.

This rule has long represented a two-fold challenge for hospitals.

1. Exactly how should this rule be interpreted, and
2. How should it be addressed operationally?

With hospitals developing more and more provider-based clinics, the possibility of providing outpatient services that should be rolled into the inpatient billing is increasing. Note that the trigger for application is not just for provider-based clinics, but for any owned or operated clinics as well. Thus, an owned freestanding clinic could also be included.

Case Study 3 – ***Rolling All Outpatient Charges*** – The Apex Medical Center has several provider-based clinics and even operates several freestanding clinics. When a patient is admitted to the hospital, billing personnel manually check to see if the patient was seen in any of the clinics or hospital outpatient areas for the three dates of service prior to the admission. If there are any services of any kind, then the charges for these services are all rolled into the inpatient billing.

Clearly, Apex is not distinguishing diagnostic and related therapeutic services versus unrelated therapeutic services. Thus,certain services that could and should be billed separately are being rolled into the inpatient billing. So what is wrong with that? The Medicare program is not paying for those outpatient services that would otherwise be paid, so everyone should be happy. Right?

Well, not quite! Because all of the services are being rolled into the inpatient billing,there are unrelated services included that will be coded under DRGs. This may result in an elevated DRG assignment so that an improper DRG payment is made. For instance, RAC auditors would want to recoup the overpayment that has resulted. In theory, the hospital should be able to refile claims and correctly bill for the unrelated outpatient services.

Standby for further developments in this area both on the RAC side as well as on the Congressional side.

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/JantoDecember2010EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2010. Contact Chris Smith at 515-232-6420 or e-mail at CSmith@aaciweb.com for information.

A variety of Webinars and Teleconferences are being sponsored by different organizations. Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, and the Eli Research Group are all sponsoring various sessions. Please visit our main website listed above for the calendar of presentations for CY2010.

The Georgia Hospital Association is sponsoring a series of Webinars. Presentations are planned for all of CY2010. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for July 20th "***Understanding Medicare Secondary Payer"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's latest book:

"***The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers***" is now available for purchase. This is a companion volume to

"***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition.

Both of these books are published by CRC Press of the Taylor & Francis Group.

A 15% discount is available for subscribers to this Newsletter. For ordering information contact Chris Smith through Duane@aaciweb.com.

Also, Dr. Abbey has just finished the second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second in the series addresses fee schedule payment systems and should be available shortly. The third book in the series is devoted to prospective payment systems and is currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below.

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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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