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 rule for the 2012 update to APCs and the Medicare Physician Fee Schedule (MPFS) should be available shortly. Standby! We will be discussing both new and on-going issues that need attention. Watch for the MPFS update because there will be further discussion of reimbursement for physician services at hospital owned or operated freestanding clinics.

CAHs – PEPPER

The PEPPER (Program for Payment Patterns Electronic Report) data is now available for CAHs as well as for PPS (Prospective Payment System) hospitals. The information provided by PEPPER is extremely useful in identifying potential compliance problem areas. ***However***, the information provided is relative data, not absolute data.

Relative data can be used as a possible indicator, not necessarily as an absolute indicator that something is skewed. Also, as usual, CAHs are different in that reimbursement is based on cost, not necessarily on the way a particular service is coded. You should still be concerned about correct coding, particularly diagnosis coding supporting medical necessity. For instance, medical necessity must be in place to support an inpatient admission; if the admission is not justified then there should be no payment because there was improper utilization.

> **Note**: The issue of services provided that are not medically necessary (i.e., inappropriate) is the main concern that CAHs have relative to the RACs (Recovery Audit Contractors). Such services lead to over utilization that then drives increased costs and associated improper cost-based reimbursement.

On the inpatient side, CAHs should review the historical problem areas that have been associated with DRGs, now MS-DRGs. Among the many issues is pneumonia. While the concern for CAHs is general medical necessity, the way PEPPER is set up, you will receive information in terms of the MS-DRGs so that you will still need to understand the target areas for DRGs.

Typical problem areas include:

- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Medical DRGs with CC or MCC
- Surgical DRGs with CC or MCC
- Three-day Skilled Nursing Facility-qualifying Admissions
- Swing Bed Transfers
- Two-day Stays for Heart Failure and Shock
- Two-day Stays for Cardiac Arrhythmia
- Two-day Stays for Esophagitis Gastroenteritis

The basic information that is available includes:

- Discharge Counts
  - Problematic DRG Discharges, and
  - All Discharges within the DRG category.
- Payments
  - Sum
  - Average
- Average Length of Stay

The discharge counts form the basic statistic that is in the PEPPER data, that is, the percentage of problematic DRG discharges in terms of the number of DRG discharges in the reference group. For example, there may be a reference group of six DRGs of which three of the DRGs are considered problematic because they involve CCs (Complications or Comorbidities) or MCCs (Major CCs). Auditors would expect the higher level DRGs would be a relatively small percentage of all the DRG discharges in the reference group.

> Note: Yes, PEPPER has really been designed for PPS hospitals, particularly for MS-DRGs. CAHs can still benefit from PEPPER, so do not shy away from studying these reports.

Using the conceptual example above, an auditor would check to see the percentage of higher level DRGs

compared to the reference group. Let us assume the percentage is 60%. This kind of percentage would be noticeable; an auditor might not notice 30%, but much of anything over 50% might raise red flags.

This percentage by itself has limited meaning. What is really important is how this compares to other hospitals. PEPPER provides comparative information for:

- State,
- FI/MAC,
- Nation.

In order to provide comparative data, the particular percentages calculated for your hospital are then calculated as a ***percentile***. This particular statistic is one of the most often misunderstood statistics. Even a little research sometimes will yield very different definitions of the percentile concept. Consider the following case study.

> Case Study 1 – The Apex Medical Center, a CAH for the Medicare program, is looking at the PEPPER statistics for pneumonia. Apex's percentage of problem DRGs relative to all the pneumonia DRGs is 80%. This seems like a high percentage, but the report indicates that this is only at the 60th percentile for all the hospitals in the state.

While 80% by itself seems high, being at the 60th percentile means that 60% of the hospitals in the state have a lower percentage while 40% have a higher percentage. Thus, the 80% *relatively speaking* is not that bad.

Be careful with statistics! In some cases you will be dealing with small amounts of data. PEPPER doesn't include data when there are less than 11 discharges for a given DRG. Also, you may have a limited number of CAHs in your state. Additionally, even with your FI, there may be a limited number of CAHs. Thus, in terms of numbers, the national figures may be more informative. With the 80% example we have been using, if this percentage is at the 90th percentile nationwide, then there should be some concern because your percentage is higher than 90% of other CAHs around the country.

So, what should you do if you have statistics that are unusually high (or for that matter low)? The typical approach is to review the situation and possibly even perform an audit to make certain that the associated coding is correct and supporting documentation is in place. While you may determine that everything is in order, this will still be a red flag, particularly for the RACs.

Bottom-Line – Obtain your PEPPER data on a routine basis, study the information and then make considered decisions as to any actions you should take. Remember, PEPPER is a useful tool; use it wisely.

3-Day Pre-Admission Window Takes On a Life of Its Own

Articles in this Newsletter have been discussing various details of the 3-Day Pre-Admission Window since the early 1990's. On June 25, 2010 Congress passed legislation that generalized the requirement for bundling outpatient therapeutic (i.e., non-diagnostic) services into the inpatient billing when an individual is admitted to the hospital. Hospitals and physicians should anticipate that there will be significant discussions regarding new billing and payment rules relative to the 3-Day Pre-Admission Window in the coming months and probably years.

Key Provisions of the 3-Day Pre-Admission Window

1. The window itself is comprised of the three dates of service preceding the date that the patient was admitted. Ostensibly the hours on the date of admission preceding the actual time of admission are in the window, BUT the bundling rules are more stringent.
2. All diagnostic services must be bundled into the inpatient billing.
3. For the three dates of service preceding the date of admission, related therapeutic services must also be bundled. For the hours preceding the actual time of admission on the date of admission, all therapeutic services must be bundled, related or not.
4. The trigger for applying the 3-Day Pre-Admission Window is unusual. The requirement is that the services must be provided in a facility that is wholly owned or wholly operated by the admitting hospital.
5. There is an equivalent 1-Day Pre-Admission Window for non-PPS hospitals. However, even this window does not apply to Critical Access Hospitals (CAHs).

Terminology Notes

Watch the terminology used by CMS in this area. CMS is now referring to this whole issue as the 3-Day Payment Window. Hospitals tend to view this much more as a billing issue than a payment issue.

Also, CMS is using phrases such as *physicians' practices*. For many this implies that the practice is physician owned. Why CMS is not using the word

freestanding from the Provider-Based Rule (PBR) seems to raise questions. See withdrawn Transmittal 87.[1]

So, What Is All The Fuss?

Because of the changes from P.L. 111-192 that broaden the concept of related services, CMS is now recognizing an issue that has been present all along. This is the issue of physician services at a freestanding clinic (1500 claim form only) that are therapeutic in nature and thus should be considered for inclusion in the inpatient billing.

There are actually several variation on this general theme. Let us look at a case study.

> **Case Study 1** – ***Acme Medical Clinic*** – The Acme Medical Clinic is owned by the Apex Medical Center, but Acme is organized as a freestanding clinic with only a 1500 claim form being filed. There are five Family Practice physicians and three Nurse Practitioners. On Monday afternoon, Sam, an elderly patient, presents to the clinic with cough, congestion and fever. He is examined by a physician, and a prescription is provided for antibiotics. On Wednesday evening, Sam presents to the Apex Medical Center's ED and finally is admitted for pneumonia.

The question is Case Study 1 does not really involve the fact that the diagnostic and therapeutic services at Acme were related to the inpatient admission. Also, Acme is owned by Apex, so the window applies. What is at issue is that the overhead costs associated with the physician's therapeutic services should be included on the inpatient claim. Here is CMS's language from the May 5, 2011 *Federal Register*:

> "*In the circumstance where a clinic that is not provider-based meets the definition of being wholly owned or wholly operated by the hospital and the 3-day (or, if applicable, 1-day) payment window applies to related nondiagnostic preadmission services, the hospital's charge on the inpatient claim would include any overhead costs associated with Medicare's physician fee schedule payment. Therefore, it should follow that Medicare's payment to the physician for the physician fee schedule service should be at the lower facility rate, which does not include overhead, staff, equipment, and supplies required to perform the service in the physician's office (rather than the higher nonfacility rate that does include those overhead costs) to avoid paying for the services twice because they are no longer being paid separately under Part B."* (76 FR 25961)

Now things are becoming complicated both conceptually and operationally. There are actually two issues:

1. Including the overhead costs on the UB-04 along with due consideration for cost reporting implications, and
2. Reduction in the professional fee for the physician by invoking the site-of-service (SOS) differential under MPFS for providing services in a facility setting.

The second issue is scheduled for consideration in the upcoming proposed update to MPFS for CY2012. This *Federal Register* entry should be appearing in the next month or two.

There are even further complications. Consider Case Study 2.

> **Case Study 2** – ***Acme Medical Clinic NP Services*** – Consider the same basic facts as in Case Study 1, but have one of the NPs actually provide the services. Because this is a freestanding clinic, the supervising physician can bill for the NP services as if performed by the physician so that 100% of the MPFS is paid in lieu of 85% if the NP directly billed.

Because the 3-Day Pre-Admission Window applies, the NP's services that were billed on an incident-to basis under the physician's name must now all be included in the hospital billing. Remember that in a facility setting (application of the Window in this case) a physician can only bill for what he or she personally provided. Restated in SSA language, the hospital is paid for all services that are incident-to those of a physician and is only paid if incident-to those of a physician.[2]

Where does this leave us? While we can conceptualize what should take place, actually implementing any sort of an operational process to meet these requirements is extremely difficult.

Again, this whole issue is scheduled for discussion in the upcoming *Federal Register* proposed rule changes for the MPFS. Anticipate that these discussions will span several years.

Editor's Note: This discussion will be continued in future Newsletters. Anticipate that this will generate significant issues for hospitals that own or operate freestanding clinics.

[1] Because this transmittal has been withdrawn, it is not readily accessible. Contact us if you need a copy. While this transmittal has been withdrawn, the discussion and concepts in this document are of interest.

[2] Yes, this is '*the if and only if* 'logic that you studied in high school mathematics although this is a subtle application.

Ambiguous Guidance from CMS: Technical Component E/M Coding – Part 1

We are now a good eleven years into CMS's implementation of a hospital outpatient prospective payment system, namely APCs (Ambulatory Payment Classifications). One of the glaring areas of long-term ambiguous guidance is with technical component E/M coding. Actually, in this case it is an almost total lack of guidance.

In 2000 when CMS implemented APCs, apparently there was a last minute decision to pay separately for E/M services such as those with the ED or provider-based clinics. The pre-cursor system, APGs or Ambulatory Patient Groups, generally bundled E/M levels if there was any other service provided. The basic idea was that the associated service would include the E/M services. For surgeries this approach makes some sense, however if you are bundling the E/M level into a diagnostic test such as laboratory or radiology, the logic tends to weaken.

If there was a standalone E/M service, then APGs used the diagnosis code or codes to determine the appropriate level for payment. For instance, the presenting diagnosis would be correlated reasonably close to the necessary level of E/M services at last for cases in which only an E/M level was provided.

> Note: Using diagnosis coding to map resources utilized to different level of E/M codes is one way in which you could meet the CMS directive of each hospital developing a mapping and then using it.

Back in 2000 hospitals anticipated that CMS would develop national guidelines within a year or two at most. CMS has not developed any specific guidelines. Some general characteristics of the E/M mappings were enumerated in the August 2, 2007 *Federal Register* (72 FR 42765). Included in this listing were directives about having the mappings available to auditors and associated procedural issues.

More recently, CMS has indicated that implementing any national guidelines might be disruptive to hospitals that already have working systems. Then in the November 20, 2010 *Federal Register* we have:

> *We [CMS] agree with the commenters that national guidelines should be clear, concise, and specific with little or no room for varying interpretations, and that hospitals should have at least 1 year to prepare for the transition. If the AMA were to create facility specific CPT codes for reporting visits provided in HOPDs, we would certainly consider such codes for OPPS use."*
> (Page 71990 – 75 FR 71990)

Apparently, after eleven years CMS would like to have the AMA develop national guidelines.

Along with the various E/M levels, there is also the question of properly using the "-25" modifier. This is the modifier that is used only on E/M codes, by both physicians and hospitals, to indicate that there was a significant and separately identifiable E/M service provided along with some other service, generally an operative service of some sort. There was very limited guidance provided for hospital use or nonuse in 2000 and 2001.[3]

Another twist in this whole situation concerns whether certain services should be coded and billed separately or integrated into the E/M levels. Keep in mind that any service that is separately codeable and billable should not be included in the E/M level. Consider a case study:

> **Case Study 3** – ***Simple Fractured Rib*** - Sam, a retired rancher, has presented to the Apex Medical Center's ED with chest discomfort. An x-ray indicates a non-displaced simple fracture of one rib. Sam is instructed to go home and take it easy, a pain medication is prescribed and Sam is discharged home.

This type of presentation to the ED is not unusual. Simple fractures of the fingers, toes, and trunk generally have a separate APC category to differentiate them from the more expensive fractures of the arms and legs. The CPT for the fracture care in Case Study 3 is CPT 21800. There would typically be an E/M level for the EMTALA mandated E/M level and the CPT code 21800. The "-25" modifier would be needed on the E/M level. However, because there is almost no direct care provided by the physician or the hospital, coding staff are often reluctant to code the 21800. The preference is to move the services into the E/M level mappings.

This particular issue created havoc with the two original APCs, that is, one for fracture of the finger, toe, trunk and another for fractures other than of the finger, toe, and trunk. The cost data in this area was so inconsistent that CMS was forced to merge all of the fracture into a single category ostensibly for any fractures. A part of the reason for this difficulty is that CMS has never issued any guidance on proper coding in this area. Thus hospitals have not consistently coded these cases, causing confusion.

Editor's Note: In Part 2 of this article we will continue our discussion of ambiguous guidance for technical component E/M coding along with the concern that the RACs will enter this area and use extrapolation to assert significant overpayments.

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[3] See PM A-00-40 – June 20, 2000 PM A-01-80 – June 29, 2001.

Questions from Our Readers

Question: For observation cases, should we be separately reviewing each case for proper coding, billing, reimbursement and then the adequacy of documentation?

Our recommendation is that each and every observation case should be reviewed by a small team. The team should include utilization review, coding, billing, and others as appropriate (e.g., revenue enhancement, chargemaster coordinator, etc.). The overall documentation should be reviewed with particular attention to the physicians/practitioners statement of medical necessity. If at all possible, the physician should document a discharge summary just as is done for an inpatient admission.

As a part of this review effort, an observation log should be developed. There is no formal regulatory requirement for an observation log. This log is used as a focal point to gather the pertinent information for the observation case. While the data elements that you include in your observation log may vary, here is a listing to start your considerations:

- ✓ Patient's Name
- ✓ Physician's Name(s)
- ✓ Date and Time of Admission
- ✓ Date and Time of Discharge
- ✓ Condition(s) Requiring Observation Status
- ✓ Information Pointing To Location Of Documentation
- ✓ Number Of Hours In Observation Status
- ✓ Number Of Units Billed
- ✓ Charges Made For The Observation Services
- ✓ Time/Activities Interrupting Observation Services During Stay
- ✓ Utilization Review Notes

You should carefully review both the claim and the associated itemized statement. Because observation cases tend to become complex, anticipate that there may be some charge capture issues and/or that strange items will appear on the itemized statement. You will also have typical challenges such as observation exceeding 48 hours, Condition Code 44, along with injections and infusions during observation.

As you address problems and challenges through this review process, your general coding, billing and documentation policies for observation can be updated as appropriate.

Note: This same small team approach is also used to review complex cardiovascular interventional radiology (CVIR) cases.

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/JantoDecember2011EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2011. 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 CY2010 and planned workshops for CY2011.

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 July 26th "***Developing Audit Program for the RACs and Proper Reimbursement***" 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 finished the second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

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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****** 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.

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