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 have not been issued by CMS at the time this Newsletter was prepared. Watch for the proposed changes for CY2013 in the near future. While both of these systems should be mature enough that evolutionary changes are the norm, still we should all be watchful for any major change. Also, there are a number of on-going issues that really should be addressed.

Hospital Outpatient Payment Panel Supervision Levels – A Beginning

As a part of the morphing saga for physician supervision requirements, CMS has established the advisory panel that will recommend supervision level for various services. This panel, the Hospital Outpatient Payment Panel, met on February 27-28, 2012 and made the first of what should be a series of determinations. CMS announced this on May 22, 2012. Note that the changes in supervisory levels are effective on July 1, 2012. Until that time, the default is direct physician supervision.

> **Note**: This new panel, as with other panels, is only an advisory panel. CMS can choose to accept or reject any recommendation that is made.

For the most part, hospitals will be looking for services that can be classified as needing only general supervision. For instance, both observation and infusions are classified as non-surgical extended duration services requiring only general supervision. One area of concern occurs when a patient is in observation and a physician orders an infusion or hydration or IV injections. An IV site must be established. See CPT code 36415. The question then becomes, does an IV start require direct physician supervision?

Based on the brief discussion in this announcement, a service like an IV start will not even be considered. CMS seems to be concentrating on the fact that two criteria must be attained to be considered for a supervision level other than direct physician supervision. These are:

1. Must be non-surgical, and
2. Must be extended duration.

If a service does not meet both of these requirements, then no consideration will be given to changing the supervisory level from direct physician supervision. If CMS pursues this approach, then there will be relatively few services that will achieve the general supervision classification.

The panel recommended that CPT 94640, *Inhalation Treatment*, be classed with a general supervision status. On the surface this appears appropriate and reasonable. Here is the CMS discussion that reveals what CMS is thinking about these services.

> *Extended duration services require an initial period of direct supervision, but the patient may be transitioned to general supervision once he or she is stable at the discretion of the supervising practitioner. One commenter believed that the physician's presence should not be required for HCPCS code 94640 in the hospital, since this service can be performed by a patient at home. Others commented that since the Panel's charter does not prohibit the Panel from recommending extended duration services, it should be permitted to do so.*
>
> *In the CY 2012 final rule, we indicated that the Panel may recommend only general, direct or personal supervision. HCPCS code 94640 is not performed over an extended period of time, and hospital patients receiving this service may require the supervising practitioner's presence depending on their condition. At a future Panel meeting the Panel may reevaluate the supervision level for this service. Therefore, we*

continue to require direct supervision for HCPCS code 94640.

Clearly CMS is requiring that any service considered by the panel must be of an extended duration. Also, if there is any possibility that medical necessity could dictate that a physician directly supervise a service, then that service could not be considered for general supervision. With our IV venipuncture example, there appears little hope in that venipuncture is surgical. Venipuncture is also not of extended duration, and there could be instances in which a physician might need to directly supervise and/or actually perform the service.

Now given this background information, from the recommendations, what did CMS approve for general supervision? Various psychotherapy codes (generally CPT 90804-90857) along with G0177, G0410 and G0411 are included. Smoking cessation counseling, CPT codes 99406 and 99407, also require only general supervision. None of these codes or services seems at all controversial relative to physician supervision. These services are provided by specialized personnel.

Of more interest are the following:

- *HCPCS code 51701, Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)*
- *HCPCS code 90471, Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
- *HCPCS code 90472, Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)*
- *HCPCS code 90473, Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid*
- *HCPCS code 90474, Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)*

Now whether these services meet the concept of extended duration is left to the reader's analysis. The insertion of the catheter is helpful while the immunization codes seem almost a non-plus. What would be helpful is to classify IM/SQ injections as requiring general physician supervision.

Much of the controversy surrounding physician has arisen because of observation services. At this point observation is classified as a non-surgical extended duration service. However, if there is an IV start or an IM/SQ injection is provided while the patient is in observation, then direct physician supervision kicks into place. For many, if not most, hospitals, documenting physician immediate availability overnight for observation services is problematic. Many hospitals would point to using ER physicians for such overnight physician supervision, but there is no way to guarantee that an ER physician is *always immediately available*. There is always the possibility that there is an emergency case being attended by the ER physician(s).

Bottom-Line: While hospitals may have envisaged significant relief through the new advisory panel classifying significant numbers of services as requiring only general physician supervision, this will probably not happen. The physician supervision requirements have now morphed to the point where most outpatient services that are incident-to those of a physician, do require direct physician supervision. This appears to apply for all provider-based situations off-campus, on-campus and/or in the hospital. At this point what hospitals really need are explicit guidelines as to what *immediate availability* really means.

OIG Report on Overpayment Collections

On May 18, 2012, the OIG issued a report, A-04-10-03059, entitled, "*Obstacles to Collection of Millions in Medicare Overpayments*". At issue are significant amounts of overpayments identified through OIG audits over a period of several years during the late 2000's. The OIG has several concerns. Here is the OIG language from the Executive Summary, page ii:

> *As of October 8, 2010, CMS had not collected the majority of overpayment amounts identified in OIG audit reports. Of the 154 OIG audit reports with sustained overpayment amounts totaling $416,287,546, CMS reported collecting $84,168,502. Specifically, CMS reported collecting the full sustained amounts totaling $83,272,666 for 113 reports and partial sustained amounts totaling $895,836 for 8 reports. However, CMS did not collect the remaining $332,119,044. CMS's collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate guidance for collecting overpayments and did not have an effective system for monitoring its contractors' collection efforts.*

Furthermore, we could not verify the $84,168,502 that CMS reported collecting, and we identified inaccuracies in the reported amount. These issues arose because CMS did not have adequate systems for (1) documenting overpayment collections identified in OIG audit reports or (2) detecting data entry errors. Therefore, CMS had no assurance that the overpayment collections information that it reported to other parties was accurate.

Note that the OIG is concerned about the collection of overpayments and particularly concerned about what the OIG terms ***statute of limitation*** on overpayment collections. This statute of limitation refers back to §1870(b) of the SSA that bars recovery from providers that are 'without fault' and deems a provider to be 'without fault' 3 years after the year in which the original payment was made. Thus the OIG considers this time period for reopening and/or recovering overpayments as the statute of limitations.

Needless to say, the OIG recommends, among other things, that the statute of limitation be extended.

This discussion should seem familiar. On February 16, 2012, CMS issued new proposed rules relative to identification of overpayments and the repayment process. (See the February issue of this Newsletter, pages 9-11.) A final rule based on this proposed creation of a new Subpart D to 42 CFR §401 has not yet been issued.

This OIG report will probably prompt CMS to make further changes to both 42 CFR §405 and §401. Note that this whole discussion falls under the category of not involving fraudulent claims under the False Claims Act (FSA), in other words, situations that are without fault.

Within the CFR language, there are different time frames for reopening initial determination and redeterminations. For instance, for the CMS contractors:

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in §405.986.

(3) At any time if there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902.

(4) At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

(5) At any time to effectuate a decision issued under the coverage appeals process.

Provider-Based Clinics – Tidbits

Establishing charges and determining how to file claims for provider-based clinics continues to raise issues. Keep in mind that two general issues must be addressed:

1. The mechanics of establishing charges and filing claims, and
2. Patient reactions, particularly regarding the perception, if not the reality, of being overcharged.

Another legal case has been reported out of St. Louis relative to the Saint Louis University Hospital and Des Peres Hospital. While the specific facts for this case are not known, the allegations stem from misleading, deceptive and improper hospital facility fees for outpatient visits.

See:
http://www.bizjournals.com/stlouis/news/2012/05/21/thomas-files-class-action-suit-against.html.

Patient sensitivities do merit careful consideration. One of the operational decisions that can mitigate patient complaints is the decision to split bill *only* for Medicare patients. This means that two claim forms are filed only for Medicare beneficiaries. Other patients, particularly for patients with insurance coverage, the typical physician fee schedule amount is charged. Thus, there are no technical component charges that can accrue to the patients' deductibles.

Note that some hospitals make the decision to split-bill Medicare primary only. Trying to bill a private payer with a single 1500 claim and then split things out for Medicare as secondary becomes quite complicated.[1]

Great care must be taken to establish a split fee schedule that is a proper combination of a professional fee along with a technical fee. Hospitals should not simply take the full current professional fee schedule and then add on a technical component fee. Typically, the professional fee schedule is split into two parts, one part for the professional and one part for the technical, so that the two parts add up to the full professional fee schedule.

[1] The process of split-billing Medicare primary only does raise some compliance issues, but these appear rather innocuous because the Medicare program ends up paying less overall.

These concepts have been discussed in previous issues of this Newsletter.

1. *Provider-Based Clinics – How Not To Set Fees* – July 2007 – 19:7, 37-38
2. *Provider-Based Clinic & Clinical Services – Setting Fees & Transparent Pricing* – Nov 2006 – 18:11, 63-64
3. *Q&As - Provider-Based Clinic Filing Only 1500* – Jan 2006 – 18:1, 4.

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: When a RAC reopens a case does the timely filing period start over, that is, do we have year to rebill after the RAC makes a determination and possibly recoups payment?

The O'Connor Hospital ruling by the Medicare Appeals Council (MAC) provides an interpretation in this area that is distinctly different from CMS guidance. First, we will address the *current* official guidance.

CMS guidance is in the form of a question and answer. In this case FAQ #2519.

> *If I receive a demand letter from a Recovery Audit Contractor (RAC) because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can we re-bill all the services on an outpatient claim?*
>
> *Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Benefit Policy Manual. That list can be found in Ch. 6, Section 10:* *http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf*.
> *Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program. Normal timely filing rules can be found in the Claims Processing Manual, Chapter 1, Section 70:* *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf*.

This answer is certainly consistent with CMS's operational approach in this area. If the inpatient services were not payable, the payment should be recouped and the hospital has no recourse if the claim is outside the timely filing requirements.

The second answer to this question lies in the discussion found in the O'Connor Hospital ruling. This case involves a short inpatient stay that the RAC claimed was inappropriate and not medically necessary. All the parties seem to agree that the inpatient stay was not necessary and was improperly paid. However, the ALJ, who was upheld by the MAC, indicated that observation was medically necessary and that payment should be paid. Not only should payment be made, the administrative contractor should work with the provider to effectuate the payment for the observation and/or at least have the observation payment offset part of the overpayment made for the inpatient services.

From the ruling:

> "*Consistent with the CMS manual provisions discussed above, the contractor shall work with the provider to take whatever actions are necessary to arrange for billing under Part B, and thus, offset any Part A overpayment*."

This logic certainly implies that once the case is reopened, there should be the ability of the provider to rebill the case for payment that is properly due. Actually, the statement above appears to go beyond just allowing a rebilling and instructs the contractor to work with the provider to arrange for proper billing.

> Note: Interestingly enough the ALJ used the word *shall* as opposed to *will*. Grammatically, the word *shall* is stronger than the word *will*.

Question: We have established several provider-based clinics in the past two years. We are having difficulty establishing what we consider acceptable technical component E/M mappings. While the E/M levels have been discussed relative to the ER, what resources are available to provide guidance for the clinics?

The short and simple answer is that there are very few resources that can provide guidance on how to establish the technical component E/M mappings for clinics. Even when CMS tries to provide some suggested guidance, the results are not at all satisfactory. For instance, over the last ten years CMS has discussed this general issue in the annual APC *Federal Registers*.

Depending upon the specific types of clinics, you will probably end up with multiple mappings all of which are different from your ER mapping. Here are three general situations to consider:

1. Primary Care/Family Practice Clinics,

2. Specialty Clinics,
3. Ad Hoc Clinical Services in the Hospital.

The main resource drivers in a clinic setting are:

- General Facility Overhead – Waiting room, reception and administrative space and services,
- Examination Room,
- Nursing and Other Clinical Staff,
- Supplies and Equipment.

Here is a much generalized mapping that can be used as a basis for developing more comprehensive mappings:

99211 – Minimal service that is not otherwise separately codeable but which consumes resources such as room and supplies that is provided by a non-physician provider(s);
99212 – Minimal service that is not otherwise separately codeable but which consumes resources and requires nursing or other clinically trained personnel;
99213 – Moderate service that is performed by a physician that is not otherwise separately codeable;
99214 – Moderate service that is not separately codeable and is performed by a physician requiring the assistance of nursing or other non-physician staff;
99215 - Complex service that is not separately codeable and is performed by a physician requiring the assistance of nursing or other non-physician staff.

For primary care clinics, the technical component E/M level tends to correlate generally with the physician level. The higher the physician level, the more likely there is greater time usage of the examination room and the more likely there is use of nursing services and assistance.

For specialists, the actual visits by the physician tend toward the level 4 or level 5. Thus, special mappings may be necessary. Also for specialists there may be brief follow-up visits that are coded as 99212 or 99213. For surgeons be certain to include some sort of mapping for post-operative visits. Note that at least for Medicare there is a post-operative period so that on the physician side 99024 can be used, but there will be a regular E/M level on the hospital side.

Hospitals are encouraged to continue diligent work on technical component E/M mappings. The time is drawing closer when the RACs will become involved in this area. Quite likely, no matter what kind of mappings hospitals have developed, the RACs will object and claim that significant overpayments have accrued from inappropriate mappings.

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 July 17th ***"Supplies, Devices & Compliance"*** that 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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****** 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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