

Medical Reimbursement Newsletter

**A Newsletter for Physicians, Hospital Outpatient
& Their Support Staff Addressing Medical Reimbursement Issues**

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APC/APG Update

While there will be a quarterly update to HCPCS next month, activity for APCs is relatively calm as CMS prepares for the changes for CY2010. Anticipate that CMS will continue the movement toward greater packaging of services.

Also, CMS is now using the word 'encounter' along with the phrase 'episode of care'. While this may not seem important, this additional phrase may indicate that CMS is planning to alter the definition of an 'encounter'. Currently, each encounter is separate. Even two different encounters in the ED on the same date of service for the same reason are paid separately. A very easy change to APCs would be to bundle all encounters that are part of an 'episode of care'. For some APG (Ambulatory Patient Group) payment systems there is a sliding 3-day window that can group services together.

Also, watch for any indication about the technical component E/M coding guidelines. Another move that CMS might make is to automatically bundle any E/M service if there is another surgical or medical procedure performed. While this is not appropriate, such a move could save CMS significant expenditures in the short term.

RACs and the Extrapolation Process - Part 2

Editor's Note: This is the second article in a series of articles concerning the extrapolation process for determining recoupment amounts.

While the extrapolation process to determine overpayments was not used by the RACs in the demonstration project, this process is fully available for the expanded RAC program. Because all states will be involved and a number of issues have been well established, the RACs most likely will want to be as efficient as possible. If there is a universe of several thousand claims of a certain type and the RAC can audit a small statistically valid sampling and then extend the

results of the audit to the whole universe, significant overpayments can be recouped with greater efficiency. That is, the RAC does not have to audit each of the several thousand cases in order to achieve the goal of recouping significant overpayments.

As you should realize, the application of the extrapolation process is quite technical. When a RAC or other Medicare auditing entity wants to use the extrapolation process, they must retain a statistician to determine the process whereby the size of a valid sample can be determined so that the extrapolation process can appropriately be applied to determine total overpayments.

This process is significantly assisted by the use of special statistical software. Governmental entities use the OIG's RAT-STATS program. Thus, if the RACs pursue extrapolation, their statistics consultants will use the various features of RAT-STATS that support the determination of a valid sample size for a given situation.

The variables include the size of the universe of cases, the error rate, the confidence interval, and the precisions level. By adjusting the variables, different sample size calculations will result.

For example, the OIG has indicated that a 90% confidence interval with 25% precision is preferable. This standard is used by healthcare organizations that must perform audits by independent review organizations (IROs) to meet corporate integrity agreement (CIA) requirements.

The one variable that is difficult to estimate is the error rate. Often a special, limited probe audit is performed to estimate the error rate. A typical probe audit is 30 although slightly larger samples can be used. From the probe audit the mean and standard deviation for overpayments can be determined and then provided to RAT-STATS.

However, be careful to study how RAT-STATS varies the selection of the sample size based on the error rate. Here are two simple examples using a 90% confidence

interval and a 25% precision level with a universe of 1,000 cases. Assume we are dealing with a study of E/M coding.

Case 1 – From the 30 case probe audit, there were 5 errors found with an average overpayment of \$5.14. The standard deviation was 2.07 and RAT-STATS indicated that the sample for valid extrapolation is 211 cases.

Case 2 – From the 30 case probe audit, there were 9 errors found with an average overpayment of \$5.52. The standard deviation was 3.43, and RAT-STATS indicated that the sample for valid extrapolation is 101.

Note that as the error rate increases, the size of the valid sample actually went down to about 10% of the universe. This may seem counterintuitive to some extent. However, the impact of the error rate on the size of the sample is dramatic. For instance, if half of the cases have an error averaging \$4.67 with a standard deviation of 4.85, then RAT-STATS gives a valid sample size of only 45 cases. In other words, the RAC would only have to sample 45 cases to be able to extrapolate to the full 1,000-case universe. Obviously, this is not acceptable.

Editor's Note: In the April issue of this Newsletter we will delve into some of the technical aspects of using extrapolation.

National Drug Codes – What Is All the Fuss?

The Deficit Reduction Act (DRA) of 2005 requires the various state Medicaid programs to obtain NDC (National Drug Code) information from claims. While the timing varies among states, these reporting requirements are currently being implemented. Note that these are reporting requirements. Specific payment for drugs may not depend upon the NDC information being provided.

In a very real sense this is the way Congress has decided to force hospitals and other healthcare providers into the process of reporting pharmacy items using NDCs. NDCs were scheduled to be implemented several years ago when the HIPAA TSC (Transaction Standard/Standard Code Set) rule was implemented. At that time CMS, due to public opposition, decided to continue to use the Level II HCPCS J-codes to process payment for pharmacy items.

So what is all the fuss about the National Drug Codes? Why is there resistance to convert from the J-codes to the NDCs?

The simple answer to this question lies with the concept of 'leading zeros'. The computer format for the NDCs is

eleven digits. Many current NDCs are in a ten digit format, and there are still NDCs out there that have less than ten digits. Converting all of these NDCs to the eleven digit format turns out to be a major task.

The ten digit format can occur in one of three different configurations:

4-4-2, 5-3-2, or 5-4-1.

The eleven digit format is 5-4-2 with the three segments representing the:

- Vendor
- Product
- Package

Here is a ten digit NDC:

60505-0186-0 (Lisinopril 10 mg, 100, oral, bottle).

Translating this to an eleven digit format is not hard. Just put in a leading '0' in the third segment. The number then becomes 60505-0186-00. Similarly, you can easily convert the 4-4-2 and 5-3-2 formats into eleven digits by inserting a leading '0' in the first or second segment respectively.

When these NDCs are put into the computer, we drop the hyphens, '-', just as we drop the decimal point with ICD-9-CM codes. This computer format is more efficient, but for legacy purposes, that is, older computer systems, this creates a nightmare. In order to convert a 10-digit NDC into an 11-digit NDC, you must know which of the three configurations has been used. To add to the confusion, some older NDCs are not even 10-digits long. In some cases there have never been leading zeros within the various segments. Thus, you may be looking at NDCs with less than 10 digits. Now what do you do?

The only real answer is that any NDCs in a computer system at least must be upgraded to the 10-digit format. While you are at it, you might as well go to the 11-digit format. In some cases, you will literally need to go to the drug packaging to determine the proper 11-digit NDC.

How many pharmacy items are there? You can also ask this by counting the number of HDCs themselves. Also, given the fact that there are thousands of pharmacy systems, some of which interface to hospital billing systems and thus the chargemaster, the need to manually intervene to adjust to the full 11-digit NDC is a major, labor-intensive task.

This is the reason why there is so much consternation concerning implementing the NDCs. There is no easy way. At least, after we fully implement NDCs and do away with the Level II HCPCS J-codes, hospital billing

systems will avoid a major on-going problem with converting NDCs into the proper J-codes with the correct number of units.

CMS-855, Provider Enrollment & PECOS

Provider enrollment with the Medicare program to gain billing privileges uses the CMS-855 forms. There are five different forms depending upon the provider/supplier types:

CMS-855-A – Hospitals,
CMS-855-B – Clinics,
CMS-855-I – Individual Practitioners,
CMS-855-R – Reassignment, and
CMS-855-S – DMEPOS.

With the exception of the CMS-855-R, which is fairly short, the other forms are quite complex and lengthy. Also, filling out and filing these forms with the correct information is challenging.

Add into the mix that every time there is any sort of change, the given form or at least the changed sections must be refiled. Also, for providers such as hospitals that have clinics and employee physicians, there will be hundreds of these forms all of which may be interrelated.

Each time a new form or updated form is filed, there must be original signature of the responsible party.¹ Thus, healthcare providers of all types that bill Medicare have been anxiously awaiting a way to file and update the CMS-855 forms through a computer on-line system or possibly through the Internet.

PECOS stands for Provider Enrollment, Chain and Ownership System. Information from the CMS-855s goes into this Medicare computer system. This will be the vehicle that CMS plans to use to accomplish this rather burdensome task.

CMS is now making PECOS available for use on-line through the Internet on a very limited basis. Currently, this new process can be used only by physicians and practitioners. The two forms that can be filed or updated are the CMS-855-I and CMS-855-R.

The basic process is as follows:

1. The NPPES User ID and password are used to access PECOS. CMS encourages physicians and practitioners to periodically change their passwords, at least once a year.

¹ A general compliance nicety is to have the official signature in blue ink (as opposed to black) to assure that it is the original.

2. Access the appropriate form, follow through the instructions to complete, review and submit the CMS-855-I or CMS-855-R.
3. Print, sign and date a two-page Certification Statement. Mail the certification statement and any support documentation within 7-days of the electronic submission.

The physician or practitioner must sign the Certification Statement. Copied or stamped signatures are not accepted.

At least this is a start! However, there appear to be some challenges even with this modest foray into the Internet world.

Current Challenges – In January during an Open Door Forum, CMS indicated that the Internet access to PECOS **was to be used only by the physician or practitioner**. Billing staff, credentialing staff, consultants and/or others are not to use the system. The use of this system by anyone other than the physicians or practitioners is considered fraudulent.

Editor's Note: It is interesting how much critical guidance is provided by CMS through the most informal and tenuous mechanisms. Certainly, if the use of the Internet access to PECOS is to be used only by the physicians or practitioners, then this should be in the formal, written guidance.

The rather obvious solution to this dilemma is to develop a security procedure so that billing staff, credentialing staff and/or whoever is actually filling out these forms can do so for the physician or practitioner. The physician or practitioner can still sign the Certification Statement. Whether CMS will develop such a procedure is for the future.

Exercise – If you have never read through 42 CFR §424, the Conditions for Payment (CfPs), then you should do so. As you read, even quickly, you will begin to realize that CMS is almost paranoid about incorrectly paying physicians and practitioners. This does not even include the DME suppliers. Keep in mind that the reason for all these security concerns comes from CMS's view of the payment process. This is why it is so important for physicians and practitioners to keep their CMS-855-R forms up-to-date. CMS does not like reassignment of payments. CMS wants to pay the physician or practitioner directly.

The good news with the Internet-access PECOS is that this is an interactive process that helps to guide you through filling out and providing information.

Future Challenges – The CMS-855-I and CMS-855-R forms are the least complicated of the five forms. Also,

these forms generally do not have a significant number of attachments. Thus, to start this Internet access process with these forms is logical.

CMS plans to expand this process to all providers and suppliers in the future. This process may take two to three years if we are lucky. Hospitals and clinics will probably be next. Likely, the DME suppliers will be last because of all the security and fraud issues surrounding DME.

Also, if there is to be an interactive process for the CMS-855-A and CMS-855-B, there will need to be significant programming developed. These two forms are quite complex, and the determination of what information is or is not needed can be a significant challenge.

Bottom-Line – We are heading in the correct direction, but this will be a bumpy road and make take years to accomplish. In the meantime, be certain you keep your typewriters repaired and in good working order.²

References – See the CMS website at:

www.cms.hhs.gov/MedicareProviderSupEnroll/

Also, see Chapter 10 – Medicare Provider/Supplier Enrollment – in the Medicare Program Integrity Manual.

Questions & Answers

Editor's Note: Readers are encouraged to submit questions for consideration.

Question: Is it appropriate to admit a patient to observation if we basically have symptoms as opposed to definitive diagnoses? For instance, the physician may document:

- **Abdominal pain,**
- **Elevated temperature,**
- **Nausea, vomiting.**

This question raises multiple issues. The first issue involves whether these diagnostic conditions on their own justify an observation admission. The general answer would probably be no. However, the whole point of observation services is to observe the patient, run tests and then make a decision about keeping in observation, admitting as an inpatient or discharging home.

During the observation stay, the presumption is that additional, and hopefully, definitive diagnoses will be developed. However, there are certainly cases in which

² Yes, there is still a need for that IBM Selectric III that has been gathering dust.

a patient does present with symptoms like those delineated in the question. Sometimes these patients may be held overnight, medicated and then in the morning are recovered and are discharged home. There may be no further diagnostic conditions noted or developed for the patient.

Note: This can easily occur if an ED physician admits a patient to observation under the name of an attending physician. The patient is placed in a bed, observed and care is provided. In the morning the attending physician will (hopefully!) see the patient and determine that the patient can be discharged. No further diagnostic conditions may be noted.

Secondly, there is the issue of documentation for coding versus documentation for medical necessity. This is not typically much of a problem. With good, clean diagnoses the coding process will justify medical necessity. However, with the RACs attacking the whole issue of medical necessity, we need more documentation that goes even beyond that which can really be coded.

The physician making the decision for observation is not documenting all of the information that is actually used to make the decision to admit to observation. For instance, the physician is probably assessing the patient's mental acuity, eye movements, physiological posturing, skin tone, and a host of other indicators. Often, these additional pieces of information are not documented although they relate heavily to the physician's decision to admit the patient to observation services for further evaluation.

The physician's documentation, particularly for observation services should be:

- Clear,
- Concise, and
- Convincing.

You will need to work with the physicians on this issue as a long-term project. With the RACs investigating the very subjective issue of medical necessity, the justification of observation services will be an issue that is sure to be investigated. While we worry about an inpatient admission that should have been outpatient observation, we must also be concerned about observation services that cannot be medically justified through the documentation present.

Question: Should Critical Access Hospitals (CAHs) be using the Level II HCPCS C-codes for various devices and expensive supply items?

The C-codes are mandated as a requirement for APCs, that is, for prospective payment system hospitals. Their use by CAHs is optional as indicated in the HCPCS Manual itself.

Now we should really ask ourselves, why does Medicare require the use of these C-codes for APCs? The reason CMS requires their use is to be absolutely certain that proper charge data is collected for these expensive devices and expensive supply items. Obviously, hospitals using these codes must properly develop charges. This is a secondary issue that we will discuss momentarily.

As a very general recommendation, CAHs should follow best practices for coding, charging and billing for services. The biggest difference with CAHs is on the payment side, not the coding and billing side. Thus, the use of the C-codes should certainly be given careful consideration.

Another reason for a CAH to use the C-codes is that if there is a need to compare cost-based reimbursement with the reimbursement that would have been made under APCs, that is, as a PPS hospital, then you will need to have the C-codes in place. Otherwise sending claims data through the APC grouper will fail, and determining the possible payment cannot be made.

Now the question of charges is important. Some hospitals simply put in a token charge for the C-codes. This completely fails the purpose of CMS' requiring the use of the codes.

However, chargemaster coordinators do need to develop a strategy for correctly developing charges. Typically, the device or supply item is delineated in the chargemaster, and the charge is developed based on the cost of the given item. The C-code is then attached to the line item. Thus, it not the C-code that drives the pricing, it is the device or supply item that drives the pricing.

Alternatively, a chargemaster coordinator could perform a rather complex calculation to determine the average cost and thus charge for a given C-code. This process would be burdensome and really has no value of significance.

As a very general pricing guideline, take the cost of the item and divide by the appropriate cost-to-charge ratio (CCR) from the cost report. Check this price against any other pricing formula to make certain you at least are charging at this level. This way when CMS converts your charge back to cost, the calculation is correct.

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 2009. Contact 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 April 21st "**Chargemaster Revenue Codes**". The presentation 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 HCPPro.

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 HCPPro for clients of Abbey & Abbey, Consultants.

E-Mail us at Duane@aaciweb.com.

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EDITORIAL STAFF

Duane C. Abbey, Ph.D., CFP - Managing Editor

Mary Abbey, M.S., MPNLP - Managing Editor

Penny Reed, RHIA, ARM, MBA - Contributing Editor

Linda Jackson, LPN, CPC, CCS - Contributing Editor

Contact Chris Smith for subscription information at 515-232-6420.

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******* ACTIVITIES & EVENTS *******

Compliance Reviews are being scheduled for hospitals and associated medical staff concerning the various areas of compliance audits and inquiries. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement.

Worried about the RAC Audits? Special audits and studies are being provided to assist hospitals 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.

Need an Outpatient Coding and Billing review? Charge Master Review? Worried 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.