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

Be watchful for the *Federal Register's* presenting proposed changes to APCs for CY2010. This FR entry should be out very soon.

RACs and Inpatient Admission Criteria

CMS conducted additional Open Door Forums on April 8, 2009 for Part A Providers and on April 14, 2009 for Part B Providers.[1] The transcripts are available for a limited period of time out at the CMS Open Door Forum web site. These transcripts do make very interesting reading and provide some insight into how CMS is approaching the RAC Program.

For hospitals, one of the major RAC issues is that of short-stay inpatient admissions that auditors will claim should have been outpatient observation. Basically, the whole inpatient admission and associated payment is identified for recoupment. Typically, there is no real way to refile the claim as outpatient observation which means that the total payment may be lost.

This particular issue is exacerbated by the fact that the RACs may choose not to adopt formal inpatient admission criteria such as InterQual or Milliman. Note that in the appeals process, the first level goes to the FI and not to your QIO. The QIO has established the criteria by which you, a hospital, need to meet inpatient admission criteria. If the appeal to a RAC finding were to go to the QIO, then you would need to meet the standards set by your QIO. However, the appeal will go to your FI where there is less likelihood of disagreement. Be certain to watch carefully for the standards that will be used by your specific RAC.

Another major point of concern for hospitals, and generally any sort of Integrated Delivery System that includes many hospitals today, is how many medical records must be prepared and sent to the RAC. Significant variability appears the norm relative to this question.

Here is a synopsis from the recent Open Door Forum:

- *Hospitals, SNFs, Hospices → 10% of Monthly Average per 45 days with a Maximum of 200*
- *Other Part A Billers → 1% of Monthly Average per 45 days with a Maximum of 200*
- *Sole Practitioners → 10 Records per 45 Days per NPI*
- *Partnerships (2-5 Individuals) – 20 Records per 45 days per NPI*
- *Partnerships (6-15 Individuals) – 30 Records per 45 days per NPI*
- *Partnerships (greater than 15) – 50 Records per 45 days per NPI*
- *Other Part B (DME, Lab, Hospital OP) – 1% of Monthly Average per 45 days per NPI up to 200.*

While it is a little hard to decipher exactly what this means, and it will probably change, let us take an example and look for the maximum that might be requested over the time period of a year.

Case Study – **Apex Medical Center** – AMC is a small integrated delivery system. There is the main hospital with the usual range of inpatient and outpatient services. There is a distinct-part SNF unit. Also there are seven provider-based clinics all of which have their own medical records systems that are cross-indexed back into the main hospital medical record system. All of the physicians and practitioners at the clinics are employed by the hospital. The hospital generates both technical and professional component claims. The hospital has an NPI, the SNF has an NPI, four of the clinics are under one NPI while the other three have their own NPIs. Of course, the physicians and practitioners have their own professional NPIs.

We cannot really determine the potential maximum without knowing the volumes of different services. For our purposes, let us assume the maximum number just for educational purposes.

[1] Interestingly, CMS uses the word 'provider' in its general sense. Technically, for Part B the correct word is 'supplier'.

- Hospital Inpatient – 200 records per 45 days for a total of 1,600
- Hospital Outpatient – 200 records per 45 days for a total of 1,600
- SNF – 200 records per 45 days for a total of 1,600
- Four Clinics Under One NPI – 30 records per 45 days for a total of 135[2]
- Three Clinics Each – 20 records per 45 days for a total of 160 cases time 3 is 480.

This brings us to a grand total of 5,410 records. While this is a theoretical maximum, hopefully this would never occur! Pulling, copying and sending this number of records would require significant resources let alone trying to track all these cases.

Note that CMS is maintaining that providers will be able to 'work with' the RACs on the number of records if the provision of records becomes overly onerous. Just how this process is supposed to work is an interesting question!

PECOS – Available for Prime Time

CMS held an Open Door Forum on provider enrollment on April 30, 2009. The Internet-based PECOS (Provider Enrollment, Chain and Ownership System) is now generally available for use. The system cannot be used for:

- Change of Ownership
- Acquisitions and Mergers or
- Consolidations

Also, CMS is not ready to use this system for DMEPOS suppliers. There are some significant problems in the DME area involving the reporting of organizational relationships.

There is a PECOS Identity and Access System that can be accessed from the CMS provider enrollment web site. As with the previous limited use, there is a 2-page Certification Statement that drives the whole process. While you can provide the information over the Internet, the actual start of the process is when your Certification Statement is received. You should receive an e-mail confirming the receipt of the Certification Statement.

As usual, the Certification Statement must be signed by an authorized official. Be sure to use blue ink for both the signature and the date. You may want to send the Certification Statement by registered mail although this may slow things down a bit.

[2] These records are for the professional component billing.

Be certain to download and read Transmittal 289 to Publication 100-08, the Medicare Program Integrity Manual (CR6310). This transmittal is some 63 pages long and contains information pertinent to billing privileges such as retroactive billing, changes in practice location. Also, the revalidation process is to begin this summer. Eventually all providers and suppliers will be required to resubmit their entire sets of 855 forms as part of the revalidation. If, for some reason, you have not updated your CMS 855 forms since November 2003, you will be high on the revalidation list.

More on the "-25" Modifier
Professional versus Technical Component

As discussed in the April 2009 edition of this Newsletter, a significant amount of activity has been occurring with hospital outpatient use of the "-25" modifier, that is, the technical component. The "-25" modifier is intertwined with the E/M levels and also any sort of surgical package definitions. From an auditing perspective, the guidelines for using the "-25" modifier on the hospital side are different from that used by physicians. Unfortunately, physician coding concepts in this area can migrate over to the hospital side and corrupt the technical component coding.

Thus, even for hospital coders and auditors, a clear understanding of the concepts used for physician, professional component coding is necessary in order to carefully distinguish the propriety of the coding processes for the professional component versus the technical component. In order to address this whole issue, we will first review this process on the physician side and then compare and contrast to the technical side.

For physicians, the "-25" modifier for a 'significant, separately identifiable' E/M service at the same time of a medical procedure started in 1992 when RBRVS was introduced along with the E/M levels of codes for office visits, ER visits, consultations and the like. From the very beginning, the use of the "-25" modifier was controversial.

One of the concerns was that if the E/M level was paid in addition to the procedure, then a separate reason is needed, that is, a different diagnosis. This issue was resolved by the AMA in 1999 when the CPT description of the "-25" modifier was changed to indicate that different diagnoses were NOT necessary in order to use the "-25" modifier.

A relatively complex global surgical package has been developed over the years for RBRVS. In general the GSP starts 1-day before the surgery, and then there is a variable post-operative period depending upon the type of surgery.

Surgeries are classified by their post-operative period:

0-Days ← Minor (Endoscopies)
10-Days ← Minor
90-Days ← Major

Thus, we have the concept of minor versus major surgeries. The use of E/M codes in conjunction with surgical or medical procedures is different depending upon whether the surgery is classified as 'minor' or 'major'. For instance, with minor surgeries the GSP starts on the day of the surgery and not one day before the surgery.

In order to understand this difference, let us look at the "-57" modifier. The "-57" modifier is described as 'Decision for Surgery' that is used only by physicians and then only on the day of the surgery or the day before the surgery. This modifier is attached to the E/M service in order to break it out of the global surgical package.

Here is an example of using the "-57" modifier.

> **Case Study 1** – An elderly patient presents to the ER after fall over some furniture. A significant injury to the spleen is diagnosed. A surgeon is called, examines the patient and proceeds to perform surgery involving a spleenectomy.

The surgeon will bill the surgical procedure and then, most likely, a consultation E/M level with the "-57" modifier. This way the surgeon will be paid for both the E/M level and the surgery itself.

However, if we move to a minor surgery, circumstances change. Consider the following case study.

> **Case Study 2** – An elderly patient presents to the ER after an automobile accident. While there are no severe injuries, there is a laceration on the forehead that will require careful closure. The ER physician decides to call in a dermatologist to perform the repair. The dermatologist comes, examines the wound and proceeds with a plastic repair.

The laceration repair will have a 10-day post-operative period and is thus classified as minor. The dermatologist, even though a consultation was provided, will not be able to use the "-57" modifier to break it out of the surgical package because, for minor surgeries, the E/M services are considered part of surgical services.

Note: The ER physician will still charge an ED level, the hospital, for the technical component, will charge for both the ED level, with a "-25" modifier, and the surgery.

If we slightly change Case Study 2 so that the ED physician performs both the MSE (Medical Screening Examination) and the surgical repair, then the application of the concept that E/M services are just a part of the surgery becomes complicated.

For instance, an auditor might review our modified case and then claim that there should be no E/M service coded by either the physician or the hospital because in a minor surgery situation, the E/M services are just a part of the surgical procedure. Of course, the ER physician will probably perform a neurological workup, which will be separate from any E/M associated with the laceration.

Note first that the concept of a minor surgery in which the E/M services are bundled is a physician concept as part of the Global Surgical Package definition. If you find this kind of language being used on the hospital, technical component side, then there is a significant problem because this is a physician concept not a hospital concept.

Second, in ED situations the hospital is required by EMTALA to perform an MSE. The MSE may be performed by the ED physician, by a combination of nursing staff and the ED physician, or even just by nursing staff if the nursing staff is qualified by the hospital's Medical Staff Organization to do so. In our modified example, the ED physician may only perform the laceration repair. In which case, on the professional side, the physician will code and bill only for the laceration repair.

However, on the hospital side, no matter who performs the MSE, resources will be consumed in performing the general E/M services mandated under EMTALA. Thus, the hospital should code the ED E/M level with a "-25" modifier along with the surgical procedure. This coding simply reflects the consumption of resources, which is the basis for hospital coding.

All of the preceding discussions concern the Global Surgical Package (GSP) concept that is a part of RBRVS or the Medicare Physician Fee Schedule (MPFS). Is there a GSP for APCs?

The simple answer to this question is 'no'. For APCs, the grouping process that would constitute a GSP is limited to the date of service for the surgery. Thus, there is no pre-operative period and no post-operative period. This also means there is no concept of 'minor' versus 'major' surgeries. Of course, any sort of E/M service that should be a part of the surgery is bundled, but only for the date of service.

This question was addressed in the November 1, 2002 Federal Register (67 FR 66793):

*"**Comment**: One commenter asked that we craft a surgical global package for facilities to provide guidance for facility billing of surgical procedures and visits.*

__Response__: The current APC structure and coding edits already do this. Payment for surgical procedures includes payment for all services related to the procedure (for example, postoperative care, preoperative valuation). Facilities may bill for visits in addition to surgical procedures when the visit is a separately identifiable service unrelated to the procedure. In such cases, the facilities attest to this by appending the –25 modifier to the line item for the visit."

The answer in this case, clearly indicates that any consideration for packaging occurs within the date of service because that is how the APC edits are applied. Note that the word 'valuation' is more likely the word 'evaluation'. Also note the use of the word 'unrelated' for the use of the "-25" modifier. Why the word 'distinct' was not used instead of 'unrelated'' is not known although this is the key word in the description of the "-25" modifier.

Because of this guidance relative to how APCs are intended to work, there is no GSP. Thus, on the hospital, technical component side, whether the '-25" modifier should be used depends solely on the documentation. If the documentation shows an E/M service that is above and beyond that which is normally provided with the service, then the E/M should be reported with the "-25" modifier, and separate payment should be provided.

Because EMTALA requires the hospital to perform an MSE, there will almost always be a technical component E/M even if a surgical procedure is performed. However, this must be clearly indicated in the documentation relative to resource utilization.

Bottom-Line – If for hospital use of the "-25" modifier, an auditor uses language such as, *the "-25" modifier should not be used because this was a minor surgery and the E/M services are bundled*, then you know that a physician, professional component standard is being used improperly on a hospital, technical component claim. The use of the "-25" modifier on the hospital side is purely a documentation issue as to whether or not the E/M services went beyond the usual resource utilization associated with the given service.

Medicare Odds & Ends

The proposed changes for FY2010 are now available as *Federal Register* entries:

- Acute and Long-Term Care Hospitals
- Skilled Nursing Facilities
- Inpatient Rehabilitation Facilities

There are a number of transmittals including:

- Transmittal 480 – Publication 100-20 – One-Time Notification – Identifying Physicians/Practitioners for DMEPOS
- Transmittal 105 – Publication 100-02 – Medicare Claims Processing Manual – Telehealth Services
- Transmittal 106 – Publication 100-02 – Medicare Claims Processing Manual – Speech-Language Pathology Private Practice

Questions & Answers

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

Question: Should we be using the "-54" modifier (intra-operative only) for our ER physicians when they perform surgical procedures?

The "-54" modifier is one of three modifiers that can be used for physician coding and billing. These three modifiers separate the Global Surgical Package (GSP) into:

"-56" – Pre-Operative,
"-54" – Intra-operative, and
"-55" – Post-Operative.

In RBRVS there is a percentage breakdown for each of these three categories. However, the Medicare program does not use the pre-operative modifier at this time, but the percentage is still in RBRVS. Perhaps the pre-operative component may be used at some point in the future.

The use of the "-54" modifiers by ER physicians has always been questionable. From Chapter 12 of Publication 100-04, Section 40.2, which was updated by Transmittal 954, May 19, 2006, we have:

"Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier."

No language appears addressing 'major' surgeries relative to the non-use of the "-54" modifier. Just where does this leave us?

For a minor surgery (10-day post-operative period) such as a laceration repair, an ER physician may perform the laceration repair, instruct the patient to see their own primary care physician for follow-up care and still not use the "-54" modifier. The primary care physician will provide the follow-up care and bill out an E/M level. Following this guidance results in the Medicare program paying twice for the post-operative care for these cases.

The use of the "-54" modifier is not excepted for major surgeries. For instance, a patient may present with a non-displaced fracture of the leg for which the ER physician examines, x-rays and then applies a cast. This surgical procedure has a 90-day post-operative period and is a major surgery by definition. Apparently, the ER physician should use the ":-54" modifier if the patient is directed to another physician for post-operative care.[3]

Of course, the ER physician could direct the patient to come back to the ER for follow-up care, and in this case the "-54" would not be used. Or, the ER physician may direct the patient to come back, and not use the "-54" modifier. Then the patient may go to another physician for follow-up care. If the second physician bills correctly, that is uses the "-55" modifier for the post-operative care, then the double payment for post-operative services may be noticed.

Note: While the use of the "-54" modifier along with the "-55" modifier for major surgeries is correct, in practice physicians tend to use the same process for major surgeries as well as minor surgeries. That is, the follow-up services are coded and billed as E/M levels, not with the "-55" modifier.[4]

Action-Steps – If, in your ED, you can keep track of 'minor' versus 'major' and whether or not the ER physician has directed the patient elsewhere for follow-up care, then only use the "-54" modifier for major surgeries in which the patient has been directed elsewhere for follow-up care.

On the other hand, if you find that this process is too complex for your ED, then you should probably use the "-54" modifier whenever the ER physician directs the patient elsewhere for follow-up care. If you take this latter approach you will lose some payments on the minor procedures, but you certainly will remain compliant. Note that a key issue is what constitutes 'transfer of care'. Such transfer should be in writing, which means many 'transfers' are informal at best.

[3] A full discussion of fracture care in the ED would comprise a small book.
[4] The OIG is currently investigating the proper use of the "-54" and "-55" modifiers by physicians. This will also become a potential RAC audit issue as well.

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 June 9th:"***Mastering Injections & Infusions***". The webinar 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.

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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.