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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 from both APCs and MPFS should be appearing in the *Federal Register* very shortly. After the proposed changes have been analyzed, suggested comments and responses will be included in this Newsletter. All readers are encouraged to make their views known to CMS concerning proposed rule changes for these two major payment systems. Standby!

Ordering and Referring Physicians

On February 17, 2012, CMS issued a memorandum, S&C-12-17-Hospitals, addressing the issue of ordering or referring physicians for hospital outpatient services. Last year, CMS issued a proposed change to Appendix A of the State Operations Manual that focused primarily on ordering and referring physicians for hospital rehabilitation and respiratory care services.

Note: See SC-11-28 issued on May 13, 2011, which was followed by Transmittal #72 dated November 18, 2011.

This clarifying memorandum eases any burden on the hospitals to credential ordering physicians and practitioners who may not be embers of the hospital's medical staff organization (MSO).

Here is the summary from the memorandum:

> ***Requirements for Ordering Hospital Outpatient Services:*** Outpatient services in hospitals may be ordered (and patients may be referred for hospital outpatient services) by a practitioner who is:
>
> - Responsible for the care of the patient;
> - Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient;
> - Acting within his/her scope of practice under State law; and
> - Authorized by the medical staff to order the applicable outpatient services under a written hospital policy that is approved by the governing body. This includes both practitioners who are on the hospital medical staff and who hold medical staff privileges that include ordering the services, as well as other practitioners who are not on the hospital medical staff, but who satisfy the hospital's policies for ordering applicable outpatient services and for referring patients for hospital outpatient services.
>
> ***Previous Guidance Superseded:*** This guidance supersedes the guidance for §482.56(b) (Tag A-1132) and §482.57(b)(3) (Tag A-1163) found in SC-11-28 (May 13, 2011) and State Operations Manual (SOM) Transmittal #72 (November 18, 2011).

This clarifying guidance goes beyond rehabilitation and respiratory care services and appears to apply in general. The key element is that the hospital must develop a policy that permits physicians and practitioners who are not on the hospital staff to order or refer services as long as they, the ordering practitioners, have the qualifications to do so.

Of course, just having a policy is not enough. Hospitals will need to develop operating procedures. From the memorandum:

> *The hospital's medical staff policy for authorizing practitioners to refer patients for outpatient services must address how the hospital verifies that the referring practitioner who is responsible for the patient's care is appropriately licensed and acting within his/her scope of practice. The policy must also make clear whether the policy applies to all hospital outpatient services, or whether there are specific services for which orders may only be accepted from practitioners with medical staff privileges.*

Thus, a hospital could elect to delimit the areas in which outside physicians and practitioners could refer patients for services. Certain high technology outpatient services may only be provided with orders from a physician on the hospital's medical staff.

Note that this approach is similar to the approach that CMS finally used for credentialing physicians and practitioners who provide services through telemedicine. There was a time period when the originating hospital had to credential any physician or practitioner that was going to provide telemedicine services.

> **Note**: See the February 2011 edition of this Newsletter, Volume 23, Number 2, pages 9-10 for an article on telemedicine credentialing.

OIG Report on E/M Coding

The OIG (Office of the Inspector General) issued a report this month concerning physician use of the various E/M (Evaluation and Management) levels. You can access the report at the OIG website, OEI-04-10-00180. While the OIG continues to investigate the E/M coding on the physician side, there is no doubt that the OIG will be looking at technical component E/M coding on the hospital side in the near future.

The study conducted by the OIG was a fairly high level statistical analysis of the use of the various E/M levels. The OIG took care to establish a sampling that reflected similar types of services and diagnoses.

> Note: The fact that the OIG was concerned about similar diagnoses relative to the E/M levels could have some significance. Physicians have fairly copious E/M coding guidelines from both CPT and CMS. For the most part, these guidelines do not depend on diagnoses. The concentration involves physician activities with some consideration for complexity of decision making which could loosely correlate to diagnostic complexity.

From the report:

> *Between 2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion. During this same time, Medicare payments for evaluation and management (E/M) services increased by 48 percent, from $22.7 billion to $33.5 billion. E/M services have been vulnerable to fraud and abuse. In 2009, two health care entities paid over $10 million to settle allegations that they fraudulently billed Medicare for E/M services. The Centers for Medicare & Medicaid Services (CMS) also found that certain types of E/M services had the most improper payments of all Medicare Part B service types in 2008. This report is the first in a series of evaluations of E/M services. Subsequent evaluations will determine the appropriateness of Medicare payments for E/M services and the extent of documentation vulnerabilities in E/M services.* (Page 1)

Even from this brief statement several factors can be identified. First, from a national level view, there appear to be vast sums of money that can be recouped in this area. Second the OIG is conducting multiple studies. For instance, from the study, page 6:

> *OIG is conducting a series of evaluations of E/M services provided to Medicare beneficiaries in 2010. OIG plans to issue two others in addition to this report. One will determine the appropriateness of Medicare payments for E/M services. The other will assess the extent of documentation vulnerabilities in E/M services using electronic health record systems.*

The methodology used by the OIG is briefly described on page 6 of the report:

> *To analyze coding trends from 2001 to 2010, we used the PBAR National Procedure Summary files. To analyze physician billing patterns, we used the carrier file from the National Claims History (NCH) file in 2010. We limited our analysis to E/M codes that correspond to visit types with three to five levels. We did not determine whether the services billed by physicians who consistently billed higher level E/M codes were inappropriate or fraudulent.*

One of the groups of physicians that the OIG identifies encompasses those that use the highest level E/M codes (e.g., 99214/99215 and 99204/99205) frequently, sometimes, almost exclusively. Statistically, this would seem the group to investigate and audit for proper use and documentation. However, the statistics in this area need stratification. Specialty physicians generally code at the level 4 or level 5 due to the types of cases they address and the E/M coding guidelines themselves. Thus, drawing a general conclusion that physicians who code in the highest categories should receive special attention must be mitigated by the difference between primary care physicians and specialty physicians.

For the 99211-99215 sequence, a fairly reasonable bell-shaped frequency distribution is present with 99213 dominating. However, for individual years, the trend is fewer codes for 99211-99213 and more cases with 99214 and 99215. Thus, there is a shift to the higher level codes.

One interesting outcome of this study is with ER physician E/M levels. This is from the sequence 99281-99285. The data analysis show a strong bias toward the 99283-99285 levels with the highest being at level 5. 99291 and 99292 are almost insignificant. Thus, the frequency distribution is nowhere close to any sort of bell-shaped curve.

So, what is happening for the ER physicians to move their levels to the 99283-99284? While significant formal studies would be needed to answer this question, one trend is for other personnel (e.g., ER nursing staff) to provide triage and medical screening examinations on these lower level patients. In some cases, presentations to the ED are not emergencies, and thus the involvement of the ER physicians would be minimal.

For hospitals, this report should be carefully reviewed even though this study was performed on the physician side. How can we translate the findings and/or concerns over to the hospital side? Consider the ED levels. CMS has indicated through discussions involving APCs that the overall distribution of ED levels continues to generate bell-shaped curves although there appears an increase toward the high levels over time. Reconciling this with the ER physician levels would require some careful analysis.

The biggest issue for hospitals is that there are no national guidelines for technical component E/M level coding. Thus hospitals must continue to study their mappings for the ED and provider-based clinics. It is only a matter of time before the OIG and the RACs (Recovery Audit Contractors) address this area.

The recommendations from this OIG report seem rather general:

- Continue to Educate Physicians on Proper Billing for E/M Services
- Encourage Its Contractor to Review Physicians' Billing for E/M Services
- Review Physicians Who Bill Higher Level E/M Codes for Appropriate Action

The third recommendation involved 1,700 physicians that the OIG identified for possible further investigation. CMS's response to this recommendation is interesting. From page 15 of the report:

> *With regard to the third recommendation, CMS stated that it will take appropriate action and forward the names of the 1,700 physicians to MACs. CMS will direct each MAC to focus on the top 10 high billers in its jurisdiction. CMS stated that it and its contractors must weigh the cost and benefit of E/M reviews against reviews of more costly Part B services.*

CMS is correct in that the review or audit of E/M levels is quite resource intensive. Stratified audits are necessary along with significant personnel resources. Also, if the intent is to develop recoupment demands, then the formal extrapolation process must be used.

The RACs will certainly take note of this study and the report. While the timing is unknown, the RACs will become involved in this area. Auditing in this area will take some careful planning, and extrapolation processes will undoubtedly be used.

O'Connor Hospital Ruling - Revisited

In the April, 2010 issue of this Newsletter, see pages 19-20, the very interesting O'Connor Hospital Ruling was discussed. The case that is, apparently, progressing through the appeals process, involves an inpatient admission that a RAC determined was not medically necessary. Thus, the entire inpatient payment was flagged for repayment back to CMS. This case has progressed all the way through the Medicare Appeals Council. The Council concurred with the ALJ ruling, which is that the inpatient admission was not appropriate, BUT observation services were appropriate. Basically the ALJ indicated that the CMS contractor should work with the provider to off-set the recoupment amount with the payment that would have been made for the observation services.

Editor's Note: The current status of this case is not known. If anyone has any information concerning current activities surrounding this case, please let us know?

While there is a tendency to concentrate on the inpatient admission versus the observation services, if you generalize what the ALJ states relative to re-opening a given case, then there are enormous implications in this ruling. Basically, when a RAC, or presumably other auditing entity, re-opens a case, then the process starts over relative to payment and/or overpayment. If there is some sort of recoupment, this would mean that the provider has the ability to re-file the claim correctly for the given service regardless of timely filing requirements.

In the language for this ruling, the ALJ, which was upheld by the Medicare Appeals Council, indicated that it was the duty of the Medicare contractor to work with the provider in adjusting the case so that proper payment is made and/or that the payment that should have been made offsets the requested recoupment.

The whole RAC process, up to this point, has been to recoup full payments generally based on the lack of medical necessity. Then the provider has the right to re-

file the claim for the correct services, but only if the re-filing is within the timeliness guidelines from Medicare, which are now basically a year. Often times, the cases for which recoupment is sought are outside the timeliness filing guidelines.

Now, what can we do with this type of information? One avenue is to include references to the O'Connor Hospital Ruling in the documentation when going through the appeals process with RAC claims of overpayments. Presumably, if this case is eventually resolved in any form resembling the current language, then hospitals would have the right to re-file the claims relative to the re-opening of the given case. Better yet would be the requirement that the Medicare contractor would have to work with the given healthcare provider to offset the repayment with what should have been the proper payment in the first place.

Editor's Note: If you do not have a copy of the Medicare Appeals Council ruling, or in this case non-ruling, for the O'Connor Hospital case, then please e-mail us at Duane@aaciweb.com for a copy.

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: I am the manager of a partnership of seven specialty physicians. Each of the physicians has their own practice. Two are sole proprietors and the remaining physicians have their own individual professional corporations. Each of the physicians is a partner in the partnership that provides all clerical, billing and non-clinical services. Nursing staff and medical assistants are employed by the partnership and then contracted back to the physicians. Several of the physicians do employ mid-level practitioners, but these mid-levels are not employed by the partnership. One of my jobs is to handle Medicare enrollment for the physicians and practitioners. Is there anything special that I should or should not be doing?

For enrollment with the Medicare program, the very first item that must be addressed, and fully understood, is the business or organizational structuring. The model described in your question is fairly common. There can definitely be variations, but the idea is fairly straightforward, and physicians tend to appreciate this approach because their individual overhead costs are correlated to their own individual activities with the exception of the general administrative overhead.

The partnership is a business entity and will have its own tax identification number (TIN). The partnership is basically a management services organization or MSO. The MSO does not file claims for medical services provided by the partnership. Thus, there is no enrollment process for the MSO itself. No national provider identifier (NPI) will be necessary for the MSO. Tax filing must be considered, but that also is separate from Medicare enrollment.

Each of the physicians must be enrolled. Thus, for each physician an NPI will be needed, and the information on file will need to be kept up-to-date. For the sole proprietor physicians, the individual and the business are essentially the same. The physicians will use their social security numbers (SSNs) as their TINs. The CMS-855-I will be needed as well as the CMS-855-B.

Similarly, for the physicians that have developed professional corporations, the CMS-855-I and CMS-855-B will be necessary for each. Because the professional corporations are separate businesses, TINs will be necessary for the businesses themselves. Note that the NPIs used will be Type 2 because we are dealing with separate legal entities.

> Note: Business structuring and the various forms of legal entities fall under state laws. Thus there may be differences between states although these differences tend to be relatively minor. States often use model language for inclusion in their state laws relative to the types of business structures that are available. See also tax treatment of certain types of business structures.

The mid-levels may create some challenges. The main question is just how the physicians are utilizing any of the given mid-levels. If the mid-levels are being used only at the individual clinics, then the physician will probably charge for their services on an incident-to basis. They will not need to enroll with the Medicare program as such. However, they will need to obtain NPIs so that proper billing can take place.

If the mid-levels will be providing services when the incident-to rules are not met, then the mid-levels will need to file the CMS-855-I. Also, the CMS-855-R will be needed to reassign their payments to the given practice for which they are providing services. The exception to the CMS-855-R process is for physician assistants (PAs) because the Medicare payment for PAs must always go to the PA's employer.

Altering the organizational structuring can create challenges. For instance, let us assume that the mid-levels are actually employed by the partnership. These mid-levels are then made available to the individual physicians. While the partnership would have to

determine appropriate charges for the mid-levels, there are also some significant questions concerning Medicare enrollment. If these rented mid-levels provided services that will only be billed on an incident-to basis, then enrollment may not be necessary. However, if the mid-levels are to provide services and then bill for them independently, then enrollment would be necessary. This may include reassignment of benefits as needed.

The bottom-line is that organizational structuring must be carefully considered relative to the enrollment process, NPIs and TINs.

Note also that the partnership in this case is serving as a management services organization (MSO). Thus on the CMS-885-B forms, the MSO will need to be listed as having a management role. Keep in mind that CMS wants to know who owns you and who controls you. Control in this case includes financial and management influence.

Question: We had a Medicare patient that came through out ED after an automobile accident. The medical payment coverage has covered most of the charges but there appears to be no other coverage that will generate any payments. How do we bill Medicare for this case?

This is a good example of the Medicare Secondary Payer process. While the concept of this process is not had to grasp, actually filing claims in an appropriate and timely fashion is far from easy to understand.

In this case, it appears that only the no-fault medical payments will pay in connection with the accident. Logically, there should be some sort of liability coverage possibly including uninsured and/or underinsured coverage.

If there is no other coverage at all, then Medicare will be billed as secondary. Medicare will consider any amount still owed, but Medicare will not pay any more than they would have paid as primary.

The actual claims filing process is too detailed to adequately discuss in this answer. Also, additional information would be needed. Cahaba Government Benefit Administrators has a useful set of flow charts that can help in sorting your way through the MSP process. See the following website:

https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_msp.pdf

These flowcharts include information on the various UB-04 Form Locators (FLs) and the different Value Codes.

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 June 12th "***Documentation Improvement for the RACs"*** 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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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 Jane 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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