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 Final APC *Federal Register* for CY2009 is out! The examination copy was available at the CMS web site on October 30th. The official publication date is November 18th. The examination copy is 1,827 pages long.[1] The FR entry addresses ASCs as well as APCs along with some additional topics. Selected APC topics are discussed in this Newsletter and will also be addressed in coming issues.

Note: This is a very long and detailed FR entry. Our readers are encouraged to download this document and read through it with some care. Different issues will be of interest to different segments of readers. However, ferreting through all the material to determine which issues are of interest is no small task.

APCs for CY2009 – Injections and Infusions

As discussed in the October issues of this Newsletter, the AMA has made some major changes with the injections and infusion codes. Also, CMS is reducing the number of APC categories to pay for injections, infusions and chemotherapy. Here are the differences in payments for the categories

	CY2008	CY2009
APC 0436 – Level I	$ 16.21	$ 24.89
APC 0437 – Level II	$ 25.13	$ 36.13
APC 0438 – Level III	$ 51.22	$ 73.67
APC 0439 – Level IV	$105.38	$128.62
APC 0440 – Level V	$114.64	$287.96
APC 0441 – Level VI	$149.34	Deleted

Table 1 – Drug Administration APCs

While this reduced set of APCs is of interest, the real question is how the codes map into the new APCs. This is buried in the logic of the APC grouper. For infusion and chemotherapy centers a financial analysis should be performed to check for any possible impact.

Here is a very simple example that shows relatively little impact.

Consider a six hour infusion and the new code combination of 96365+5*96366:

CY2008 → $114.64 + $150.78 = $265.42
CY2009 → $128.62 + $124.45 = $253.07

This shows a decrease of about 5% while we would expect a small increase except for the restructuring of the APCs.

APCs for CY2009 – Closed Fracture Treatment

CMS has at last addressed a long-standing issue with closed fracture treatment. However, the changes that have been made still defy conventional logic.

When APCs were developed, for closed fracture treatment the APG (Ambulatory Patient Grouping) approach was taken. There were two APCs:

APC=0043–Closed Fx Tx Finger/Toe/Trunk
APC=0044–Closed Fx Tx Other Than Finger/Toe/Trunk

The basic idea is for a relatively small payment for treating broken toes, ribs, fingers, etc. These types of fractures require little resource utilization. Fractures of legs, arms, feet, and the like require significantly more resources and should generate higher payment.

This approach did not work with APCs due to the fact that some coding staff would not code broken toes, ribs and fingers. The charges, and thus costs, for these services were thus moved into the E/M levels, and the cost data from closed fracture treatment became highly skewed. CMS actually dropped APC 0044 and paid for all closed fracture treatment only with APC 0043.

Now we have the following three new APCs:

APC=0129 – Level I Closed Tx Fx Finger/Toe/Trunk → $105.54

[1] Page references in this Newsletter are to page numbers in the Examination Copy of the FR entry.

APC=0138 – Level II Closed Tx Fx Finger/Toe/Trunk → $406.12
APC=0139 – Level III Closed Tx Fx Finger/Toe/Trunk → $1,312.75

The three APCs make some sense in terms of payments. However, strangely CMS did not rename these three APCs! These three APCs address all types of closed fracture treatment, just not those of the finger, toe or trunk.

As with injections, the real test is to see how the various CPT codes map into the different APCs. Here is a very small sampling.

CPT=21800, Fx Rib → APC=0129 - $ 105.54
CPT=24500, Fx Humerus → APC=0129 - $ 105.54
CPT=25680, Fx Wrist → APC=0129 - $ 105.54
CPT=25720, Fx Kneecap → APC=0129 - $ 105.54
CPT=23575, Fx Shoulder Blade → APC=0138 - $ 406.12

If you study these three APCs and what codes map into them, you will find that APC 0129, which is the lowest paying APC, is the most common. See Table 17.

APCs for CY2009 – Technical Component E/M Codes

Do not plan on any guidance from CMS for selecting E/M levels for the ED and various provider-based clinics. The initial guidance in this area came from the April 7, 2000 *Federal Register* that directed hospitals to develop their own mappings of resources utilized into the different E/M levels.

In the last several years CMS did pull together some principles that these mappings are supposed to follow, although these principles are relatively general and do not provide any specific guidance.

Also CMS has delimited the actual E/M codes that are to be used for APCs. The ED has five levels with a special set of HCPCS codes for Type B EDs. For office visits or other outpatient visits, CMS has eliminated the consultation codes so that we are basically left with the five levels of established patients (CPT 99211-99215) and the five level of new patients (CPT 99201-99205).

Interestingly enough, CMS will continue to distinguish new versus established patients. Apparently, the cost data for the new versus established patients is enough to distinguish these levels.

There is a major change in the definition a 'new' patient for hospital clinic encounters. There have been hints that the 3-year rule in CPT for physicians should also be applied to hospitals. However, the way in which the 3-year provision was to be applied was a bit ambiguous. Now we have:

> **"*Specifically, the meanings of "new" and "established" patients would pertain to whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. Under this proposed modification, hospitals would not need to determine the specific clinic where the patient was previously treated because the modified definition would not rely upon when the medical record was initially created but rather, would depend upon whether the individual has been registered as a hospital inpatient or outpatient within the previous 3 years.*"** Page 710, CMS-1404-FC

Note that the new criterion is based on whether the patient was registered as an inpatient or outpatient within the past three years.

Alright, back to the mappings. Hospitals are correctly concerned about their mapping whether they are point systems, narrative systems or some combination of the two approaches. An inappropriate system that is judged, after the fact, to generate upcoding and thus overpayments is a major compliance concern. While the RAC audits are not yet into this area, the E/M levels will probably become a part of the RAC audit reviews in the future.

While hospitals have developed mappings, many of the systems used have been designed to temporarily fill a gap in anticipation of national guidelines. Apparently there will not be any national guidelines in the near future. ***What should hospitals do?***

First, your current mappings for the ED and various provider-based clinics should be carefully reviewed. You may want to statistically analyze the frequency distributions for each of the levels. CMS believes that you, along with other hospitals, should have a normal distribution through the levels. Of course, this is pretty close to fantasy depending upon the types of patients and types of services you are providing.[2]

You should also carefully analyze your mappings to make certain there is no overlap between what goes into the different levels versus that which is separately coded and billed. With ongoing changes in CPT and HCPCS you may start reporting something separately that was previously lumped into the E/M level mappings.

[2] CMS has found that on a national level with all hospitals that there is a fairly normal distribution. However, at an individual hospital level this generally will not be the case.

After you have reviewed your current mapping systems, then you might want to consider requesting that your FI review your mappings. An interesting directive from CMS in the Federal Register is:

"***In addition, we note our continued expectation that hospitals' internal guidelines will comport with the principles listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66805). We encourage hospitals with more specific questions related to the creation of internal guidelines to contact their local fiscal intermediary or Medicare Administrative Contractor (MAC).***" Page 738, CMS-1404-FC

Thus, after you have reviewed your mapping, you might consider sending it on to your FI for their review and approval. If they approve your mapping, then you have some degree of protection from future compliance concerns.

The FY2009 OIG Work Plan Is Out! – Part 2

The new FY2009 OIG Work Plan is out and longer than ever. We will discuss selected topics from the new work plan. Of particular interest are issues that seem to carry over from year to year.

Critical Access Hospitals & Medicare Advantage Payments to Critical Access Hospitals – CAHs are mentioned at least twice in the FY2009 Work Plan. There are the normal concerns about overall payment and associated cost reporting. There is now the issue of Medicare Advantage payments to CAHs. The MA payment process is supposed to mirror the 101% process for inpatient and outpatient services. Here is the OIG's statement for this issue:

"***We will review the appropriateness of Medicare reimbursements paid to CAHs for services provided to MA beneficiaries. Under the Social Security Act, §§ 1814(1) and 1834(g), CAHs are generally to be paid 101 percent of the reasonable costs of providing covered inpatient and outpatient services. Our review will involve examining the financial arrangements between MAOs and CAHs for services furnished to MA beneficiaries, including the application of the 101-percent provision."***

Of particular interest is how the MAOs are paying the physician professional fees under Method II. Some MAOs modify the physician payment process by paying an increased percentage of the regular MPFS payment. Critical Access Hospitals should carefully review any contractual relationship with MAOs relative to overall payment and then special consideration for Method II physician payment processes.

Medicare Billings with Modifier GY – The OIG is investigating this modifier on the physician side. Hospitals also should consider taking a look at the use and associated payment for services or items that are not covered by the Medicare program. In theory, the given MAC (i.e., FI or carrier) should pay the claim if appropriate even if the "-GY" modifier is present.

Evaluation and Management Services During Global Surgery Periods – E/M services during the post-operative period are of greatest concern. There is little question that physicians encountering patients in a post-operative period do not always use the "-55" modifier with the surgical code. Often the common process is to code and bill a low-level E/M for the post-operative service. Consider the case below.

Case Study – An elderly patient presented to the Apex Medical Centers ED with a laceration on the arm. The ED physician sutured the laceration and directed the patient to return to the ED for suture removal in a week. However, the patient has presented to the Acme Medical Clinic. After a very brief examination by a physician, the sutures are removed by the nurse at the clinic.

The chances are very good that, on the professional side, the ED physician did not use the "-54" modifier (intra-operative only), and the ED physician has been paid the full global surgical package (GSP) payment. The physician at the Acme clinic will code and bill a low-level E/M visit, probably a 99212. From the OIG's perspective or from the perspective of a Medicare auditor there has been an overpayment in that the suture removal was paid as a part of the original service at the ED.

Both physicians and hospitals should be concerned about this issue. At some point this will probably become a RAC audit issue as well.

Physicians' Medicare Services Performed by Nonphysicians – The OIG's concern is with *incident-to billing*. The word 'nonphysicians' is used in the most general sense and includes nursing staff and other technical staff that are not classified as practitioners.

The basic idea is that a physician directs subordinate personnel (nurse, technician, medical assistant, etc.) to perform services, and the physician then codes and bills for the services as if the physician had performed the services.

Currently, this type of billing is allowed for freestanding clinics. If the physician is performing these services in a facility or provider-based situation, then the services of any subordinate personnel are paid through the facility or technical component billing.

Note: CMS attempted to refine their guidance on the whole issue of incident-to billing in Transmittal 87. This transmittal was quickly withdrawn because of significant concerns raised by healthcare providers, particularly hospitals. In this transmittal, CMS introduced the concept of a physician-based clinic that included ownership criteria relative to incident-to billing.

Let us consider a simple case study that illustrates some of the difficulties in this area.

> **Case Study**: A local group of cardiologists provide services at the fictitious Apex Medical Center. Typically a cardiologist goes to the hospital to perform rounds and brings along a specially trained and certified nurse. The nurse is employed by the cardiologist. The nurse performs significant services by assessing patients, obtaining interval histories, talking with hospital nursing staff and preparing physician orders and associated documentation. The cardiologist does see all the patients and gives changes in orders and medication that are transcribed by the nurse.

From a patient care perspective and from an efficiency perspective this is a wonderful arrangement. However, from a coding and billing perspective, at least for the Medicare program, this arrangement has some serious drawbacks. The nurse, even though employed by the physician, is providing services in a facility setting (i.e., the hospital) and ***thus the hospital is paid for these nursing services***. Thus, the physician should only code and bill for those services that are personally provided by the physician.

There is a very real, and understandable, possibility that the physician will code and bill for the level of service provided based on the work by both the physician and the nurse. Physicians must be very careful to code and bill only for the components of the services provided personally.

Note: This joint provision of services changes dramatically if the other provider is a practitioner such as a nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS). For a physician and practitioner, the provision of joint services is allowed. Only one of them can code and bill. The physician typically bills because there is higher payment. See the rather infamous Transmittal 1776 issued October 25, 2002.

The degree to which the OIG will investigate the several issues in this area is not known. Also, whether or not the RAC auditors will delve into this area is unknown. However, physician and hospital alike must be very sensitive to the 'incident-to' issues.

Medicare Payments for Colonoscopy Services – Colonoscopies are a high volume procedure, both for physicians and hospitals. Several compliance issues arise. First is the question of frequency, medical necessity and billing screens. Second is the issue of proper coding and appropriate charging.

On the physician side, the MPFS through RBRVS uses a pancaking approach for payment. Thus, for physicians the question is purely that of proper coding, charges are not relevant. For hospitals care should be given as to how charge structures are established. Because a physician could remove polyps using different techniques, take a biopsy of the colon, and perform other services, the hospital charge can escalate significantly if each of these services is fully charged as if being performed individually. On the outpatient side, the APC payment is based on charges converted into costs. By having significantly escalated costs, the APC payment may be set too high.

Physicians and hospitals should carefully review both the medical necessity issues as well as proper charging for these incremental services within the colonoscopy family.

Physician Reassignment of Benefits – If you have read the Conditions for Payment (CfPs) found at 42 CFR §424, you realize that CMS is greatly concerned about paying for services to someone other than the actual provider or supplier of the service. In fact, some would almost call it paranoia. Granted, the Medicare program has experienced a great deal of fraud by making payments to other than providers or suppliers.

The reassignment of benefits is generally made by physicians and practitioners. There are cases in which a healthcare provider will use a billing agency and actually have the payments made to the billing agency. If you study the CMS-855 forms, particularly the CMS-855-R for reassignment and the CMS-855-B for organizations filing Part B claims, you will see some of CMS's concern through the information that is required.

The CMS-855-R is a form that may have to be updated quite frequently. This is particularly true with physicians and practitioners that are employed on a part-time basis, and may be performing moonlighting activities and the like. Someone, namely the physician or practitioner, must keep this form up-to-date every time there is a change.

If you employ physicians or practitioners and their Medicare payments are reassigned to you, then you must make certain that the CMS-855-R forms are current.

Skilled Nursing Facility Consolidated Billing – SNFs not only have their own prospective payment system, that is, RUGs (Resource Utilization Groups), but they are also subject to significant bundling of other services. This follows from the fact that payments are under Medicare Part A, and significant bundling is a basic philosophy.

Thus, the fact that the OIG would include the general issue of consolidated billing for review is no surprise. Most likely, this will also be a RAC audit issue.

The general compliance issue is that some services provided by another provider might be billed and paid separately when the services were actually a part of the SNF consolidated payment. For instance, hospitals often provide physical therapy and occupational therapy services. Some of these PT/OT services may be to SNF residents. Care must be taken for the hospital to contract these services to the SNF. The SNF pays the hospital and then the SNF is paid for the services.

If the Medicare adjudication of claims is working properly there should be no occurrences of this type of inappropriate payment. Be particularly careful when the provider other than the SNF is billing Part B to a Carrier while the SNF bills Part A to a Fiscal Intermediary, and the overlap may not be noticed. When CMS has completed the implementation of the regional MACs (Medicare Administrative Contractors), this issue should disappear.

Part B Services in Nursing Homes: Enteral Nutrition Therapy – Nursing homes or nursing facilities (NFs) do receive separate payment for Enteral Nutrition Therapy (ENT) as a DME. You may also see the acronym PEN Therapy for Parenteral and Enteral Nutrition Therapy. Note that for SNFs, PEN Therapy is considered part of the RUGs payment.

Proper billing in this area is more complicated than might be expected. While the OIG is concerned about overpayment or inappropriate payments, it is much more likely that NFs are not being fully reimbursed for these services because of the billing difficulties.

Medicare Odds & Ends

RAC Audit Expansion Delayed – CMS has indicated that the full implementation of the RAC audits will be delayed until early in 2009. The delays results from challenges to the bidding process for companies to perform the audits.

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:
http://www.aaciweb.com/July2008June2009EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2008 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. Instruct-Online, AHC Media, LLC, Accuro Health, Progressive Business, and the Eli Research Group are all sponsoring various sessions. Please visit our main website at www.aaciweb.com in order to view the calendar of presentations for CY2008 and 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 December 4th, "***APC Issues and Problem Areas: 2009 Update***". The presentation will run from 9:30 a.m. to 11:00 a.m. EDST.

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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FOR UPCOMING ISSUES

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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.

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 for more information and scheduling.