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

Both the APC *Federal Register* and the MPFS *Federal Register* were released in examination copy format on November 1, 2012. The official release was November 15th for APCs and November 16th for MPFS. Both of these FR entries are significant, constituting hundreds of pages.

Note that CMS has a tendency to insert unrelated items in these routine FR entries. Be careful to check the contents of these entries for items that are not directly related.

Hospitals should note that there is a significant section in the MPFS FR that addresses new reporting requirement for physical therapy, occupational therapy and speech-language pathology. Technically, PT/OT/ST is not under APCs. This is the reason why this discussion is in the MPFS FR entry.

APCs – Geometric Mean for Recalibration

As anticipated, CMS has moved to the geometric mean from the median in order to calculate the relative weights for the APC categories. While this is a technical change that occurs in the background, there can still be significant impacts that result from this process. While we are yet to really learn exactly what will be impacted, either up or down, we can start running models or developing sets of case mixes to assess the overall impact of recalibration for 2013.

Editor's Note: See the August issue of this Newsletter for a discussion of this process.

APCs – Visits and E/M Coding

CMS continues to discuss E/M coding, but nothing is being done to actually develop and implement national guidelines and/or to create a new set of codes for hospital use. Only a brief mention is made in the final rule for APCs for 2013. From page 68402 (77 FR 68402):

> *We agree with the commenter that we should not move to national guidelines for visits in CY 2013. As we have in the past (76 FR 74345 through 74346), we acknowledge that it would be desirable to many hospitals to have national guidelines. However, we also understand that it would be disruptive and administratively burdensome to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals. As we have also stated in the past (76 FR 74346), if the AMA were to create facility-specific CPT codes for reporting visits provided in HOPDs [based on internally developed guidelines], we would consider such codes for OPPS use.*

Clearly this response is to a comment that favors ***not*** moving to national guidelines. There have been numerous comments encouraging CMS to develop and implement facility E/M coding guidelines. Note that CMS is encouraging the AMA to develop hospital specific E/M codes, but CMS is also indicating that the codes that are developed would be used based upon individual hospital internal guidelines.

> **Note**: See a related discussion in the Q&A section of this issue of the Medical Reimbursement Newsletter. While CMS is requesting special codes, there does not appear to be any request for the AMA to develop guidelines for the use of the new codes.

This whole situation is almost surrealistic. Hospitals face enormous challenges with justifying their E/M level mappings and fending off auditors such as the RACs who will probably want to recoup significant monies because of inappropriate upcoding.[1] These audits will

[1] See the OIG FY2013 Work Plan in which there is an issue involving electronic health record (EHR) documentation that

also involve the incorrect use of the "-25" modifier. This is another area in which CMS has provided no guidance since CY2001.

One change was made to the APC grouping of a special E/M code, namely G0379, that is, a direct admission to observation. The change in mapping is to map G0379 to the highest level E/M group, which is APC 0608. This is the same as for 99205 or 99215. Payment at this level is $168.92. Before anyone becomes overly excited about this change, G0379 is rarely paid separately. Keep in mind that if a nurse provides an extensive assessment during a direct admission of a patient to observation, and if the observation composite is paid, then G0379 is packaged into the observation payment. In the unusual circumstance that a direct admission and observation were provided for less than eight hours, then the G0379 would be separately paid.

There are two new, really interesting codes for ***transitional care management***. These have been developed and now recognized by CMS. From page 68043 (77 FR 68403):

> *In the CY 2013 MPFS proposed rule (77 FR 44774 through 44780), we discussed a multiple year strategy exploring the best means to encourage the provision of primary care and care coordination services to Medicare beneficiaries.*

CPT 99495 → APC 0605 - $73.68 (See Also MPFS)

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
- • Medical decision-making of at least moderate complexity during the service period; and
- • Face-to-face visit, within 14 calendar days of discharge.

CPT 99496 → APC 0606 - $96.96 (See Also MPFS)

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
- Medical decision-making of high complexity during the service period; and
- Face-to-face visit, within 7 calendar days of discharge.

> *"Transitional care management is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction."* (77 FR 68404)

Note that transitional care management is paid under the Medicare Physician Fee Schedule as well. Thus these two codes can be used in provider-based clinic situations for relatively good payment. Here are the relative value units. Note that the actual payment amount is not included because the conversion factor for physician for CY2013 is still up in the air. Hopefully, Congress will act shortly relative to the Sustainable Growth Rate (SGR) reduction.

	Work	Fac PE	NonFac PE	Medical Mal
99495	2.11	1.71	2.57	0.14
99496	3.05	w.56	3.54	0.20

APCs – Ambulatory Surgical Centers (ASCs)

ASCs are now being paid through a hybrid system of APCs and MPFS. Relative to APCs, ASCs are supposedly paid at 65% of the APC payment rate for those services paid under APCs. The actual percentage is slightly below 60%.

Thus, ASCs are being paid significantly less for the same outpatient procedures that can be performed in a hospital outpatient setting. As a result, hospitals that own ASCs are quick to consider making the ASC operations provider-based and thus a part of the hospital outpatient department. If the ASC can qualify as provider-based, then there will be significant increases in payment made by the Medicare program.

Editor's Note: See also the FY2013 OIG Work Plan. The OIG as well and CMS has recognized the trend of converting freestanding ASCs into provider-based operations.

OIG Report on ALJ Rulings

The OIG has issued an interesting report concerning ALJ (Administrative Law Judge) rulings relative to appeals made by healthcare providers generally in connection with RAC (Recovery Audit Contractor) demands for recoupments. This report was issued in November, 2012. The title is a bit long: ***Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals***. See report OEI-02-10-00340.

Two lesser used acronyms will help you understand the OIG discussion:

QIC – Qualified Independent Contractor, and
OMHA – Office of Medicare Hearings and Appeals.

Here is the OIG's summary:

expresses concern that the ease of developing additional documentation may lend to upcoding.

Providers filed the vast majority of ALJ appeals in FY 2010, with a small number accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed QIC decisions and decided in favor of appellants; this rate varied substantially across Medicare program areas. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. In addition, the favorable rate varied widely by ALJ. When CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. Staff raised concerns about the acceptance of new evidence and the organization of case files. Finally, ALJ staff handled suspicions of fraud inconsistently.

These findings are astounding! In the audit the OIG found that more than half of the appeals reaching the ALJ level were reversed in favor of the provider appealing the case. Also, 85% of the cases reaching the ALJs for appeals in 2010 were filed by healthcare providers. Obviously, the RAC program and demands for recoupment are really ramping up the appeals process.

While we will review some of the extensive recommendations made by the OIG, clearly various Medicare rules and regulations are not precise and can be interpreted differently. Additionally, there is enormous guidance issued by Medicare Administrative Contractors at the subregulatory level that even seems to contradict the formal rules and guidance.[2]

In this kind of environment it is not surprising that there would be reversals of the application of subregulatory guidance in the context of formal statement from the Code of Federal Regulations (CFR) and various Medicare manuals.

Here are the recommendations from the report. These have been reformatted to make them a little more intelligible.

We recommend that OMHA and CMS:

(1) develop and provide coordinated training on Medicare policies to ALJs and QICs,

(2) identify and clarify Medicare policies that are unclear and interpreted differently,
(3) standardize case files and make them electronic,

(4) revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence, and

(5) improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.

Further, we recommend that OMHA:

(6) seek statutory authority to establish a filing fee,

(7) implement a quality assurance process to review ALJ decisions,

(8) determine whether specialization among ALJs would improve consistency and efficiency, and

(9) develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly.

Finally, we recommend that CMS: (10) continue to increase CMS participation in ALJ appeals.

Some of the recommendations involve substantive changes (or clarifications) to Medicare rules and regulations while other recommendations involve process changes. For instance, recommendation (4) involves the introduction of new evidence at the ALJ level or presumably the MAC (Medicare Appeals Council) level within the appeals process. While the issue of introducing new evidence can certain evoke discussion, by the time the provider and CMS are at the ALJ level, the evidence in the form of documentation and summarizations[3] should already be fixed.

The second recommendation is probably the most important. There are multiple issues to which CMS has not been clear in the way the rules and regulations have been written. Consider the following four phrases involving current key issues:

- ***Clinically Related*** – See the MS-DRG 3-Day Payment Window,
- ***Active Monitoring*** – See Observation Services,
- ***Immediately Available*** – See Physician Supervision Requirements,
- ***Reasonably Relates*** – See Facility Component E/M Coding.

[2] One of the more recent pronouncements is that an inpatient stay of less than 48 hours should be automatically outpatient observation cases.

[3] See the concept of payment documentation, that is, documentation and/or reformatted documentation to support payment.

These represent four key phrases that CMS has either not explicitly defined or has refused to clearly define. These four phrases are yet to become RAC issues.

The first recommendation involving coordinated training on Medicare policies for the ALJs and QICs will be most interesting to track. There are many healthcare providers, attorneys and consultants that would be very interested in such training. Depending upon the audience, such training easily could generate very different opinions in interpreting the rules, regulations and applicable subregulatory guidance.

The remaining recommendations involve mainly process issues. The development of a filing fee could be intimidating because of the volume of appeals that are often pursued. A process of recognizing previous rulings should be instituted. Once an ALJ ruling has been made, and possibly reviewed by the MAC, then CMS should implement whatever determination has been made. Obviously, CMS has the right to go to Federal Court if an ALJ/MAC ruling has been made favorable to an appellant and CMS continues to disagree.

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 with due care.

Question: We are assessing our overall structure in preparation for revalidation of our Medicare enrollment. At our hospital we have a relatively large campus with several buildings housing different kinds of service including clinics and an infusion center. The buildings on the campus have their own addresses, and mail is delivered directly to a given building. Obviously there are separate telephone numbers. Do each of these operations need separate reporting as a practice location?

The general answer is 'yes'. Each of these would be a practice location. If these operations did not have separate addresses, then they could, and most likely would be considered a part of the hospital itself for enrollment purposes. In some cases these building will not only have a separate address, they will also have separate parking that further distinguishes them from the main hospital (i.e., main provider).

The language in the provider-based rule (PBR) is somewhat ambiguous in that the definition of being in the hospital refers not only to the main building but also to main buildings, that is, in the plural. What constitutes more than one main building is an interesting question.

Note that in reporting practice locations, any facilities that are separately enrolled in Medicare should not be reported. This would include skilled nursing facilities, home health agencies and the like. Be careful to distinguish property and operations that are not part of the hospital. For instance, a physician may have established a practice by renting space from a hospital for use in the hospital or some hospital space in a building on the campus. The rented space is not part of hospital property unless the physician clinic is established as provider-based.

There are nuances to this general question of reporting practice locations. Consider Case Study #1 below.

> **Case Study 1** – The Apex Medical Center has built a very nice medical office building. Basically, this is a multi-story building right across the street from Apex. Apex has a rehabilitation department (i.e., physical therapy, occupational therapy, cardiac rehabilitation, etc.) and several specialty clinics that are provider-based. The remainder of the space in this building is rented to physicians who have established their own freestanding practices.

In considering the PT/OT operation and the provider-based clinics, will it be necessary to report each of these individually as separate practice locations on the hospital's CMS-855-A?

Question: Is the use of the CPT E/M codes by CMS for hospital visits at provider-based operations HIPAA compliant?

A very real argument can be made that CMS's use of the CPT E/M codes for emergency department visits (CPT 99281-99285 and 99291/9929) and provider-based clinic visits (CPT 99201-99205 and 99211-99215) is ***not HIPAA compliance***. Part of the HIPAA legislation and associated rules and regulations falls under the general heading of 'TSC – Transaction Standard/Standard Code Sets'.

One of the standards within HIPAA TSC is that the code sets used on claim forms (i.e., standard transactions) are standardized and that there is a standard code set maintainer who promulgates the codes and then provides official guidance on how the codes are interpreted and utilized.

The E/M codes appear in the CPT Manual. Thus the official standard code set maintainer is the AMA (American Medical Association). Only the AMA can provide official guidance on how these codes can be used and how these codes should be interpreted. AMA through the CPT Manual has developed specific coding guidelines that appear with the CPT Manual itself. All of

the directives are for physician use of the E/M codes. For instance, the three main key components are the:

- History,
- Examination, and
- Medical Decision Making.

There is no discussion or directive for using the E/M codes for hospital facility coding and associated reimbursement under APCs (Ambulatory Payment Classifications).

Part of this confusion goes back to the time when (theoretically) CMS had three code sets for which CMS provided guidance:

HCPCS Level I – CPT
HCPCS Level II – National
HCPCS Level III - Local

The Level III codes have been discontinued for a number of years.[4] The equivalence of HCPCS Level I to CPT has faded due to the enactment of the HPAA TSC rules and regulations. CMS no longer has any official purview over the CPT code set, that is, other than being a user of the CPT code set.

Note: The role of CMS in this area must be separated into two parts:

a. CMS's role as being the federal entity that administers the HIPAA TSC, and
b. CMS's role as a user of the various code sets for the Medicare program.

Whether there is a conflict in these two roles is left to the discretion of the reader.

Since the implementation of APCs on August 1, 2000, hospital providers have awaited guidance from CMS in the form of national guidelines for the use of the E/M codes for hospital outpatient claims. CMS has never issued these guidelines. Recently[5], CMS has been hinting that the AMA should develop new codes for hospital or facility E/M coding. However, CMS is not asking the AMA to develop guidelines.

How this will all play out may take years. However, everyone in healthcare, providers and payers, should really be carefully following the HIPAA TSC rules and regulations.

[4] At least the Level III codes were supposedly discontinued. Even today you may see a Local Code, but they are no longer part of a standard code set.

[5] See related article on pages 61-62 of this Newsletter.

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 December 11th - "***OPPS/APC Update for CY2013"*** 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.

E-Mail us at Duane@aaciweb.com.

Abbey & Abbey, Consultants, Inc., Web Page Is at:
http://www.aaciweb.com
http://www.APCNow.com
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Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

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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 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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