Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

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

October 2011– Volume 23 Number 10

ISSN: 1061-0936

APC/APG Update

The update *Federal Registers* for both APCs and MPFS should be out shortly. Watch carefully because there are some significant issues that require additional guidance. There should be guidance relative to physician supervision for hospitals. This is an issue that has taken on a life of its own since in 2008 CMS abruptly changed their interpretation of the need for direct physician supervision for provider-based services on the campus of a hospital.

Additionally, there should be information in the MPFS update concerning how to apply the 3-Day Payment Window to hospital owned or operated freestanding clinics. At issue is how services at the freestanding clinic should be billed relative to the application of the window. Be certain to analyze these *Federal Register* entries with great care.

OIG Work Plan for FY2012 – Part 1

The OIG's work plan for 2012 is now out. Needless to say, it is longer and more complex than ever. While some of the work plan issues have been carried over from past years, there are a number of new issues that hospitals, physicians and other healthcare providers should review and analyze.

One of the major, new work plan issues is:

"We will review Medicare payments to hospitals to determine compliance with selected billing requirements. We will use the results of these reviews to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations, and inspections have identified areas that are at risk for noncompliance with Medicare billing requirements. Based on computer matching and data mining techniques, we will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same data analysis techniques, we will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. We will then review the hospitals' policies and procedures to compare the compliance practices of these two groups of hospitals. We will also survey or interview hospitals' leadership and compliance officers to provide contextual information related to hospitals' compliance programs."

This work plan issue and the associated OIG activities represent a significant departure from previous OIG audits. In the past the OIG has identified an issue and then on a random basis has selected hospitals (or other healthcare providers) to determine if the work plan issue is really prevalent.

This new approach involves actively monitoring hospitals and associated claims to see if there are suspect hospitals that should be audited. Note that audits focus on the policies and procedures so that compliance practices can be assessed. This is a significant departure from other studies conducted by the OIG.

Ask yourself, what if the OIG came in and wanted to look at all of your coding, billing and chargemaster policies and procedures? Are your P&Ps all developed, updated and fully implemented? These P&Ps would then be assessed in terms of your overall compliance program. Having such a study performed is indeed of great concern.

The OIG continues their concern with Critical Access Hospitals (CAHs). Here is a newly, somewhat restated, issue:

"We will review CAHs to profile variations in size, services, and distance from other hospitals. We will also examine the numbers and types of patients that CAHs treat. To be designated as CAHs, hospitals must meet several criteria, such as being located in a rural area, furnishing 24-hour emergency care services, providing no

more than 25 inpatient beds; and having an average annual length of stay of 96 hours or less. (Social Security Act, § 1820(c)(2)(B).) CAHs represent a separate provider type with their own Medicare (CoP) as well as a separate payment method. There are approximately 1,350 CAHs, but limited information exists about their structure and the type of services they provide. "

The OIG notes that, relatively speaking, there are quite a few CAHs. For rural areas this has become a very popular designation and many CAHs are financially sound. This fact may be a little disconcerting because CAHs, at least for Medicare, are being paid only 1% above their allowed Medicare costs. If this payment level is allowing CAHs to gain financial stability that cannot be achieved with the prospective payment systems, then there may be something fundamentally wrong with our current payment mechanisms.

Note that the OIG has included a study of the different patient populations being served by CAHs. The CAH designation is only for Medicare beneficiaries; for other patients the CAH is simply a hospital.

Inpatient Rehabilitation Facilities (IRFs) are on the work plan this year. Given the fact that the IRF PPS is quite new, this is not really surprising. Here is the work plan issue:

"We will examine the appropriateness of admissions to IRFs. We will also examine the level of therapy being provided in IRFs and how much concurrent and group therapy IRFs are providing. IRFs provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve their ability to function. Patients must undergo preadmission screening and evaluation to ensure that they are appropriate candidates for IRF care."

The Present-On-Admission (POA) indicator has made it onto the OIG's work plan. Note that this will probably become a RAC audit issue as well.

"We will review the accuracy of POA indicators submitted on inpatient claims submitted by hospitals nationally in October 2008. Hospitals do not receive additional payment for certain conditions that were not present when the patient was admitted. (DRA, § 501.) Beginning in FY 2008, CMS required hospitals to submit POA indicators with each diagnosis code on Medicare hospital inpatient claims. These indicators identify which diagnoses were present at the time of admission and those conditions that developed during the hospital stay. Recent law provides that hospitals with high rates of hospital-acquired conditions (HAC) will receive reduced payments. (Affordable Care Act, § 3008.) Accurate POA indicators are needed for CMS to implement the requirements in the DRA and the Affordable Care Act. We will use certified coders to review medical records and Medicare claims."

Interestingly, the 3-Day Payment Window (a.k.a., 3-Day Pre-Admission Window) appears in a slightly reworded statement:

We will review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals. Pursuant to the Social Security Act, § 1886(a)(4), and 42 CFR § 412.2, inpatient prospective payment system (IPPS) payments to hospitals for inpatient stays are payment in full for hospitals' operating costs and hospitals generally receive no additional payments for nonphysician services. For nonphysician services provided to inpatients by entities under arrangements with the hospitals, the Social Security Act, §§ 1862(a)(14) and 1861(w)(1), as interpreted by CMS in its FY 1983 IPPS final rule, prohibits submissions of any additional claims to Part B. **Section 1886(a)(4) prohibits separate payments for outpatient diagnostic services and admission-related nondiagnostic services rendered up to 3 days before the dates of admission.** ***Prior Office of Inspector General (OIG) work in this area found significant numbers of improper claims.***

Given the current changes taking place surrounding the 3-Day Payment window, it will be interesting to see what the OIG has to report in this area.

Medicare secondary is also an ongoing issue in which the OIG has restated what they are investigating.

"We will review Medicare payments for services to beneficiaries who have certain types of other insurance coverage to assess the effectiveness of procedures in preventing inappropriate Medicare payments. (Social Security Act, § 1862(b).) This review will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from

Medicare and other insurers exceed the providers' charges or the allowed amounts."

There are already special RAC considerations for MSP, so what the OIG will find relative to processes should be interesting. Whether the OIG will delve into the mandatory reporting issue for hospitals is also an open question.

An issue that has been present in the OIG work plan for a number of years concerns medically unnecessary radiology services. Here is the most recent statement of this issue.

"We will review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862 (a)(1)(A).)"

For this statement of the excessive diagnostic testing, the OIG is looking for redundant tests that are performed by both a primary care physician and a specialist. Often these same tests are separated in time so that the whole question of medical necessity becomes subjective. The question then becomes, what guidelines will the OIG auditors use? Certainly the RAC will be watching for any sort of guidelines in these cases.

Here is a new issue involving ambulance services.

"We will compare reimbursements by other payers for ambulance services to Medicare fee schedule amounts for similar services to determine whether Medicare amounts exceed the reimbursements by other payers. Medicare payments are based on the lesser of the actual charge or the applicable fee schedule amount. (42 CFR § 414.610(a).) We will examine reimbursements made by Medicare Advantage (MA) plans, State Medicaid programs, and the Federal Employees Health Benefits Plan (FEHB)."

Ambiguous Guidance from CMS: Technical Component E/M Coding – Part 4

At some point in the coming years the RACs (Recovery Audit Contractors) will be allowed to address possible overpayments relative to technical component E/M coding and the improper use of the "-25" modifier. The two main questions are:

- What will they investigate, and
- How will they go about doing the investigations?

Both the issue of the E/M levels and the use of the "-25" modifier lend themselves to a formal extrapolation process. For the RACs to use this process, as well as other auditing programs, there must be a very well-defined, formal statistical process. Hospitals and other healthcare providers can also use this process internally if compliance issues are discovered and the healthcare provider wants to voluntarily report and make restitution.

Whoever uses this process must engage a mathematician or statistician to determine the validity of this approach for a given set of circumstances.

The basic idea is to take a given population of claims, determine the error rate for a statistically valid sampling and then extend the results to the whole universe, that is, extrapolate outside the data set.

We will use a much generalized example to illustrate the process. Let us go to the fictitious Apex Medical Center that has ten, fairly active provider-based clinics. At issue is the proper use of the "-25" modifier. Over the past three years, there have been 100,000 claims filed using the "-25" modifier. The RAC has performed a preliminary probe audit using 30 cases. While there has been quite a bit of controversy, the RAC claims that out of the 30, there are 8 cases in which the "-25" modifier was used incorrectly, and an overpayment averaging $50.00 has occurred for each of those 8 cases.

Note: Exactly how the extrapolation process will work is in question, particularly if the alleged overpayments are contested through the appeals process.

Now the probe audit of 30 cases is much too small to broadly apply the finding for the full 100,000 claim population. However, the probe audit does provide an approximate error rate that can then be used in the statistical formulas to determine a valid sample size. Most likely the RACs will use the OIG's RAT-STATS program to calculate the sample size and then choose a random sampling.

Note: If you have never looked at RAT-STATS, you should download this free program from the OIG web site and at least familiarize yourself with this software.

The typical parameters used to determine the valid sample size include a 90% confidence level with 25% precision. These two parameters along with the population size, 100,000 in our case, and the error rate from the probe audit will generate the actual sample size that is needed.

A random sample is then obtained based upon the sample size. No extra samples will be determined because if a case is missing or documentation is missing, then the case in considered as a total overpayment.

Presuming that there is a 25% error rate found with an average overpayment of $55.00 we can calculate the recoupment amount as:

0.25 * 100,000 * $55.00 = $1,375,000.

This is oversimplified, but it illustrates the fact that in extrapolation cases the amount of repayment can add up very quickly.

There are other issues that should be considered. One issue is what to do about possible underpayments along with the overpayments. Is it possible to reduce the recoupment amount by underpayment amounts?

Because hospitals must deal with long-term ambiguous guidance, it is quite possible that a given hospital may be doing everything in their power to establish proper policies and procedures and then discover at a later date that the hospital is out of compliance. If the issue at hand is something like technical component E/M levels or the use of the "-25" modifier for which extrapolation can be used, the overpayment claims can be quite significant.

Editor's Note: If you need more information on the extrapolation process, please contact Dr. Abbey at Duane@aaciweb.com

Regulatory Reform

Various federal agencies are working on reviewing a wide range of regulations to determine if any simplification is possible. This activity extends to CMS and the Medicare program as well. Two *Federal Registers* in examination copy format have been issued. These two entries will appear on October 24, 2011.

1. CMS-3244-P, "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation", and
2. CMS-9070-P, "Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction.

There is a full 60-day comment period. Some of the proposed changes are innocuous while others are fairly significant. Here are some of the areas being addressed:

- Conditions of Participation for Hospitals
- Conditions of Participation for Critical Access Hospitals
- Part B Appeals
- Enrollment and Billing Privileges
- Ambulatory Surgical Centers
- Electronic Prescribing
- Conditions for Coverage

This may be the start of a larger series of changes and really needed updating in some cases.

Editor's Note: Some of the more substantive changes will be discussed in future issues of this Newsletter.

Questions from Our Readers

Question: **With increasing frequency we are receiving requests from private insurance companies to re-bill short stay inpatient admissions as observation cases. Sometimes this involves cases in which the patient was in the hospital for up to four or five days. The insurance company is basically stating that they will not pay the claim as an inpatient stay but they will pay for the stay as observation. What should we do?**

Basically, there are two different answers: one is the politically correct answer, and the second is the pragmatic real answer.

If the stay was an inpatient stay and met the inpatient admission criteria, then the claim should be filed as an inpatient claim. The insurance company should pay the claim as an inpatient claim. Particularly, if you are dealing with cases that involve more than one day or 24 hours, then observation becomes questionable. At two days you are generally outside the range of observation.

You should check for any contractual obligations that you might have, assuming that you have a contract with the given private insurance company. These obligations may not be in the contract itself, but they may be referenced in the contract and contained in companion manuals that address coding, billing and reimbursement. There may be some special provisions that allow the insurance company to review cases and use extended criteria to judge whether a given inpatient claim should be considered as observation.

The pragmatic answer is that hospitals, as with any other healthcare provider, want to be paid for the services that they provide. If the given claim must be filed as an outpatient observation claim in order for payment to occur, then hospitals are quite likely to alter the claim in order to meet the insurance company's demands.

Note that this whole situation illustrates the long-standing question that healthcare providers have been asking third-party payers, namely, 'You tell me how to code and bill this service in order to get paid, and I will code and bill it as you instruct'. This practical question runs completely contrary to the intent of the HIPAA Transaction Standard/Standard Code Set (TSC) rule. Under the HIPAA rules you should be able to provide a service and then code and bill the service, using standard code sets, exactly the same way for all third-party payers. As you can quickly surmise, this whole question is really a payment or adjudication issue not a coding and billing issue.

Now if you are going to accede to the insurance companies request, then you should carefully document what you did and include documentation regarding the request to alter the normal coding and billing process. You should also look at the difference in reimbursement between the inpatient stay and the observation stay to make certain that you are not losing too much reimbursement by following this process.

Question: We are in a physician's clinic. While Medicare has discontinued the use of the consultation codes, other payers will pay for these codes, generally more than they do for the office visit codes. If Medicare is secondary and we use the consultation codes on the primary claim, what should we do on the Medicare secondary claim?

This same question arises for hospitals that have provider-based clinics in which both a professional and technical component claim are filed.

There is really no good answer to this question. One approach is to change the consultation code to a closely equivalent office visit code on the secondary claim. Now this raises another question in that the charge for the consultation code and the closely equivalent office visit code may not be the same. Now we have a situation in which we are not only changing the code, we are also changing the charge. From a compliance perspective, this appears very questionable.

If we retreat to the fundamental idea behind Medicare's being a secondary payer, we should try to make changes that will ensure that Medicare is not overpaying for the services based on the code used and the charge made. Thus, using a lower level E/M code and a charge that is no greater than the original charge, Medicare should calculate a payment amount that is on the low side. This should mitigate compliance concerns.

As usual, watch for any and guidance that might be available for cases of this sort. This is one of many gray areas within all the rules and regulations.

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/JantoDecember2011EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2011. 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 CY2010 and planned workshops for CY2011.

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 November 15th. ***"The OIG and RAC Initiatives for 2012"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's latest 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 second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

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
http://www.HIPAAMaster.com

Abbey & Abbey, Consultants, Inc.
Administrative Services Division
P.O. Box 2330
Ames, IA 50010-2330

INSIDE THIS ISSUE

FOR UPCOMING ISSUES

Affordable Care Act Issues
More on RAC Audits and Issues
Chargemaster Pricing Issues
More on Coding, Billing Compliance
More on Payment System Interfaces

****** 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: Duane@aaciweb.com