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 APC update Federal Register should be out on or about November 1st. Most likely this FR entry will be released in 'examination cop prior to the official printing. With all of the federal regulations being issued in other part of the government, there is almost a one month lag from submitting a document to the time the document is actually published.

OIG Work Plan for FY2013 – Part 1

The OIG has issued their Work Plan for FY2013. This work plan was issued right on time this year. As might be expected, this work plan is longer, has more issues and to some extent a little more detail. While compliance personnel should study this document in some detail, almost everyone involved in coding, billing and reimbursement from the Medicare program should be aware of the more significant issues.

A given work plan should not be studied in isolation. The past five years of work plans should also be studied to look for ongoing patterns, that is, issues that seem to appear, in sometimes modified form, year after year. One of those general issues is excessive diagnostic testing in the ER.

Also, keep in mind that for issues presented in the work plans, after the studies have been completed, generally several years down the road, reports are issued. For issues of interest be certain to download the reports and study with care.

Also, be certain to look at the full range of issues, even for healthcare providers with which you do not work. For instance, hospital personnel should review physician issues. There are certain issues that have been studied for one type of healthcare provider that may become applicable to other types of healthcare providers. A good example of this is with the "-25" and "-59" modifiers. Both of these modifiers have been investigated by the OIG on the physician side. The OIG did find significant misuse of these modifiers by physicians.[1] Hospitals also used these two modifiers for APCs (Ambulatory Payment Classifications),and the compliance issues are very much the same as with physicians. In the near future Medicare and the RAC (Recovery Audit Contractors) will undoubtedly conduct audits on the use of these modifiers. Generally, these audits will involve some form of extrapolation.

Here are some of the more interesting issues.

Hospitals-Diagnosis Related Group Window (New) – This relates to the DRG preadmission window or what CMS is now calling the DRG Payment Window. In 2010 there was a major change[2] relative to which outpatient services[3] should be bundled into the DRG billing during a 3-day window. Now the OIG wants to investigate this window to see how much Medicare could save if the window were increased to 14 days. "*We will analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the diagnosis related group (DRG) payment.*"

Interestingly, the concept of a 14-day window is not new. For FY2001, the OIG work plan had basically the same issue,and the report that was issued appeared in August of 2003.[4] Although not proposed by the OIG, there have been indications that a *post-discharge window* might also be considered.

Hospitals—Non-Hospital-Owned Physician Practices Using Provider-Based Status (New) – The language used by the OIG seems inconsistent. "*We will determine the impact of non-hospital-owned physician practices billing Medicare as provider-based physician practices*".

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[1] See OEI-07-03-00470 and OEI 03-02-00771 both issued in November 2005.

[2] See Section 102 of Public Law 111-192.

[3] The trigger for applying the 3-Day Payment Window is a facility that is wholly owned or wholly operated by the hospital which, by definition, includes in provider-based activities.

[4] See OIE Report A-01-02-00503.

Under the provider-based rule (PBR)[5] only a provider-based clinic could bill as provider-based. The provider, or technically the main provider, is generally a hospital but could be some other type of entity such as a skilled nursing facility, that is, a healthcare provider that has a provider agreement with the Medicare program.

What the OIG actually means by the phrase, *provider-based physician practice*, is not completely clear. The main intent of this work plan issue really appears to study the possibility that there should be no payment differential between physician, freestanding clinics and hospital, provider-based facilities. With the growth of hospitals establishing provider-based clinics, if the additional reimbursement were removed, there would be a significant impact on hospitals.

Hospitals—Inpatient Billing for Medicare Beneficiaries (New) – "*We will describe how hospital billing for inpatient stays changed from FY 2008 to FY 2012. We will also describe how billing for inpatient stays in FY 2012 varied among different types of hospitals and how hospitals ensure compliance with Medicare requirements for inpatient billing.****"*** This issue seems quite general in nature. While the types and billing for inpatient stays can be approached statistically, the question as to how hospitals are ensuring compliance is a very different issue. This will require on-site visits and review of hospital compliance plans and programs.

Hospitals—Compliance With Medicare's Transfer Policy (New) – "*We will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers. We will determine whether such claims were appropriately processed and paid. We will also review the effectiveness of the MAC's claims processing edits used to identify claims subject to the transfer policy*." While the issue of incorrect categorizing discharges relative to home health and/or skilled nursing is certainly valid, the frequency of these incorrect categorizations is an interesting issue. When these incorrect categorizations occur, it is often due to the fact that the hospital coding staff does not know about after-discharge care such as home health.

Note that a part of this issue is whether or not the MACs have procedures in place to catch and identify incorrect categorizations. From the programming side, the MACs really should have no difficulty in identifying specific cases.

Hospitals—Payments for Canceled Surgical Procedures (New) - "*We will determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures. Our preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed by a second, higher PPS payment to the same hospitals for the rescheduled surgical procedure. For these claims, the canceled surgical procedure was the principal reason for the initial hospital admission. For these short-stay claims, few, if any, inpatient services (i.e., laboratory or diagnostic tests) were provided by the hospitals because the surgical procedure was canceled. Medicare makes two payments to hospitals that generate two bills unless the patient is readmitted to the hospital on the same day, in which case a single payment is made. Our analysis also identified inpatient claims with canceled surgical procedures for stays of less than 2 days that were not followed by subsequent inpatient admissions to the same hospitals for the rescheduled surgical procedures*."

This is a new issue for the OIG. Hospital compliance personnel should run some statistical reports to see how many inpatient cancelled surgeries are present and whether or not the surgery was rescheduled for a later date. Note that under the 3-Day Payment window, there may have been some outpatient services that were bundled into the billing for the cancelled surgery. Although the OIG did not expressly include the concept, there could also be some questions about the medical necessity of cancelling a surgery.

Hospitals—Quality Improvement Organizations' Work With Hospitals (New) – *"We will determine the extent to which Quality Improvement Organizations (QIO) worked with hospitals either to conduct quality improvement projects or to provide technical assistance. We will also assess the barriers QIOs experience when engaging hospitals. CMS is required to enter into contracts with QIOs, formerly called utilization and quality control peer review organizations."*

Critical Access Hospitals—Payments for Swing-Bed Services (New) – This is an issue that was fully expected. CAHs are cost-based reimbursed for their swing beds or skilled nursing beds. Skilled nursing facilities are paid under a complex prospective payment system including consolidated billing. What the OIG will probably examine is the difference in payments to the CAH versus a SNF for the same types of services.

Hospitals—Payments for Mechanical Ventilation (New) – "*We will review Medicare payments for mechanical ventilation to determine whether the DRG assignments and resultant payments were appropriate. We will review selected Medicare payments to determine whether patients received fewer than 96 hours of mechanical ventilation. Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient*." Given the construction of DRGs in this

[5] See 42 CFR §413.65.

area, the rationale for the OIG to investigate this type of issue is appropriate.

Hospitals—Quality Improvement Organizations' Work With Hospitals (New) – "*We will determine the extent to which Quality Improvement Organizations (QIO) worked with hospitals either to conduct quality improvement projects or to provide technical assistance. We will also assess the barriers QIOs experience when engaging hospitals. CMS is required to enter into contracts with QIOs, formerly called utilization and quality control peer review organizations*." The results of this study should be most interesting. With the significant increase in auditing through the Recovery Audit Contractors (RACs) and others, there have been changes in the relationship between hospitals and their QIOs.

HHAs—Home Health Face-to-Face Requirement (New) – "*We will determine the extent to which home health agencies (HHA) are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries."* Because there is an extensive nursing assessment prior to providing services, there can be situations in which the physician may sign the plan of care but not immediately see the patient. There is a 120 day window, 90 days prior to start of services and then up to 30 days after services have been commenced, in which the physician or qualified practitioner should see the patient face-to-face.

Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New) – With the difficulties that the Medicare Administrative Contractors (MACs) are having with the overall revalidation process, adding on-site visits would be resource intensive. The OIG's concern appears to address mainly DME (Durable Medical Equipment) suppliers. At this point in time hospitals and other healthcare providers, particularly those that employ physicians, should consider procedures for addressing unannounced visits for enrollment purposes. Particularly with physicians, a given individual physician may not be available for several days. The onsite visitors would most likely not be prepared to stay several days to confirm that a particular physician does, indeed, exist.

Hospitals—Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending (New) – This issue involves changing ASCs to hospital outpatient surgery departments. ASCs are paid on a hybrid system including both APCs and the MPFS. Additionally, even under APCs the ACS receive a reduced payment. Thus, there is certainly a significant economic incentive to switch ASCs over to provider-based status as a part of the hospital outpatient surgery operation. In the OIG's parlance, "*We will determine the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments. We will also determine the effect of such acquisitions on Medicare payments and beneficiary cost sharing*."

Long -Term-Care Hospitals—Payments for Interrupted Stays (New) – With the relatively new DRG payment system for LTCHs, appropriately handling interrupted stays is a complex process. "*We will determine the extent to which Medicare made improper payments for interrupted stays in long-term -care hospitals (LTCH) in 2011. We will also identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. LTCHs are generally defined as inpatient acute care hospitals with an average length of stay greater than 25 days. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days. Interrupted stays in LTCHs cause an adjustment in Medicare payments*."

Editor's Note: In Part 2 we will continue the discussion of various OIG Work Plan issues.

Provider-Based Rule – Unresolved Issues Part 1

Provider-based clinics are of significant interest for hospitals. While the concept and use of provider-based clinics goes back to the 1980's, there were relatively few such clinics at that time. During the 1990's there was renewed interest and then in 2000 the provider-based rule (PBR) was formalized in the April 7, 2000 *Federal Register*.

Over the last decade changes to the PBR have been made, but there are still a number of issues for which explicit guidance would certainly be appreciated.

Note: The latest major change[6] relative to the PBR involved physician supervision issues. While there are certainly open questions for physician supervision, these issues are addressed with separate articles in this Newsletter. See for instance:

1. Volume 24:6, Pages 31-32, June 2012,
2. Volume 24:3, Pages 13-14, March 2012,
3. Volume 23:7, Pages 38-39, July 2011,
4. Volume 23:8, Pages 43-44, August 2011.

In this article we will discuss:

[6] CMS has steadfastly maintained that no *changes* were made; only *clarifications* were provided.

1. Split-Billing Issues, and
2. Shared Facilities Issues.

One of the main advantages of provider-based clinics is that two claim forms are filed. One is for professional, physician services on the 1500 while the other is for hospital, facility resources filed on the UB-04. Prior to the April 7, 2000 *Federal Register*, there was some controversy concerning whether all third-party payers must be split-billed. Interestingly enough, CMS (then HCFA) indicated that it was acceptable that only Medicare patients be split-billed. From page 18519 of the April 7th *Federal Register*:

> "…*we [HCFA] have decided to revise it to restrict the requirement for uniform billing to Medicare patients only, thus allowing hospitals to bill other payers in whatever manner is appropriate under those payers' rules. As revised, § 413.65(g)(6) states that hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.*"

Some hospitals have chosen to split-bill all patients and all types of third-party payers. Other hospitals have decided to split-bill Medicare only. There is another complicating factor when Medicare is secondary. If a hospital is split-billing only Medicare and not split-billing other payers, the initial claim for the primary payer will be a physician claim on the 1500 claim form. Now, how is the hospital going to bill Medicare as secondary?

If you give this a moment's thought you will realize the split-billing the secondary when the primary is not split-billed is extremely difficult. Thus, the policy that may be adopted is to split-bill Medicare primary only.

However if you read the above quotation, you will see that CMS wants all Medicare beneficiaries treated as hospital outpatient, that is, split-billing should be used. Thus, when a hospital decides to split-bill Medicare only, Medicare beneficiaries that have Medicare secondary are not being treated the same way.

Does this mean that hospitals cannot pursue this approach? No, what it means is that there is some degree of compliance risk. Generally, there are not very many cases in which Medicare is secondary. Also, by using this approach, the Medicare program is paying less overall than they would have if split-billing was being used on the secondary cases.

Another issue that hospitals often encounter is shared space. There are literally dozens of possible facility structuring.

> Case Study #1 – The Apex Medical Center built a nice small facility several years ago and started providing physical therapy occupational therapy and radiology services in about one-half of the building. Hospital UB-04 billing was established. A year or two later the other half of the building was remodeled by Apex into a family practice clinic. Due to competitive pressures, the clinic is organized as a freestanding clinic. All the employees of both operations are hospital employees. There is a common reception area, common waiting room, and a common area for clerical staff.

Part of this facility is provider-based, the other part is freestanding. Does this create any problems?

> **Note**: There can be significant variations on this little case study. The clinic space may be rented from the hospital by a group of physicians. Conversely, a group of physicians may own the building and then lease part of it back to the hospital.

One of the main difficulties with shared space is that any space being used as part of the hospital must be clearly indicated through proper signage. The Medicare beneficiary must know that they are in hospital property. In some shared space situations, there is no clear delineation. In our case study, reception and the waiting room are shared. Most likely, if a patient registers for PT or radiology services, they will go through a separate door that clearly indicates hospital property. Also, it would be best if the hospital space was discrete and distinct from the clinic space, that is, a nice wall separating them.

For the specifics of this case study, there is also a cost-reporting issue. The shared space and personnel must be carefully allocated between the freestanding clinic and the provider-based operation. For the clinic, the MPFS physician payment will include the overhead associated with the facility. On the hospital side, that portion of the costs must be reported on the hospitals cost report.

While different allocation formulas can be developed, the important point is that there be a considered allocation that is reviewed and updated on an annual basis as appropriate.

Editor's Note: In the second part of this article we will continue the discussion of shared facilities and challenges with the provider-based rule.

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: For radiology, when a hospital files a facility or technical component is it required that a physician or professional component also be filed before payment will be made?

Generally for radiology, there would be a professional claim filed along with the hospital's facility charges. From the hospital perspective there is really no way to know if a professional claim is being filed. Now if the radiologists are employed by the hospital and the hospital is performing the professional billing, then the hospital would know if a professional claim has been field.

If the interpreting radiologist is independent from the hospital, there is no meaningful way for the hospital to know if a professional claim has been filed.

As far as payment is concerned, the hospital's technical component claim will be adjudicated through a system that is distinct from the physician's professional claim. Most likely the hospital's claim will be adjudicated and paid regardless of whether there is a professional claim filed.

This question does raise a valid issue that both hospitals and physicians should consider. Since the Medicare program has gone to regional MACs (Medicare Administrative Contractors), both UB-04 claims and 1500 claims are adjudicated by the same MAC. While MAC's individual adjudication systems would require examination, the process of checking professional claims and facility claims for the same patient on the same date for the same services should be relatively easy.

While such checking may not involve claim denial based on the fact that there is not an associated professional and/or facility component claim, the adjudication system can certainly check to see if the services and CPT codes are the same. While there are some instances in which the codes may be different and/or some codes may be missing from one of the two correlated claims, generally the CPT will be the same.

Based on this matching process, the MAC could then suspend the claims and request further information before making payment. This is not a completely new issue. In years past the challenge has been that UB-04 and 1500 claim forms were adjudicated by completely different computer systems. In some cases the Fiscal Intermediary and Carrier were even separate organization that contracted with CMS. Now that we have gone to regional MACs, this particular issue can be addressed.

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 November 13th - ***"Understanding the CMS 855-A Enrollment for Hospitals"*** will run from 1:00 p.m. to 2:30 p.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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FOR UPCOMING ISSUES

****** 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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