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

You should submit your comments to CMS concerning any issues surrounding the proposed changes for CY2009. We will now have to await the final Federal Register entry that should appear close to November 1st. This year the timetable for issuing the final rule on time appears to be reasonably good.

RAC Audit Issues – Part 5

In Part 5 we will divert momentarily from possible RAC audit issues in order to discuss developing the needed organizational infrastructure to meet possible demands by the RAC auditors.

The biggest difference between the more traditional Medicare, OIG and DOJ audits versus the RAC audits is that virtually every hospital and most clinics will be subjected to scrutiny. In the past if a hospital had an audit, the request for records and associated itemized statements and claim forms was viewed as episodic special project. Also, any recoupment and appeal processes would have been focused to a particular issue and/or audit.

With the RAC audits there may be multiple requests for documentation, and there may be a need to use the appeal process repeatedly. There may also be multiple recoupment efforts so that financial preparation and tracking is also necessary.

Let us discuss a case study at the fictitious Apex Medical Center.

> Case Study: The Apex Medical Center has just received another request from the RAC auditors. This time one-hundred and twenty cases (120) have been requested. Short stay inpatient admissions are the topic of interest. This is the third batch of such claims that has been requested surrounding this inpatient versus observation issue. Medical records personnel along with patient financial services personnel seem to be spending more time providing documentation than doing their regular jobs!

The extent to which your hospital will be impacted by requests of this type is difficult to gauge. However, considering the possible financial impact, your hospital will need to consider how to respond to such requests. Also, you will need to track the cases, make decisions on what is to be appealed and to what level the appeals are to be taken. Much of this activity can be performed internally, but some consideration will need to be given to utilizing outside resources.

Note: We are addressing only the infrastructure to respond to requests and then to track activities. You should also consider the substantive issues of whether or not you are at risk relative to the many RAC audit issues that we have discussed in previous articles.

In view that resources, possibly significant resources, are going to be consumed, someone or some department in the hospital should be assigned responsibility to handle requests and to then track and address cases relative to possible recoupment. While this assignment will vary, a logical place is with the compliance department and/or with compliance personnel.

Because different departments will be involved in addressing RAC auditor demands and then the RAC audit issues themselves, the assignment of coordination should be placed at a level where there is a comprehensive overview and reasonable authority to get the job done.

Since there can be numerous, possibly hundreds of cases, you will also need to establish some sort of tracking mechanism. For instance, you will want to identify each case, the issue being addressed, whether the case is to be appealed, the financial risk, and resources consumed relative to the case (particularly if external resources are being utilized). If the case is appealed, you will want to track the appeal process, which could become lengthy.

In many cases you can probably use MS Excel or MS Access to set up your tracking data base. Commercial software to use pre-established, specially designed software will probably become available as well.

Many of the RAC audit issues that we have discussed in these articles involve ***subjective judgment***. This is particularly true with medical necessity. For instance, we have discussed short-stay inpatient admissions that should have been observation, and also, the issue of a 3-day inpatient stays prior to skilled nursing placement.

Given that you are trying to retain payments already made, you will need to carefully consider appealing all or at least select cases. A moment's reflection will indicate that to appeal a case will require someone internally to carefully review the case, and the associated documentation and then develop justification for an appeal.

The appeal process is convoluted and can become quite lengthy. Here are the main steps in the process. Obviously, you may choose to discontinue at any step in the process.

- Rebuttal – 15-30 Days to File a Rebuttal with the RAC
- Redetermination – 120 Days to File an Appeal with the MAC (FI or Carrier or DMERC)
- Reconsideration – 180 Days to File an Appeal with the Qualified Independent Contractor
- Administrative Law Judge (ALJ) – 60 Days to File an Appeal with the Office of Medicare Hearings and Appeals
- Medicare Appeals Council/Departmental Appeals Board – 60 Days to File an Appeal
- Federal District Court – 60 Days to File an Appeal in Federal District Court

As you can see, pursuing the appeal process to the limit will be extremely time consuming and, at the latter stages, expensive due to legal representation. However, if you are looking at millions of dollars in recoupment relative to subjective medical necessity decisions, the appeals process may be appropriate.

Note that there are circumstances in which coding and/or other billing errors will be discovered by the RAC auditors. Some of these mistakes will be episodic in nature and will result in minimal recoupment. However, you may find that some errors are systematic in nature. For instance, you may be inadvertently double coding services by having professional coding staff developing a code that is also being generated through the chargemaster. The code appears twice when it should only appear once. In cases of this type, the recoupment of the overpayment is justified, and the appeals process will not have to be pursued.

Bottom-Line: Because of the pervasive nature of the RAC audits and the concentration on hospital services, hospitals will need to carefully develop an infrastructure to deal with:

- Demands for Documentation – Medical Records, Claims and Itemized Statement,
- Tracking Cases,
- Assessing The Validity of RAC Auditor Determinations,
- Determining and Tracking Cases That Are To Be Appealed At Different Levels,
- Assessing and Tracking Internal and External Resource Utilization,
- Assessing and Tracking Financial Implications of These Activities.

Note: The Medicare Program is not the only third-party payer involved in these types of activities. You may well find your other major private third-party payers performing similar audits and making requests for documentation and then demanding repayment. Thus, the development of this type of organizational infrastructure may be useful in other situations as well.

DRG Pre-Admission Window

The DRG Pre-Admission Window continues to generate many questions. This brief article discusses this rule and provides the necessary references so that our readers can access the pertinent resources directly. There has been a recent update through Transmittal 1429 to Publication 100-04, Medicare Claims Processing Manual. This transmittal was issued on February 1, 2008. As we will discuss below, this transmittal does not change any aspect of the rule itself. What is changed is the processing of claims relative to the DRG Pre-Admission Window.

Here are the four main references with two additional references for completeness:

1. February 11, 1998 Federal Register pages 6864-6869 (63 FR 6864-6869);
2. 42 CFR §412.2;
3. 42 CFR §413.40;
4. PM A-03-013, February 14, 2003.
5. PM A-03-008,
6. PM A-03-54.

The intent of the DRG Pre-Admission Window is that certain outpatient services, if performed at a hospital owned or operated facility, within three dates of service of an admission to the hospital are paid through the DRG payment process. Note that this is a payment issue that quickly becomes a billing issue because CMS wants us to alter our billing process.

There are two types of services that are considered within this window:

a. Diagnostic, and
b. Non-Diagnostic or Therapeutic.

All diagnostic services provided on an outpatient basis within the window are to be included on the inpatient claim. There is no consideration as to whether the diagnostic services are associated with the reason for the inpatient admission.

Only certain therapeutic services are to be bundled. The services that are bundled are to be related to the inpatient admission. CMS has gone further to give us a fairly precise definition of *related*. From PM A-03-013:

> *In the February 11, 1998, final rule (63 FR 6864), we made several refinements to the 3-day payment window provisions. Effective March 13, 1998, we defined non-diagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay.*

This statement begs the question of what is meant by *principal diagnosis* for outpatient services. On the outpatient side we generally refer to the *primary diagnosis*, that is the first listed diagnosis on the UB-04, that is, in the principal diagnosis form locator. Circumstances on the 1500 claim form differ even more because the first diagnosis can be different for each line item.

While the intent is reasonably clear, hospitals can have operational difficulties in deciding when to include therapeutic services on the inpatient claim versus billing separately on the UB-04 and/or 1500 claim form.

Note: The ***trigger*** for the DRG Pre-Admission Window is that the outpatient services are provided at a facility that is wholly owned or operated by the hospital. This certainly includes provider-based clinics in which both a UB-04 and 1500 claim form can be filed. However, it also applies to freestanding clinics, owned or operated by the hospital, that file only a 1500 claim form.

Case Study – The Apex Medical Center owns and operates the Acme Medical Clinic. The clinic is about 20 miles from the hospital. The clinic has a physician office laboratory (POL) and x-ray equipment. If a patient has diagnostic services at Acme and is then admitted to Apex within the 3-day window, these diagnostic services are to be included on the hospital's inpatient billing on the UB-04.

Is it possible that Apex is not including these diagnostic services? Who would notice if this were happening?

Hospital billing personnel may have no way to know that these diagnostic (or related therapeutic) services were even provided at Acme. Because Acme's services are filed on a 1500 claim form to the Part B Carrier, the Carrier will not know that there was an associated inpatient claim submitted to the Part A Fiscal Intermediary. Thus, the answer to the second question is that nobody will notice that this is happening. The exception would be if auditors were to explicitly match up clinic and hospital claims.

For the most part, hospital billing personnel will look for hospital outpatient services that are within the window. Even in looking for such services, there has been a tendency to simply put all the outpatient services, diagnostic and therapeutic, on the inpatient claim. This is certainly a safe approach for compliances purposes.

Because CMS is moving to regional MACs (Medicare Administrative Contractors), the MAC will have the ability not only to aggregate hospital outpatient and inpatient claims, they will also have the ability to aggregate 1500 claims with associated outpatient and inpatient claims.

Transmittal 1429 is a first step in this process. While this transmittal addresses only hospital outpatient claims relative to associated inpatient claims (i.e., not associated 1500 claims), the enforcement of the DRG Pre-Admission Window is tightening significantly.

Transmittal 1429 has the following two, almost identical statements:

> *Effective for dates of service on or after July 1, 2008, CWF will reject **diagnostic services** when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.*

> *Effective for dates of service on or after July 1, 2008, CWF will reject **therapeutic services** when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.*

Exactly how the MACs will implement these new requirements should be watched carefully. The intent is clear: CMS wants diagnostic and therapeutic services to be correctly billed within the specifications of the rule. In

many cases, hospitals will be forced to review rejected claims, correct claims as necessary and then refile.

Also in Transmittal 1429, CMS has added new Revenue Codes to the list of diagnostic services. Additionally, CMS is now including specific CPT codes in the listing (see MCPM, Chapter 3, Section 40.3 – Outpatient Services Treated as Inpatient Services). Diagnostic cardiac catheterizations under RC=0481 or 0489 with the following codes:

93501 93503 93505 93508 93510 93526
93541 93542 93543 93544 93556 93561
93562

These are the diagnostic coronary catheterizations. Clearly, if a patient has a diagnostic catheterization on an outpatient basis and is then admitted to the hospital for any reason (remember all diagnostic services must be moved to the inpatient billing), the coronary cardiac services must be included on the inpatient claim.

Note that some of the situations involving the DRG Pre-Admission Window can become quite complex. Also, the OIG has recommended that this window be increased to 14 days. In some states, certain Medicaid programs have also instituted a 3-day post-discharge window. Given CMS's propensity to implement any rules that will save the Medicare program money, there may be further action in this area. As usual, standby!!

EMTALA – The Continuing Saga – Part 2

We will continue our discussions concerning recent changes that have occurred to EMTALA – the Emergency Medical and Labor Act. In the first article, we discussed two major changes: transfers relative to specialty hospital services and community on-call plans.

Here some other changes that have occurred over the past several years. Note that many of these changes continue to address difficult areas under EMTALA.

Determination of False Labor – The definition of 'labor' has been revised at 42 CFR §489.24(b) to allow not only physicians and practitioners to determine false labor, but also to allow other 'qualified medical persons'. At issue is the propriety of obstetric nursing staff to determine that a pregnant lady is not truly in labor.

This is the same issue surrounding ED nursing staff being allowed to perform the medical screening examination to determine if an emergency medical condition exists.

Basically, CMS is taking the stance that if the nurse is qualified by state law for proper scope of practice and if the hospital's Medical Staff Organization accepts the nurse as being qualified, then the nurses can perform such determinations under EMTALA.

Note:

1. Procedurally, it is recommended that any nursing staff that is to be so qualified must be specifically named through the Medical Staff Organization;
2. CMS, in the EMTALA discussions, does not indicate how such services are to be billed.

See Survey and Certification Letter S&C–06–32 issued on September 29, 2006 for further information.

Arrive By Ambulance – The issue is when a hospital's EMTALA obligations actually start. If a patient presents by ambulance but the patient is not moved from the stretcher to an ED bed, has the hospital delayed the starting time for EMTALA? The answer in the Interpretive Guidelines is a definitive "no".

Additionally, if an individual is brought by emergency medical services and the hospital's ED physicians are occupied with other cases, then the individual must still be triaged to determine the priority of receiving care when it is available.

See Survey and Certification Letter S&C–07–20, issued on April 27, 2007 for further information.

Refuse Transfer by Ambulance – A receiving hospital may want to refuse a transfer based on the method in which the individual is being transferred. While this type of issue involves medical decision making, there appear to be situations in which the receiving hospital wants to specify the specific ambulance company that is to be used.

See Survey and Certification Letter S&C–07–20, issued on April 27, 2007 for further information.

Telehealth/Telemedicine – On-Call Physician -

The Interpretive Guidelines now discuss situations in which a consulting physician may be accessed by telecommunications. However, it is still the treating physician or practitioner that must make the decision concerning requesting an on-call physician to come to provide services.

See also the Survey and Certification Letter S&C–07–23, issued on June 22, 2007 for further information.

While EMTALA is conceptually simple (i.e., if an individual presents you assess and provide services as appropriate), in practice there are dozens of difficult

issues many of which have significant compliance overtones.

Questions from Our Readers

Question: Should we be using the "-JW" modifier on all drug units that are discarded?

According to Chapter 17, §40, Discarded Drugs and Biologics, the "-JW" modifier is to be used only on single use vials for which some portion of the drug must be discarded. Typically, the drug or biologic involved has a limited time period in which to be used. Note that the phrase *single use* can be a little misleading. The contents of the vial can be used on multiple patients (depending on the drug, of course!). The single use is referring to the limited time period once the vial is opened and/or some sort of compounding of the drug occurs.

Here is the main statement from this section of the Medicare Claims Processing Manual:

> "*When processing all drugs … local contractors may require the use of the modifier JW to identify unused drug or biological from single use vials or single use packages that are appropriately discarded. This modifier will provide payment for the discarded drug or biological."*

For example, you may dispense a drug that comes in a 100 ml vial. Once the vial is opened, the drug must be used within 10 hours. One patient receives 30 ml and a second patient receives 50 ml. The remaining 20 ml are discarded. Assume that the HCPCS code unit is 10 ml. The first patient will be charged 3 units, but the second patient will be charged for 7 units even though the documentation will show that only 5 units were administered.

While this is conceptually straightforward, compliance issues immediately arise. What kind of documentation requirements are there relative to discarding the drug and the amount discarded? What if the first patient is a Medicare patient, the second patient is not Medicare, and there is no payment for the discarded drug with the second patient? Is it appropriate to charge the Medicare patient for the discarded drug even though they were not the last subsequent patient on whom the drug was used?

Also, be certain to follow your MACs directives in this area. Note that CMS used the phrase "… *may require the use of the modifier JW…"* with the operative word being *may*. Be certain that you have clear guidance from your MAC (FI or Carrier) before using this modifier.

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 October 14th, "***Developing CBR Policies and Procedures***". 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 is 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**
- **Chargemaster Coordinator's Handbook** is currently in preparation.

A 20% discount is available from HCPro for clients of Abbey & Abbey, Consultants.

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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.

Interventional Radiology, Catheterization Laboratory and Vascular Laboratory a Challenge? Special studies are being provided to assist hospitals in coding, billing and establishing the Charge master. 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 preparing for the RAC audits? Contact Mary Wall or Chris Smith at 515-232-6420 for more information and scheduling.