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Medical Reimbursement Newsletter

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

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APC/APG Update

The comment deadlines for the APC update *Federal Register* and the update for MPFS are now past. The next major event should occur on or about November 1st. CMS was basically ahead of schedule for the proposed changes for APCs and MPFS, so we may be pleasantly surprised this year by having the final changes even before November 1st. Stand-by!

Medicare Enrollment – CMS Form 855s New PDF Formatted Form 855s

Dated July 1, 2011 CMS has released yet another revision of the CMS-855 forms. These new forms were placed on the CMS website with virtually no fanfare or announcement.

There are two items to note:

1. The new forms are not only in Adobe Acrobat format. They are now interactive, and
2. There are some changes for the different forms.

Also, there is a new form, namely the CMS-855-O, which is addressed in a related article in this Newsletter.

One of the challenges with the paper CMS 855 forms is how to fill them out so that they are legible. While PECOS (Provider Enrollment, Chain and Ownership System) can be used in certain circumstances, there is still an on-going need to use the paper format. Thus, there are now three options:

- Handwritten – Neatly of course!
- Typewritten – Pull out your old IBM Selectric III.
- Printed – Use the interactive PDF format.

There are advantages and disadvantages to all of these. If possible, use PECOS for simple updating and the shorter 855 forms (i.e., 855-R, 855-O). Be certain to keep copies of everything!

One of the challenges with the CMS 855 forms is that sometimes certain sections and/or pages must be repeated. If you are developing these by hand or by typewriter this is not too much of a burden, you simply copy the necessary page or pages of the forms and fill them out. With interactive PDF it is more difficult to replicate a page as such. You can fill out one page electronically, print it out and then enter new data over the old and print that out. Basically, it will be difficult to have a complete electronic record if you have to repeat certain pages.

In some cases you also have to submit additional documentation in the form of attachments. Overall, manually submitting these forms whether handwritten, typewritten or printed from the interactive PDF has some advantages. Although as feasible, the electronic format of PECOS should be used.

One of the unanswered questions at this point, is when do these new forms go into effect. Because the forms are available, they can certainly be used. Providers and suppliers should use the new forms as quickly as possible because there are increased informational requirements. The real question is, when will the old forms cease to be acceptable? Anticipate that CMS will give us some guidance in this area in the coming months.

Because of formatting changes, the new CMS 855 forms are somewhat longer. Of greater interest is the new, additional information that is now being requested particularly for the CMS 855-A.

CMS Form 855-A – Section 6001 of the Affordable Care Act (ACA 2010) addresses physician ownership of hospitals. There is a new question in Section II-A-4 that addresses physician ownership. If there is physician ownership, which includes physician family members[1], then Attachment 1 must be completed. There are two parts to Attachment 1, one for organizations that have any ownership interest and one for individuals that have any ownership interest. For hospitals that have

[1] This type of language is found in the Stark law.

physician ownership, this new requirement can be a significant burden.

Hospitals must now indicate their year-end cost report date in Section 2B. Organizations and individuals that have ownership or managing control must report their exact percentage of ownership in either Section 5 or Section 6. Likewise, organizations with ownership or managing control must indicate the type of organization, such as, medical staffing company, holding company, etc. If there are any sorts of contracted services, then this must be reported in Section 5 and/or 6 as appropriate.

Finally, in Section 17, the MACs may request, at any time during the enrollment process, additional documentation going beyond that listed in Section 17.

CMS Form 855-B, 855-I, 855-S – There are fewer changes with these forms. Suppliers must be identified as for-profit versus not-for-profit. Accreditation of IDTFs (Independent Diagnostic Testing Facilities) that perform advanced diagnostic imaging services is required. Also, the place and country of birth for individuals that have an ownership interest or management control in the supplier is required.

Editor's Note: See the related article on the new CMS-855-O.

Medicare Enrollment – CMS Form 855s
The Revalidation Process

Over the past several years the 5-year revalidation process has been taking place. CMS and the MACs have concentrated on any suppliers and providers that have not filed a CMS-855 since 2003. Now Section 6401a of the ACA - 2010 requires that such revalidations involve screening for different levels of risk to the Medicare program.

The levels are:

- Limited,
- Moderate, or
- High.

The 'High' category includes newly enrolling home health agencies (HHAs) and DME suppliers. The 'Moderate' category includes hospice, revalidating HHAs and DME suppliers along with Mental Health Centers and Independent Clinical Laboratories. Most providers and suppliers will come under the 'Limited' category. While there are additional requirements for the 'Moderate' and 'High' categories, one of the requirements is an on-site visit. Very little has been heard concerning on-site visits as part of the revalidation process.

Another interesting feature of this new or renewed revalidation process is that for institutional providers, there is now a fee! For 2011 the fee is $505.00. This will be changed annually by a cost of living adjustment.

The starting point for this new revalidation effort is March 2011. By March 2013 everyone should have at least started the revalidation process.

Medicare Enrollment – CMS Form 855s
The New CMS Form 855-O

There is now a new CMS Form 855, namely the 855-O. The "O" apparently represents "Other". This particular form fills a rather large gap in the world of NPIs (National Provider Identifiers) and proper billing. We now have six different CMS-855 forms.

- CMS-855-A – Hospitals
- CMS-955-B – Clinics
- CMS-855-I – Individuals
- CMS-855-O – Other
- CMS-855-R – Reassignment
- CMS-855-S - DME

Over the past several years CMS has indicated that providers and suppliers should start reporting the ordering or referring physician/practitioner. These edits have not been turned on because there are many physician and practitioners who can legally order services, but who are not enrolled in the Medicare program. This means that they are not billing Medicare for services provided. These physicians and practitioners can order services. Thus, the provider of the ordered services must report the appropriate NPI, and the physician or practitioner must be recognized by CMS.

We will consider several different examples. The first example we will consider is the class of physicians and now practitioners who can affirmatively opt-out of the Medicare program. The opting-out process is a formal process of filing an attestation with Medicare. The attestation must be updated annually. Often these physicians and practitioners only see Medicare patients under private contract, and no billing is made to Medicare.

However, opt-out physicians/practitioners can still provide emergent and urgent care[2] services to Medicare beneficiaries and bill the Medicare program. Also, in theory they could be ordering or referring physicians. Thus, the Medicare Carrier or MAC (Medicare

[2] This is the whole reason that CMS had to define what constitutes *urgent care* using a 12-hour rule.

Administrative Contractor) would still need to know about these opt-out physicians and practitioners.

Opt-out physicians and practitioners would use the CMS-855-O only if they will never be billing the Medicare program. They may still order and refer so that the entity providing the ordered or referred services would need to report the physician's or practitioner's NPI and have it recognized by Medicare.

The issuance of the CMS 855-O updates the cumbersome process from Transmittal 328 to Publication 100-08, Program Integrity Manual, dated March 19, 2010. Up to the point of having the CMS-855-O, CMS has indicated that the CMS-855-I can be used with certain limited information being provided. The availability of the CMS-855-O should certainly make this process much easier. This, in turn, should help with the backlog that CMS has indicated relative to getting PECOS totally up-to-date.

Who should use the CMS-855-O? Here is the list:

- Doctor of medicine or osteopathy
- Doctor of dental medicine
- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife
- Clinical social worker[3]

Typically, these individuals would be employed by some institution, such as, a Veteran's Administration Hospital or possibly a cost-based reimbursed Critical Access Hospital, and there would be no direct claims filed with the Medicare program. Although such an individual might order services, such as, laboratory or diagnostic radiology, which in turn might be separately billed to Medicare. Thus, the ordering physician/practitioner would need to be listed on the claim.

One reason this might occur in cost-based reimbursement systems is that the cost of the physician or practitioner, when there is no professional billing to Medicare, can be included in the cost report. Eventually payment would occur through the cost reconciliation.

Thus the institutional situations in which this might occur include:

- Department of Veterans Affairs (DVA),
- Public Health Services (PHS),
- Department of Defense (DOD) TRICARE,
- Indian Health Services (HIS),
- FQHCs and RHCs
- Critical Access Hospitals (CAHs),
- Dentists,
- Licensed Residents and Fellowship Physicians,
- Pediatrician.

[3] Note that Chiropractors are not included. Chiropractors can only perform and/or order a limited range of services.

PECOS – Ordering/Referring

Confusion has resulted from anticipated CMS requirements that claims must contain information concerning ordering or referring physicians and practitioners. The new CMS-855-O has been developed partially to address this situation.

However, there are physicians and practitioners who are fully enrolled in the Medicare program but are not yet in PECOS. Consequently, hospitals and other institutional providers are placed in the position of identifying which of their possible ordering or referring physicians are or are not in PECOS.

You can determine (to some degree of certainty) if a provider or supplier is in PECOS by downloading a rather large file from the following CMS website:

https://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp.

CMS is indicating there is a backlog that is still being processed. Apparently this is delaying the date on which the edits can be turned on. At this point CMS is indicating that there is no specific date for turning on the edits. This whole situation has been in flux over the last several years.

While the CMS requirement is not unreasonable, the full implementation of PECOS is taking longer than was anticipated. The actual date on which the edits will be established most likely will not occur until at least January 1, 2012, if even then.

In the meantime, hospitals should work diligently to identify any possible ordering or referring physicians/practitioners that are not in PECOS. These physician and practitioners should be encouraged to get into PECOS. In some cases you may discover that the physician or practitioner has already taken steps to get into PECOS, and they are part of the backlog that needs processing.

Ambiguous Guidance from CMS: Technical Component E/M Coding – Part 3

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?

We have some history in this area. Most of the investigations have involved physician E/M levels and physician use of the "-25" modifier. These investigations have been conducted by government auditors such as the OIG and Medicare contractors.

On the hospital side, there has been limited activity. Over the past several years, the DOJ has conducted some audits in Western Pennsylvania relative to the improper use of the "-25" modifier. These studies concentrated on the use of the "-25" modifier in the ED with some consideration for provider-based clinics.

The findings from these audits show that hospitals are inappropriately using the "-25" modifier on the technical component side, that is, with the E/M levels. Unfortunately, the auditors are using a physician coding guideline from the NCCI Policy Manual. Here is the language from Version 16.3, chapter I, and Page 11:

> ***"If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles."***

Now the NCCI policy manual indicates that all of the guidelines come over to the hospital side. With the discussion in this paragraph there are two significant problems:

i. There is no global surgical package under APCs other than services provided on the same date of service as the surgical procedure, and
ii. There is no definition of a ***minor surgical procedure*** in APCs.

Thus, this guideline is essentially meaningless under APCs. However, there is a tendency on the part of the auditors to take this physician concept and apply to the hospital side as well. Let us consider an example in the ED.

> **Case Study 1** – ***Laceration Presentation in the ED*** – Steve, a resident of Anywhere, USA was washing his car when he suffered a laceration on the right arm from the windshield wiper blade. He is presenting for a laceration repair. The ER physician performs a general medical screening examination (MSE) and then repairs the laceration.

The laceration repair, on the professional side, is a minor surgical procedure, and the NCCI policy manual indicates that there should be no E/M level, at least on the professional side. However, under EMTALA (Emergency Medical Treatment and Labor Act), the hospital is required to have an MSE performed by a qualified medical person, in this case the ER physician.

Now we have to make two different decisions, that is, should there be an E/M level with the "-25" modifier on the professional side, and should there be an E/M level with the "-25" modifier on the technical side?

On the technical side there is no definition of a minor surgical procedure, so the NCCI policy guideline does not appear to apply. With the EMTALA requirement, there is a good argument for having a technical component E/M level with the "-25" modifier along with the laceration repair.

Even on the professional side, the facts as listed in Case Study 1 would still support an E/M level on the physician side because a general MSE was performed by the ER physician.

Let us change this little case study slightly.

> **Case Study 2** – ***Laceration Presentation in the ED*** – Steve presents with a small laceration on the right arm suffered while washing his car. The ER nurse encounters Steve and performs a thorough assessment. Steve has no other presenting symptoms, and the nurse determines this is not an emergency although the laceration needs repair on an urgent basis. The nurse thoroughly cleanses the

wound, and obtains a suture tray and the ER physician repairs the laceration using skin adhesives.

Now in Case 2, the MSE was performed by the ER nurse. We will assume that the ER nurse has been qualified by medical staff to perform the MSEs in these kinds of non-emergent situations. On the professional side, the ER physician's activity involves only the laceration repair, so there will not be a professional E/M code.

However, there was still an MSE performed on the hospital side, in this case by the nurse. Thus, there will be an E/M level on the technical component side with a "-25" modifier along with the laceration repair code.

Note: In both of these case studies, we will assume that there is appropriate documentation on the part of both the hospital and the ER physician.

Let us look at example with a provider-based clinic.

Case Study 3 – ***Scheduled Vitamin Injection*** – Sarah is presenting to the Acme Medical Clinic, a provider-based clinic associated with the Apex Medical Center. Sarah is presenting for a periodic vitamin injection, but she has not been seen at the clinic for more than a month. The nurse performs a thorough assessment, including an interval history to determine if Sarah is appropriate for the injection. The assessment does not contraindicate the injection, so the injection is provided.

At issue in Case Study 3 is whether or not the nursing assessment goes above and beyond the normal services provided in conjunction with an injection. If the services are above and beyond the normal, then a technical component E/M is appropriate and the "-25" modifier will be needed. Of course, a great deal depends upon the documentation, and nursing staff should be encouraged to document such cases with great care.

These little case studies are just the tip of the iceberg. There are many more situations involving questions about the use or non-use of the "-25" modifier. CMS needs to provide significantly more guidance in this area. The only guidance was provided in 2000 and 2001. Even this guidance was brief. In the meantime, hospitals must prepare for the RACs even in light of ambiguous guidance.

Editor's Note: In Part 4 of this article we will continue this discussion by examining the anticipated auditing and extrapolation process.

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 September 27th "***The Medicare Secondary Payer Program***" 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.

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