

## Medical Reimbursement Newsletter

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

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### APC/APG Update

Hopefully you have submitted your comments concerning the proposed changes for CY2013. While the APC Federal Register entry was shorter than normal, there are certainly some significant changes that are proposed. We will all need to wait patiently until November 1<sup>st</sup> to see just what changes are being implemented.

### Proposed APC Changes for CY2013

CMS has proposed to pay the Average Sales Price (ASP) plus 6% for separately payable drugs. This is basically a 2% increase. Inexpensive drugs are bundled for APCs. The cost threshold for bundling pharmacy items has risen steadily in the past several years, and CMS is proposing \$80.00 as the threshold for CY2013.

If the increase to ASP+6% becomes final, then this will be of significant benefit to hospitals. This increase will also help to address the pharmacy overhead questions relative to charges and cost reporting.

In Section XI of the July 30<sup>th</sup> Federal Register, CMS solicits comments relative to the outpatient versus inpatient status. Ostensibly, the outpatient status involves observation so this is really the whole issue of short-stay inpatient admissions that are recognized as observation stays after the fact. Often, the RAC and MAC audits find that the short inpatient stays are not medically necessary and the hospitals are left to their own devices possibly to bill for outpatient services, but certainly not for observation through Condition Code 44.

At issue is the payment system interface between MS-DRGs (the inpatient admission) and APCs (outpatient observation). CMS does a nice job of summarizing how inconsistent the two different payment methodologies are for a short stay. From page 45156:

*“For instance, if a beneficiary is admitted as an inpatient, the beneficiary pays a one-time deductible*

*for all hospital services provided during the first 60 days in the hospital. As a hospital inpatient, the beneficiary would not pay for self-administered drugs or have any copayments for the first 60 days; whereas if the beneficiary is treated as an outpatient, the beneficiary has a copayment for each individual outpatient hospital service. While the Medicare copayment for a single outpatient hospital service cannot be more than the inpatient hospital deductible, the beneficiary’s total copayment for all outpatient services may be more than the inpatient hospital deductible. In addition, usually self-administered drugs provided in an outpatient setting are not covered by Medicare Part B and hospitals may charge the beneficiary for them. Also, the time spent in the hospital as an outpatient is not counted towards the 3- day qualifying inpatient stay that the law requires for Medicare Part A coverage of postacute care in a SNF (section 1861(i) of the Act).”*

From CMS’s summarization, the way that inpatient payment interfaces to outpatient payment is ragged and somewhat haphazard. In theory if a patient has a medical condition that will take 24 to 48 hours to diagnosis and possibly resolve, then there should be a modest difference in payment between the outpatient observation and an inpatient admission. In reality, the difference in payment may well run into the thousands of dollars.

Note that MS-DRGs and APCs, as payment systems, have been developed quite differently under very different legislative direction. Thus, there should be little surprise that the two payment systems will pay differently for similar services.

Given the fact that many, if not most, CMS auditing activities involve inpatient stays that are not medically necessary, this issue of inpatient versus outpatient status is quite timely. While there are many suggestions that can be made, one fairly simple change is for CMS to accept the NUBC definition for use of Condition Code 44. With the NUBC definition, hospitals would have time to review cases, determine if the inpatient admission

was justified and, as appropriate, bill for the care on an outpatient basis.

Another step that CMS can take is to formally adopt standards for inpatient admissions. If CMS were to officially adopt the InterQual and/or Milliman and/or any other standards, then hospitals and auditors would have guidelines on whether an inpatient admission was justified. Without formal inpatient criteria for hospitals and auditors to use, we will continue to address subjective moving targets relative to inpatient admissions.

Another suggestion is to allow physicians to more liberally use outpatient observation for one or two days and then, if appropriate, switch to inpatient status. The time spent in observation should then be allocated to the inpatient stay. Thus, any qualifying stays to meet coverage requirements for skilled nursing can be handled.

No matter what changes CMS makes, a focal point in this overall discussion is the proper definition and instructions for using Condition Code 44. At the very least CMS is asking for public input on a rather complicated issue. With the time necessary to cycle through the national public rulemaking process, do not expect any immediate changes.

## CMS Ramps up Prepayment Activities

CMS is engaging in multiple projects involving prepayment audits and associated activities. Currently, there are three different approaches that CMS is using.

1. RAC Prepayment Demonstration Project,
2. MAC Prepayment Programs, and
3. Prepayment Analytics.

The third project involves developing predictive models that will identify patterns of possible fraud and abuse. Then auditors can hone in on those issues for further investigation. See the update article in the April issue of this Newsletter, Volume 24, Number 4, Pages 19-20, for further information.

The RAC Prepayment Demonstration was scheduled to start on January 1, 2012. There were delays, and the project started on August 27, 2012. On August 9<sup>th</sup> there was an Special Open Door Forum to discuss how the demonstration is to move forward. This is a three year demonstration project that will, with little doubt, be extended to all hospitals nationwide in the future.

There are eleven states involved, namely, seven states with high fraud activity (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volume of short inpatient

stays (PA, OH, NC, MO). While a 100% review of specific issues may be the ultimate goal, at first there is a single DRG, namely MS-DRG 312, Syncope and Collapse. Inpatient admissions of two days or less will be targeted. Note that the selection of cases will be made by CMS, and at first a limited percentage of cases will be identified.

**Note:** This is an issue oriented auditing process, not a hospital based auditing process. We are all accustomed to use the terminology such as “a 100% prepayment review” relative to a specific hospital not a specific issue ranging over all hospitals.

In the coming months, the following issues will also be added to the list:

- ✓ MS-DRG 069, transient ischemia and MS-DRG 377, gastrointestinal (GI) hemorrhage with MCC
- ✓ MS-DRG 378, GI hemorrhage with CC and MS-DRG 379, hemorrhage without a CC or MCC
- ✓ MS-DRG 637, diabetes with MCC, MS-DRG 638, diabetes with CC, and MS-DRG 639, diabetes without a CC or MCC

This prepayment program is truly integrated into the current RAC activities. In theory hospitals will not have to exceed their normal 45-day limits of providing records. The RAC reviews that are made are certainly complex reviews and none of these activities relate well to automated reviews.

The RAC will receive their contracted contingency fees on these cases just as they do on other cases. The same appeal processes are in place. The main difference is that payment will be withheld as opposed to recoupment of payments.

The main issue is the medical necessity of an inpatient stay versus an observation stay or even just treating the patient on an outpatient basis.

**Case Study #1 – Fainting Spell** - In the mid-afternoon Sarah was using her speed walker to go to the grocery store that is about three blocks away from her home. She became light-headed and fainted. A neighbor brought her and her speed walker to the ED. Sarah is assessed and her attending physician is called. After a preliminary workup her physician decides to admit her as an inpatient for further tests. The tests were generally inconclusive and it appears that there was a slight electrolytic imbalance that caused a brief episode of hypotension. She is discharged from the hospital in the afternoon.

The auditing issue is whether or not Sarah really needed to be admitted as an inpatient. Based on the overall case, that is, retrospectively, an inpatient admission was

not really necessary. Observation would have been more than enough. However, the physician had to make a decision prospectively based on the best information available. In cases like this, hopefully utilization review personnel can become involved before the patient's discharge and make appropriate changes in the patient's status.

Second on our list of increased prepayment activities are the MAC Prepayment audits. Currently, these activities appear limited and are occurring mainly in Florida.<sup>1</sup> There are two main areas of focus:

- Cardiovascular, and
- Orthopedic.

The cardiovascular MS-DRGs of interest are:

- MS-DRG 226 – Cardiac Defibrillator Implant w/o cardiac catheter with MCC
- MS-DRG 227 – Cardiac Defibrillator Implant w/o cardiac catheter w/o MCC
- MS-DRG 245 – Automatic implantable cardiac defibrillator generator procedures
- MS-DRG 247 – Percutaneous cardiovascular procedure with drug eluting stent w/o MCC
- MS-DRG 251 – Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC
- MS-DRG 287 – Circulatory disorders except acute myocardial infarction with cardiac catheter w/o MCC
- MS-DRG 242 – Permanent cardiac pacemaker implant with MCC
- MS-DRG 243 – Permanent cardiac pacemaker implant w/o CC
- MS-DRG 244 – Permanent cardiac pacemaker implant w/o CC or MCC
- MS-DRG 253 – Other vascular procedure with CC
- MS-DRG 264 – Other circulatory system OR Procedure

On the orthopedic side, we have:

- MS-DRG 458 – Spinal fusion except cervical w/spinal curve, malign, or 9+ fusions w/o CC
- MS-DRG 460 – Spinal fusion except cervical w/o MCC
- MS-DRG 470 – Major joint replacement or reattachment of lower extremity w/o MCC
- MS-DRG 490 – Back and neck procedures except spinal fusion w/CC/MCC or disc device/neurostimulator

MS-DRG 470 is almost taking on a life of its own, particularly with procedures like knee replacements. Medical necessity for a knee replacement must be provided. This should include previous, more conservative measures that have been taken, possibly by different physicians, to treat the knee problem.

The MAC prepayment activities differ from the RAC prepayment audits in that physicians are included relative to payment. While the hospital's payment is held, the physician is paid but may then be subject to a take-back provision depending on whether the case meets medical necessity criteria.

## Non-Covered Services – Private Rooms

The Medicare program has a number of non-covered services or items. Some of which become problematic for proper billing. For instance, here are two examples:

1. Self-administrable Drugs – For Medicare outpatient services, drugs that are self-administrable, including some injections, are not covered by Medicare. Thus the provider, typically a hospital, must bill the beneficiary separately for these pharmacy items. Because of the consternation created by billing for these self-administrable drugs, some hospitals have opted to not charge for these items. While this raises the specter of possible allegations of inducements (i.e., giving away free drugs), this does not appear as an overriding compliance issue.
2. Error Correcting IOLs – When cataract surgery is performed an IOL is typically inserted. There has been significant progress relative to IOLs (Intraocular Lenses). These lenses can now correct conditions such as astigmatism and myopia. However, historically the Medicare program has not covered error correcting lenses of any sort. Thus Medicare covers the base IOL and then the beneficiary must pay for the non-covered error correcting portion of the IOL. Because there are significant costs involved, hospital do charge the beneficiary for the non-covered part of the IOL.

On August 30, 2012, Novitas Solutions issued a brief Provider Bulletin on private room billing. The Medicare program pays for the use of a semi-private room. Private rooms are paid only if there is a medical reason why the patient must be isolated.

Actually the use of the word 'pay' in the above paragraph is a little misleading. Payment is through MS-DRGs, thus all room accommodations are paid the same amount.

<sup>1</sup> If you have any further information on these types of activities in other states, please let us know!

Depending on the given hospital's circumstances, some analysis should be conducted.

- Some hospitals have only private rooms. In this case a Value Code of 02 should be reported with a \$0.00 amount.
- Some hospitals have both private rooms and semiprivate rooms.
  - If all the semiprivate rooms are in use, then a private room can be assigned to the patient. Use Condition Code 38.
  - A private room may be assigned if there is medical necessity on file. Use Condition Code 39.
  - If a private room is assigned without proper medical necessity then the patient is charged the difference between the private and semiprivate room rate. This charge is reflected in the remarks page.

This logic does not appear overly intimidating. However, there are certainly a number of questions that are raised.

- i. If the hospital directly bills the patient for the difference in charges, should the hospital issue some sort of notice of non-coverage?
- ii. What kind of accounting procedures should be put into place?
- iii. How are we going to train encounter personnel to handle this appropriately?
- iv. What if there are different charges for different types of private rooms and different types of semi-private rooms?
- v. How does this impact the Medicare cost reporting process?
- vi. Is the hospital's chargemaster affected by this whole process?
- vii. What kind of documentation must be developed in order to justify the use of a private room?
- viii. Is this any sort of an audit issue for the MACs or RACs?

**Case Study #2 – Sam Placed in Telemetry** – Sam has presented through the ED with an apparent heart attack. The attending physician orders Sam placed in telemetry as an inpatient. The telemetry ward has only private beds. However, there several semi-private overflow telemetry beds on the floor below. Hospital policy dictates that physicians use the main telemetry ward before using the overflow beds due to personnel constraints.

Case Study #2 illustrates how quickly seemingly innocent situations can arise. Also, you may find different variations in arrangements. For instance, your hospital may have telemetry packs that allow any bed in the hospital to have telemetry capabilities.

However, Case Study #1 does raise questions. Does the order for telemetry mean that a private bed in the telemetry unit should be used? If so the hospital will be charging for a private bed<sup>2</sup> and also use Condition Code 38 indicating that a semi-private is not available. Or was a semi-private bed available?

**Case Study #3 – Sarah Admitted to Hospital** – Sarah's physician has decided that she should be admitted at the Apex Medical Center. She is having continual problems with electrolytic imbalances, syncope and general fatigue. Her physician requests that a private room be assigned so that she can properly rest.

Assuming the Apex has both private and semi-private room and setting aside the issue as to whether this case even constitutes an inpatient admission, the real question is that of medical necessity. Does Sarah's need to rest justify a private room? That is, does this justify isolation? If not, then what sort of documentation is required to justify the use of a private room?

**Bottom-Line:** As a compliance exercise, take a look at how you are currently handling this situation and whether or not at your hospital this is even an issue. If you do have both private and semi-private rooms, then you should make certain that proper policies and procedures are in place.

## Medicare Odds & Ends

CMS has announced that the official start for ICD-10 will be for FY2015, that is, will start on October 1, 2014. See the February issue of this Newsletter, Volume 24, Number 2, page 11 for a related article. Most likely this is a firm date even given all of the changes in implementation date over the past several years.

## 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: I am a solo, specialty physician and I have been in practice for 20 years. I have never had any difficulty billing or being paid by Medicare. I started through the revalidation process almost six months ago. Currently I am not being paid by**

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<sup>2</sup> We will not address the issue of differential charging for the telemetry bed relative to a regular medical-surgical bed.

## Medicare because my revalidation information is not being accepted by my Carrier. What should I do?

There is no simple answer to your question. Enrollment in Medicare, including the revalidation process, requires fastidious attention to detail and also an understanding of business organizational structuring, tax identification numbers (TINs), assignment of NPIs (National Provider Identifiers), use of various types of practitioners, recognized healthcare provider types, and an understanding of the payment mechanisms used by the Medicare program.

The most important point of the various CMS-855 forms is to understand what kind of information that CMS wants in order for you to enroll in the Medicare program so that you can legitimately be paid for services and/or products. The main categories of information include:

- Who you are,
- What you are,
- Where you are located,
- Who controls you, and
- Whether you have had problems in the past.

If you keep these fundamental questions in mind as you fill out the various CMS-855 forms, you can keep things in perspective. Of course, CMS wants to assure that you have the appropriate licenses, certifications, accreditations and the like.

One of the areas that can create consternation is to fully understand the business structuring that is in place. This includes your official, legal business name that can be significantly different from your doing-business-as name. This then leads into your TIN or sometimes multiple TINs.

Be very careful about reporting all of your practice locations. CMS really wants to know exactly where services are being provided or, for DME, exactly where products are dispensed.

Currently, physicians and practitioners are the most heavily affected by the revalidation process. If you are having difficulty, then contact your state medical society for referrals to local consultants that may be able to assist. Individuals can also request referrals from the hospital(s) where they are on the medical staff. Hospitals can also request assistance from the state hospital associations.

Also, if you are having difficulties, then, if at all possible, establish a contact with your Medicare Administrative Contractor. If needed, even making a trip to your MAC may be a good way to resolve any impediments to having your enrollment approved or revalidated.

## 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](http://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](mailto: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](mailto:CHughes@gha.org). The webinar scheduled for October 30<sup>th</sup> "**Payment Documentation for the RACs**" 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"**, 2<sup>nd</sup> 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](mailto: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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\*\*\*\*\* **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](mailto:Chris@aaciweb.com).

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