CAH Billing and Compliance Hot Topics

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Today's Topics

- Physician Supervision Update
- Anesthesia Services
- Prosthetic/Orthotic Items
- Method II vs. EHR Incentive
- Technical Portion of Pathology
- 24/7 Physician Non Coverage Notice
- Emergency Room Services
- Observation Services
- Condition Code 44
- Routine Services/Supplies
- Self-Administrable Drugs

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Physician Supervision

- The APC Panel is the mechanism used to review and recommend physician supervision requirements
- Added 4 new members
  - 2 – CAH
    - Can't vote on APC issues
  - 2 – Small Rural OPPS Hospitals
  - CMS encourages nominations of clinicians but will not mandate them

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Physician Supervision

- Panel will consider
  - Complexity of service
  - Acuity of patients
  - Probability of an unexpected or adverse patient event during the service
  - Expectation of rapid clinic changes during the service
  - Changes in technology or practice patterns that affect a procedure's safety
  - The clinical context in which the service is delivered

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Physician Supervision

- Request Priority
  - Service volume
  - Total expenditures
  - Frequency of requests
  - Existing requests from commenters
- All requests must have written justification
- Second requests only if there are technology changes

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Physician Supervision

- The panel will recommend "General", "Direct" or "Personal" supervision for each service
  - Notice will be made through sub-regulatory method (e.g., posted on the OPPS website)
  - 30 day public comment period
  - 60 day response period
- CMS will decide whether to accept or not accept the recommendation
  - Effective July 1st or January 1st

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Physician Supervision

- Effective July 1, 2012, 28 codes were assigned "general supervision" status:
  - 20 Mental Health CPT codes
  - 51701 – insertion of non-indwelling catheter
  - 90471 – 90474 immunization administrations
  - 99406 – 99407 smoking cessation visits
- CMS did not accept the recommendation for general supervision for CPT code 94640
  - Not a non-surgical extended duration service

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Physician Supervision

- The August 28th Advisory Panel agenda includes:
  - Observation
  - Drug Administration and related services
  - Selected bladder and skin/wound care services
- CMS will post a preliminary decision on its web site within 60 days and there should be a final decision by January 1st.

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Physician Supervision

- The proposed OPPS 2013 rule:
  - CMS anticipates extending the "non-enforcement instruction" for 2013 for:
    - All CAHs
    - Rural Hospitals with 100 or fewer beds
  - "We expect that this will be the final year for the instruction, regardless of the services reviewed by the Panel during its summer meeting".
- Therapy services will not be subject to the supervision requirements in a CAH

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Anesthesia Services

- Technical anesthesia – RC 370
  - Often packaged into the OR charges
- Professional Anesthesia (CRNA) – RC 964
  - Do not bill CRNA services with RC 370
  - CAH or OPPS "exempt"
    - Services billed on a UB-04 claim form
    - Modifier QZ (or QX) not needed for Medicare
    - Cost based reimbursement

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Anesthesia Services

- Professional Anesthesia (CRNA) – RC 964
  - CAH Method II for CRNA
    - OP billed on a UB-04 claim form
      - 15% bonus applies
    - IP billed on a 1500 claim form
      - 15% bonus does not apply
    - Modifier QZ (or QX) needed
    - Can exclude CRNAs from Method II election
      - If qualify for "exemption"

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Anesthesia Services

- Professional Anesthesia (CRNA) – RC 964
  - Know how your commercial payers pay for these services
    - Some commercial payers accept RC 964
    - Many commercial payers require CRNA services to be billed on a 1500 claim

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CRNA Charges – Anesthesia

- Two common charging methods
  - Per minute amount
    - Minutes are required for Method II billing and 1500 claim form billing
  - Per unit amount
    - Works ok for CRNA Exempt billing
    - Manual entry of minutes for Method II billing and 1500 claim form billing

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CRNA Charges – Anesthesia

- Labor Epidurals (01967) can (and should) have a reasonable cap
  - Total minutes with a charge cap
  - Tiered charge caps
  - Total minutes for placement plus 15 minutes per hour
  - Total minutes of personal attendance
- IHC typically sees the third methodology noted above

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CRNA Charges – Non-Anesthesia

- Charges should be established at a fixed amount per code
  - Price similar to a physician charge
  - Modifier QZ (or QX) not used
- There should be a facility fee for each CRNA non-anesthesia professional fee
  - Revenue to the department where the service is provided
    - OR, Recovery Room, Treatment Room, etc.

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CRNA Charges – Non-Anesthesia

- CRNAs in Washington are dually licensed as NPs and can perform any non-anesthesia service allowed under their state scope of practice
- Currently, in other states, NAS limits billable non-anesthesia codes to certain codes
  - This may change based on a proposed rule

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CRNA Charges – Non-Anesthesia

- Currently, NAS limits billable non-anesthesia codes to:
  - 31500, 36410, 36600, 36620, 36555, 36556, 36568, 36569, 62273 & 0213T-0218T
  - 62270, 62310, 62311, 62318, 64400-64530 (using modifier 59)
  - 76937 (ultrasound guidance)
  - 77003 (except if billed with 64479-64484 and 64490-64495)

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CRNA Charges – PS&R

- PS&R handling of revenue code 964
  - For exempt hospitals, Medicare charges are included on Report Type 850
  - For Method II hospitals, outpatient Medicare charges are included on Report Type 855
  - For CAHs doing normal 1500 claim form billing, Medicare charges are not included on any PS&R report

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Prosthetic/Orthotic Items

- DMEPOS
  - **D**urable **M**edical **E**quipment
  - **P**rosthetics
  - **O**rthotics
  - Take Home **S**upplies (specific ostomy and wound care supplies)
- A separate Part B benefit category
- Can be unbundled from an outpatient encounter

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Prosthetic/Orthotic Items

- Billed Using HCPCS codes
  - DME – generally "E" codes
  - Orthotics/Prosthetics – generally "L" codes
  - Supplies – generally "A" codes
- Only DME suppliers can bill for DME items
  - Establish a DMEPOS closet in the hospital
  - Include Prosthetic and Orthotic items?

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Prosthetic/Orthotic Items

- Hospitals can bill for most Orthotic and Prosthetic items on a UB-04 claim form using revenue code 274
  - Appendix 1 of the UB Editor provides a list of hospital billable "L" codes
  - The item must meet the definition of the "L" code
    - If not, the item is billed as a supply

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Prosthetic/Orthotic Items

- These items are paid on a fee schedule basis, even for CAHs
  - The beneficiary's co-insurance is 20% of the fee schedule amount
- Considered a non RHC service
  - Billed through the hospital in a provider-based RHC
  - Costs should be excluded from RHC costs

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Prosthetic/Orthotic Items

- Most descriptions indicate:
  - Includes fitting and adjustment, or
  - Custom fabricated
- The Orthotic or Prosthetic management codes can't billed in addition to the "L" code
  - 97760 – 97762
- No hospital billing if an outside supplier bills for the item

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Method II vs. EHR Incentives

- Currently, Medicare does not track and accumulate CPT/HCPCS codes billed on a UB-04 under Method II
- Causes problems for:
  - EHR Incentive Payments
  - eRx
  - PQRS

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Method II vs. EHR Incentives

- Services billed under Method II are not being included in the allowable charges for the EHR Incentive
- Depending on the physician, it may be beneficial to not bill under Method II for a number of years
- An analysis should be done for each physician

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Method II vs. EHR Incentives

- Example:
  - $30,000 in allowable Medicare charges
  - All are PB clinic or hospital OP services
  - Physician becomes a meaningful user in 2012
- EHR incentive payment is $18,000
  - $30,000 X .75 = $22,500 (capped at $18,000)

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Method II vs. EHR Incentives

- Example:
  - $30,000 in allowable Medicare charges
  - All are PB clinic or hospital OP services
  - Physician becomes a meaningful user in 2012
- Method II bonus would be $3,600
  - $30,000 X .80 X .15 = $3,600

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Method II vs. EHR Incentives

- If a Method II physician also has a significant amount of allowable charges that are billed on a 1500 claim form, then Method II may still be beneficial

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Technical Portion of Pathology

- Effective July 1st, 2012 hospitals are required to bill for the technical portion of pathology for their inpatients and outpatients
- Applies to the physician anatomic pathology technical component services paid under the Medicare Physician Fee Schedule

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Technical Portion of Pathology

- Applies to provider-based clinics and provider-based RHCs
- These technical components will be paid at cost in a CAH
- Will need to have agreements with the reference lab or independent pathology group
  - May need to renegotiate the current contract

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24/7 Physician Notice

- CAHs must give written notice to all patients if a physician (MD or DO) is not present in the hospital 24/7 – 42 CFR 489.20(w)
  - Cannot be a midlevel provider
  - An MD or DO must be "present in the hospital"
    - On campus departments should be ok

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24/7 Physician Notice

- The notice is required for
  - Inpatient Admissions
  - Observation services
  - Surgery services
  - Any other service requiring anesthesia
- Effective January 1, 2012, there must be a signed acknowledgment from the patient prior to the admission or registration for these types of services

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24/7 Physician Notice

- There must also be a sign posted in the Emergency Department
  - The notice must provide a description of how the hospital will meet the medical needs of a patient who presents with an emergency medical condition when there is no MD or DO present in the hospital

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Emergency Room Services

- Continues to be an area of significant lost revenues (gross and net)
  - E/M Level Distribution
  - Charge Levels
  - ER Provider Procedures
- The ER typically has one of the lowest percentage of Medicare patients

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Emergency Room Services

- ER E/M Level Mapping Systems
  - Should be reviewed and updated annually
  - Should not include "points" or resources for any separately billable procedure
  - The distribution should be reasonable, given the services provided in the ER

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Emergency Room Services

- Charges for ER services in a CAH are typically lower than in OPPS hospitals
  - The board may want to keep charges low
  - The board may not understand reimbursement impact
  - Look at the 75th percentile market pricing for this area
- Emergency Room CCRs are often .80 or higher in a CAH

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Emergency Room Services

- Both provider and nurse procedures need to be captured
  - Any procedure with a valid CPT/HCPCS code should be separately billed (and should not contribute to the E/M level)
  - Provider procedures are typically provided in 8% to 12% of visits
  - Provider procedure charges generally average around $200 per procedure

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Observation Services

- Observation hours must be correctly tracked for billing and cost reporting
- For a CAH, Medicare's share in observation costs is typically less than it's share in routine costs
  - Less observation hours may increase Medicare reimbursement in CAHs
- Need to have B.O. or HIM begin to charge for observation services

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Observation Services

- Start Time – When observation "services" are initiated in accordance with a physician's order
  - Typically, when a patient is placed on the floor
  - No more "admission to observation" or "admit to observation status"
  - Order for "observation care" or "observation services"

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Observation Services

- End Time – when all medically necessary services related to observation care are completed
  - Waiting for transportation does not count
  - Follow-up clinic or ER services should not be counted
  - Hospitals should have a set of reasonable internal guidelines

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Observation Services

- In-between Time – Observation hours should not include time when other services are being provided that require active monitoring by nurses
  - Colonoscopies
  - Blood Administration
  - Chemotherapy
  - Infusion Therapy ??
  - Other time absent from the room

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Observation Services

- No good definition of active monitoring
- Can the documentation support both services simultaneously
- Conservative approach is to carve out IV Therapy
- Some hospitals have a written policy of which infusions (i.e., drugs) require active monitoring by nursing

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Observation Services

- Hospitals will need to develop a method of tracking observation hours for each separate period of observation
  - Notations in the record of floor absences – time in and time out
  - Carve out of other services requiring active monitoring
  - Can use average times for interrupting procedures

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Observation Services

- NAS has indicated that a hospital can choose to bill for observation services rather than other services (1/28/10 NAS ATC Q&A document)
  - Typically billing for the other services will generate the same or higher reimbursement from Medicare
  - Typically billing for the other services will generate higher reimbursement from commercial payers

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Observation Services

- Front end loading of observation charges
- Two levels of observation if two room rates
- Don't use the ICU rate for observation services
- An ABN should be issued for non medically necessary observation

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Observation Services

- All hours should be billed with HCPCS code G0378
- Observation hours for stays that go past midnight should be reported on one line with the beginning date
- Observation hours in excess of 48
  - Billed on a separate line as non covered
  - NAS Q&A #20 from the NAS 12/09 Outpatient Observation training session

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Condition Code 44

- Used to turn inpatients who do not meet acute care criteria into outpatients
- Many additional services are paid when billing a claim as outpatient versus "inpatient no Part A"

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Condition Code 44

- Utilization Review (UR) Committee requirements
  - Two or more practitioners
  - At least two members must be doctors of medicine or osteopathy

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Condition Code 44

- Condition Code 44 Requirements
  - The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient
  - A physician concurs with the UR committee's decision
  - The physician's concurrence must be documented in the patient's medical record

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Condition Code 44

- Condition Code 44 Requirements
  - One member of the UR committee can make the decision, with the attending physician's agreement or if the attending physician fails to present his or her views when afforded the opportunity
  - In all other cases, the decision must be made by two members

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Condition Code 44

- Condition Code 44 Requirements
  - The UR committee must consult with the practitioner(s) responsible for the patient's care
  - The UR committee must provide written notice to the hospital, the patient and the patient's physician within two days of the change and its impact on the patient, including financial liability for applicable deductible and coinsurance amounts

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Condition Code 44

- When the criteria are met the entire episode can be billed as outpatient using bill type 13X (PPS) or 85X (CAH)
- The beneficiary's out of pockets will change from an IP deductible to outpatient co-insurance amounts
  - May be more or less depending on the services provided

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Condition Code 44

- Self-administrable drugs will need to be billed appropriately
  - There may be system issues
- Observation services can only be billed from the date and time of an observation order
  - NAS bulletin posted 9/24/09
  - The attending physician should order observation status as soon as possible

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Condition Code 44

- CMS has indicated that hospitals **may** bill for observation services when an IP is converted to an OP for the time prior to the actual observation order
  - CMS FAQ 9973 & MedLearn Matters Article MM7117
  - Bill a second line using RC 762 only and not G0378

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Condition Code 44

- CMS has indicated that hospitals **may** bill for observation services when an IP is converted to an OP for the time prior to the actual observation order
  - There are significant cost report implications with billing following this guidance
  - Be very cautious about this guidance

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Condition 44 vs. 12X Bill Type

- If the requirements for Condition 44 are not met, the claim will need to billed using bill type 12X
- Only limited services will be paid (IOM 100-2, Chapter 6, Section 10)
  - The UB Editor provides a list of revenue codes that are not paid on a 12X bill type
  - The hospital must also submit a no pay claim (NAS bulletin 5/14/09)

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Condition 44 vs. 12X Bill Type

- No Pay claim for inpatients converted after discharge
  - Bill type 110 for entire stay
  - All days as non-covered
  - All units and charges as non-covered
  - 77 Occurrence Span Code with the dates of provider liability
  - A remark stating that the patient did not meet inpatient criteria

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Routine Supplies/Services

- The Reimbursement Manual sections most often quoted relate to SNFs (2203.1 & 2203.2)
  - Past bulletins issued by the FI/MACs refer to these SNF manual sections
  - Commercial payers may attempt to deny payments based on these sections
- The hospital manual is much less restrictive as to what can be billed

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Routine Supplies/Services

- In a CAH, revenue and expense matching is key
- Industry Standard definitions (?)
  - Billable Items and Services
    - Services identifiable to individual patients
    - Items or services not generally furnished to most patients
    - Items that are not reusable
    - Items that represent a cost for each preparation

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Routine Supplies/Services

- Non-Billable Supplies or Services
  - Depreciated Equipment
  - Reusable items that are sterilized
  - Floor stock items
  - Routine nursing services
- Per-use rental items should be chargeable
- The facility has a choice in floor stock items

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Routine Supplies/Services

- Each hospital should have a billable supply policy that addresses:
  - Patient convenience items
  - Equipment
  - Reusable supplies
  - Routine supplies
  - Low cost items
- Eliminating low cost items typically increases Medicare reimbursement

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Routine Supplies/Services

- Need to carefully model the elimination of routine items
  - Identify the appropriate routine or procedure charges
  - Document the process
  - Monitor changes
- Typically, rates in other areas are increased to offset the reduction
- May reduce lost charges

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Bundling Supplies

- Can reduce lost charges
- Can reduce overhead cost
- The price should reflect billable items
- Averaging may not be the best approach in a CAH
- Document all bundling decisions for future reference

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Self-Administrable Drugs

- These drugs are not covered by Medicare Part B and should not be billed as covered
- Bill as non-covered using:
  - revenue code 637
  - HCPCS code A9270
  - Modifier GY
- Billing as covered is a compliance risk

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Self-Administrable Drugs

- Revenue code 637 may not be allowable on an inpatient claim
  - Set up a tier charge for this
  - Use of 250 vs. 637 as the base or tier
- Some self-administrable drugs may be covered by Medicare Part D
  - The patient may ask for a statement indicating the NDC number

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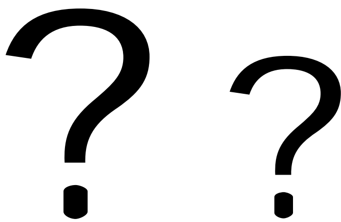
QUESTIONS



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