2009 Outpatient Compliance Challenges Moving to Propose 2010 OPPS Rules

Outpatient RAC Vulnerabilities Exposed - Real Audits, Real Examples

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Opening Thought…..

“Strengthen your polices and procedures with regard to billing for OP services under OPPS.” per Office of Inspector General
2009 Outpatient Compliance Challenges
Are you RAC Proof?

- Critical Care Services
  - Time and Services Included
- Outpatient Orders
- Outpatient Diagnosis Reporting
- Drug Administration Services
  - ED, Oncology and Ambulatory Care
- Wound Care Revenue Cycle
- Radiology Revenue Cycle
- Duplication of CPT Codes
  - HIM versus CDM
- MLPs and Incident to Outpatient Therapeutic Services (also in 2010 proposed rules)

2009 Outpatient Compliance Challenges
Critical Care Services – Facility

- Critical Care Services – How many of you remember this?
  - Per Federal Register / Vol. 65, No. 68 / Friday, April 7, 2000 /
    Rules and Regulations - “We used the CPT definition of “critical care”
    which is the evaluation and management of the critically ill or injured
    patient. Under the outpatient PPS, we would allow the hospital to use CPT
    code 99291 in place of, but not in addition to, a code for a medical visit or
    for an emergency department service. Although the CPT system allows the
    physician to bill in 30-minute increments following the first 74-minute
    period of providing critical care, we proposed to pay separately for only the
    initial period (CPT code 99291), packaging the few instances in which the
    30-minute increments (CPT code 99292) were billed. We do not believe
    that paying hospitals for incremental time as critical care would better
    reflect facility resources. The most resource-intensive period for the
    hospital is generally the first hour of critical care. In addition, we believe
    it would be burdensome for hospitals to keep track of minutes for
    billing purposes. Therefore, we will pay for critical care as the most
    resource intensive visit possible as defined by CPT code 99291.”
2009 Outpatient Compliance Challenges
Critical Care Services – Facility

- Now we have this –
  - Per Federal Register/November 1, 2006/Rules and Regulation/Transmittal 1139
  - The CPT code 99291 is defined by CPT as the first 30-74 minutes of critical care. This 30 minute minimum has always applied under the OPPS and will continue to apply for CY 2007. We are continuing to provide packaged payment for CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, for those periods of critical care services extending beyond 74 minutes, so hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical care service provided.
  - As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

- Transmittal 1139 January 2007 OPPS Updates
- "Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once."
- From the current CPT book -
- "Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (eg, participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time."
SLIDE#7

Critical Care Services – Facility

- Critical Care Services – How many of you remember this? – **OPPS 9/12/00**
- **Q. 71.** Critical care codes have excluded procedures that are not covered under the listed codes; can those codes, when appropriate documentation is present, be listed in addition to the critical care codes?
- **A. 71.** The edits for services excluded when critical care is billed relate to physician services. For example, Medicare does not pay a physician for reading an EKG while providing critical care. The hospital, however, incurs costs for the technical component of such tests and procedures. Therefore, we have removed the critical care edits from the CCI edits used within the OCE.
- **Now we have this...**

SLIDE#8

2009 Outpatient Compliance Challenges Moving to Propose 2010 OPPS Rules

- **Federal Register effective for January 1st, 2009 OPPS Updates –**
- “…hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291, hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital. In establishing payment rates for visits, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for visits according to the standard OPPS methodology for packaging costs.
- **April 1st, 2009 - Full set of CCI edits incorporated under OPPS**
2009 Outpatient Compliance Challenges
Critical Care Services – Facility

- Next steps internally to ascertain your RAC Risks and move to RAC Proofing –
  - October 1st, 2007 and forward –
    - Frequency of 99291 assignment for Medicare patients
      - Transferred or Expired = OPPS payment
    - E/M Leveling = Time Determination
      - Points contributing to 99291?
      - Electronic or algorithm determination?
      - Nursing or ED determination?
    - 99291 2009 APC payment unadjusted $485
    - 99285 2009 APC payment unadjusted $323
    - RAC Minimum Risk = ($162)

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SLIDE#9

2009 Outpatient Compliance Challenges
Critical Care Services – Facility

- Next steps internally to ascertain your RAC Risks and move to RAC Proofing –
  - Services included – unadjusted APC national $
    - 94002 = ($192)
    - 71020 x2 = ($88)
    - 91105 = ($99)
    - 82803 = ($30)

($409) Minimum Services

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SLIDE#10
2009 Outpatient Compliance Challenges
Critical Care Services – Facility

Minimum Services ($409)

\[ + \]

E/M Level Down Grade ($162)

Minimum RAC Risk Per Claim ($571)

\[ \times 100 \text{ claims} = \] ($57,100)

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2009 Outpatient Compliance Challenges
Outpatient Physician Orders

- How many of you remember?
  - As specified in §4317(b) of the Balanced Budget Act (BBA),
  - Also effective January 1, 1998, physicians and practitioners are required to provide diagnostic or other medical information to other entities that furnish services ordered by the physician or practitioner. Physicians and practitioners will be required to provide diagnosis or other medical information to the entity furnishing the service at the time the service is ordered when the Secretary (or fiscal agent of the Secretary) requires such information in order for payment to be made. For example, physicians and practitioners will now be required to provide diagnosis or other medical information at the time the service is ordered to the entity furnishing the service when a Local Medical Review Policy (LMRP) exists requiring such diagnosis or other medical information from the entity performing the service.
CERT Physician Orders for Labs and Diagnostics
- FI/MAC...would like to alert all providers that CERT continues to make second requests for medical records and lack of physician orders for lab and diagnostic services remains a primary reason for denials.
- Documentation must clearly convey "the physician’s intent that the test be performed."
- CMS Pub 100-2 Benefit Policy Manual, Chapter 15, Section 80.6
  http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf states:
  - A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;
  - A telephone call by the treating physician/practitioner or his/her office to the testing facility; and
  - An electronic mail by the treating physician/practitioner or his/her office to the testing facility.
  - If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.

State Operations Manual - Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
- Hospitals are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment. The goal of a hospital survey is to determine if the hospital is in compliance with the CoP set forth at 42 CFR Part 482.
  - 482.23(c)(2)(i) – If verbal orders are used, they are to be used infrequently. This means that the use of verbal orders must not be a common practice
  - 482.23(c)(2)(ii) – when verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedure consistent with Federal and State Law
  - 482.24(c)(1)(i) – all orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner
Verbal orders are orders for medications, treatments, interventions, or other patient care that are transmitted as oral, spoken communications between senders and receivers, delivered either face-to-face or via telephone.

482.24(c)(1)(iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

The time and date of each entry (orders, reports, notes, etc.) must be accurately documented. Timing establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating entries is necessary for patient safety and quality of care. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or time lines of various signs, symptoms, or events. (71 FR 68687)

The requirements for dating and timing do not apply to orders or prescriptions that are generated outside of the hospital until they are presented to the hospital at the time of service. Once the hospital begins processing such an order or prescription, it is responsible for ensuring that the implementation of the order or prescription by the hospital is promptly dated, and timed in the patient’s medical record.
2009 Outpatient Compliance Challenges
Outpatient Physician Orders

- The Medical Review Department will deny claims for not meeting the signature requirements on records requested on Additional Development Requests (ADR). According to the Medicare Program Integrity Manual (100-08), Chapter 3, Section 3.4.1.1 states:

  "Providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. Facsimile and hard copies of a physician’s electronic signature must be in the patient’s medical record for the certification of terminal illness for hospice. For example, providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

  All state licensure and state practice regulations continue to apply. Where state law is more restrictive than Medicare, the contractor needs to apply the state law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

2009 Outpatient Compliance Challenges
Outpatient Physician Orders

- Instill Medicare compliance of billing and documentation requirements
- Insufficient documentation = lack of medical necessity for services rendered
- Ensure services performed are clearly substantiated and that starts with a physician order
- Program Integrity Manual: Chapter 3, Section 3.11.1 states:
  - For Medicare to consider coverage and payment for any services, the information submitted by the provider or supplier...must be corroborated by the documentation in the patient’s medical records that Medicare coverage criteria have been met.
  - It must support the fact that whatever is billed was needed by the patient, provided to the patient and certified by the provider.

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2009 Outpatient Compliance Challenges
Outpatient Physician Orders

➢ Make sure #1 you have physician orders PLUS -
  ✓ Legible
  ✓ Dated
  ✓ Signed – Rubber stamps are NOT acceptable in any part of the medical record to include orders
  ✓ Time
  ✓ Intent or Diagnosis(es)
    ○ Narrative or # form

2009 Outpatient Compliance Challenges
With Orders Comes the Diagnosis

➢ As noted, documentation must clearly convey “the physician’s intent that the test be performed.”
➢ Per the BBA of 1997 - physicians and practitioners will now be required to provide diagnosis or other medical information at the time the service is ordered to the entity furnishing the service when a Local Medical Review Policy (LMRP) (now LCD) exists requiring such diagnosis or other medical information from the entity performing the service.
➢ Per LCD documentation requirements - Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed.
2009 Outpatient Compliance Challenges
With Orders Comes the Diagnosis

- Use of Arrows for the Assignment of ICD-9-CM Diagnosis (es)??
- Question provided to AHA –
  - Outpatient encounters only – If a physician documents chronic conditions with arrow symbol up or down, for example ↑ lipid, ↑ chol or ↓ thyroid can we code "hyper" or "hypo" – please clarify with answer.
  - Letter dated 11/06 -
    ○ Diagnosing the patient’s condition is solely the responsibility of the physician, therefore it is not appropriate for a coder to report a diagnosis based on up and down arrows.
    ○ The physician should be queried regarding the significance and request appropriate documentation.

2009 Outpatient Compliance Challenges
With Orders Comes the Diagnosis

- Official Outpatient Coding Guideline -
- For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.
- Do not assign I9 DX from the BODY of radiology report
- Do not assign I9 DX from HEADER of radiology report

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2009 Outpatient Compliance Challenges
With Orders Comes the Diagnosis

Coding Clinic – Third Quarter 2005

- Terms as documented in the FINAL IMPRESSION or INTERPRETATION
  - "Consistent with", "compatible with", "indicative of", "suggestive of", and “comparable with” – terms fit the definition of a probable or suspected condition which are not coded – code the conditions(s) to highest degree of certainty.
  
- New terminology – “evidence of cerebral atrophy”, “appears to be a nasal fracture” – are being reviewed @ the National Level for AHA for final determination of code assignment - Stay tuned !!
  - Established DX versus “R/O” DX rules?
  - Will be published in 3rd Quarter 2009 Coding Clinic

2009 Outpatient Compliance Challenges
With Orders Comes the Diagnosis

Coding Clinic – Third Quarter 2008

- Injection of thiamine – can we assume thiamine deficiency?
  - Answer – NO – physician must clearly document diagnosis being treated

- Think about the following areas –
  - Ambulatory Care, Oncology, Chemotherapy, Radiology, Laboratory, Cardiology
  - For Example – Blood transfusion order without DX -
    - Automatic assignment “anemia”? Ø NO
  - For Example – Bovina Injection order without DX -
    - Automatic assignment of “osteoporosis” ? Ø NO
  - For Example – Shoulder x-ray 1 view order with DX of "Fall"
    - Automatic assignment of “injury to shoulder”? Ø NO

Ordering Physician must clearly convey the DX being treated before the test is performed
2009 Outpatient Compliance Challenges

With Orders Comes the Diagnosis

- **Case in Point – follow the bouncing ball with me**
  - FACE SHEET/Registration – DOS 5/1/09
    - Chronic Anemia/Malnutrition (285.9, 263.9)
    - No physician signature
  - Situation Report – DOS 5/1/09
    - Chronic Anemia, Malnutrition (285.9, 263.9)
    - No physician signature; DX written by nurse
  - Blood Administration Flow Sheet – DOS 5/1/09
    - Reason for transfusion – Anemia (285.9)
    - No physician signature; DX written by nurse
  - Outpatient Blood Transfusion Orders – DOS 5/1/09 (None)
    - Diagnosis absent however now we have physician signature
  - Prescription – DOS 5/1/09
    - Diagnosis and signature of physician – iron deficiency anemia (280.9)

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2009 Outpatient Compliance Challenges

With Orders Comes the Diagnosis

- With all the hard work your facility does on a daily basis with charge capture reliability – *stop and re-visit* the following -
  - Order, signature and DX operational process for ambulatory services –
    - Where are orders presented for these types of services?
      - Registration, Department, None?
      - By the way – where are they housed and kept for easy retrieval if audited?
    - When does the process of medical necessity, LCD and ABN generation kick in and occur, if applicable?
    - Who assigns the ICD-9-CM diagnosis(es) code(s) for this area?
      - Registration, HIM, department, “I don’t know”
    - How do we assign ICD-9-CM code(s) for these types of encounters?
    - Monthly/Series/Recurring or Episodic by DOS
    - What type of documentation at time of code assignment is present?
      - Registration Form, Data Listing, Nurses’ Form, Original Physician Order/Requisition, faxed copy of what the department sends us
REVISIT THIS IMPORTANT FUNCTION TO ASSURE REVENUE INTEGRITY

COMPLIANCE & PAY-FOR-PROF
CHARGE CAPTURE
E&M PROCEDURES
INJECTIONS AND INFUSIONS
ICD-9 CODING

DOCUMENTATION IMPROVEMENT

OPERATIONAL PROCESS
Are we sacrificing ACCURACY for PRODUCTIVITY?
In other terms – Are we Coding Too Fast?

2009 Outpatient Compliance Challenges
Drug Administration Services

- When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be used. (CCI Manual)
  - This is defined as incompatibility of drugs require two lines.
  - If two lines initiated for convenience i.e. flushing or decreasing the time of infusion they are not billable as separate lines.
  - Report both lines and the second lines would have modifier 59 attached to indicate separate and distinct.
We continue to have trouble with incomplete clinical documentation to include start and stop times and appropriate abbreviations. We developed an internal list to assist with what drugs can be pushed, infused and the associated time frame. Is this sufficient documentation to support our CPT code(s) and charge capture even if the clinicians information is incomplete?

If in your mind the following words are triggered based on incomplete clinical documentation on a continued basis …

- "I believe we are; Fairly accurate; presuming; in the ballpark; estimating; assuming; guessing; connecting the dots; using protocol or instructions; using an interdepartmental list; downgrading to be safe; giving up”

**WOW – can you spell RISK and potential CERT and RAC initiatives**

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In the most simplistic terms –
“Time units are calculated based on how long the fluids have infused. (PERIOD) The documentation must have both start and stop times recorded to justify the amount of time billed.” (AND REVENUE RECEIVED)
“Time-Based” CPT codes require “Time-Frame” documentation
No ifs, ands, buts or sometimes...this is the rule; not the exception.

Real Time Documentation
You are the RAC Auditor – Pretend....

Patient stayed 12 hours in the ED. A « banana bag » started @ 6 pm. Patient discharged @ 6:00 am. A typical composition of a banana bag is Thiamine 100 mg + Folic acid 1 mg + MVI 1 amp to 1 Liter of normal saline. One to two grams of Magnesium Sulfate may also be added to the mixture. The solution is typically infused over four hours. OPTIONS of code selection below based on documentation above:
A. NONE = BUPKIS = NADA = ZIP = NILL = ZILCH B.96365 x 1 (they must have given at least one hour, right?) = $128 C.93674 - no downtime so default to a push = $36 D.96365 x 1, 96366 x 3 – standby the PROTOCAL and hope for the best = $152 E. Need to provide feedback to nursing staff regarding RISK and opportunity base on complete documentation
2009 Outpatient Compliance Challenges
Drug Administration Services

- We are assigning injection and infusion services during CPR and critical care services – that’s OK – right?
- CCI Manual Instructions starting from 10.3 and forward -
  - "In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately reported. A number of therapeutic and diagnostic cardiovascular procedures (e.g., CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intraarterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate codes for routine access, monitoring, injection or infusion services are not to be reported."
- Review your operational practice and discontinue with the guideline as listed above.

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CPR and Injections/Infusion
PLUS Critical Care

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2009 Outpatient Compliance Challenges

Critical Care Services – Facility

Minimum Services  ($409)

+  

E/M Level Down Grade  ($162)

+  

Pushes during CPR x 8  ($288)

Minimum RAC Risk Per Claim  ($859)

\[ \times 100 \text{ claims} = \$85,900 \]

Drug Administration Services

- We continue to report pre and post operative injections and infusions along with medical necessity (DX) – we have physician orders and we implemented this is our CDM a few years ago – is this OK?

- **Do not report pre-operative injections/infusions – Case in point, antibiotics pre-operatively given** –
  - CCI Manual Version 13.3 and 14.3 – Do not report drug administration CPT codes for injections/infusions related to procedure to include anesthesia, hydration and medications as anxiolytics and antibiotics.

- **"Do not report pre injections for other tests** =
  - CCI Manual Version 13.3 and 14.3 - Do not report 96360-96375 or 96379 with codes for which IV push or infusion is an inherent part of the primary procedure (e.g. administration of contrast material for a diagnostic imaging study.)
2009 Outpatient Compliance Challenges

Post Operative Injections

RAC RISK

CPT 96375-59 x 2 plus 96365-59 ($200)

Minimum RAC Risk Per Claim ($200)

\[ \times 100 \text{ SDS claims} = \]$20,000

Again - the bottom line revolves around the operational process to achieve Revenue Integrity
2009 Outpatient Compliance Challenges
Wound Care Revenue Cycle

**Issues continue to plague this area -**

- **Facility E/M levels criteria and assignments -**
  - Lack of dedicated E/M facility criteria overall
  - Lack of Policy Procedure how to determine E/M level
  - Crossing physician E/M assignment to facility side
  - E/M with procedure on the same day
    - Modifier 25
  - New versus established facility definitions
  - *Just to name a few .....

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When a **CERT** is performed by FI/MAC regarding E/M reported in addition to a procedure/service on the same day prompting modifier 25

Key documentation **TIPS** that will help support reporting an E/M visit on the same day as a procedure/therapy – thus prompting modifier 25

- Making a clinical decision to change the current regimen i.e. decision to change therapy resulted in another procedure being performed that day
- Assessment of a new symptoms/issues unrelated to the established ones, for which the patient was initially seen for
- Review of lab work, (if the key elements of E/M are demonstrated and not part of the another assessment)
- Ordering of new lab for an issue that is not already part of the basic established assessment or
- Medication changes for development of new system/issue.
2009 Outpatient Compliance Challenges
Wound Care Revenue Cycle

- **Frequency of E/M with modifier 25**
  - New Payments more than Established Payments
    - Review NEW Definitions and ensure that dept/coders understand when selecting assignment = 34 = ($2,147)
    - **1123 remaining visits** = ($74,502)
    - **Total RAC Risk** = ($76,649)

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<td>Office or other outpatient visit for the evaluation and management of an 42</td>
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- **Additional Issues**
  - **Surgical Excisional Debridement**
    - Type of tissue excised; not just to Level
    - LCD documentation requirements
    - Frequency of debridement **(11040 – 11044)**
    - Duplication between HIM and CDM
      - **Unit greater than 1**
  - **Biological/Skin Substitutes**
    - LCD documentation requirements
    - **Diagnosis sequencing required via LCD**
    - JW and wastage of biological
  - **Diagnosis assignment and medical necessity**
    - **Monthly submission of claims versus DOS**
2009 Outpatient Compliance Challenges
Diagnostic Radiology

- If it isn’t documented it wasn’t done!
  - **Test Orders – MEDICAL NECESSITY**
  - CPT Code from HEADER of Report
  - Complete vs. Limited US
  - # of views
  - Use of contrast
  - Imaging guidance
  - Radiopharmaceuticals
- Use of 76376/76377
- CT vs. CTA
- Mammography
- US & Duplex same DOS

2009 Outpatient Compliance Challenges
Interventional Radiology

- Biopsies – Core & FNA same session
- Dialysis Access Maintenance
  - Assign 1 PTA for entire AV graft
- Supervision & Interpretation Codes
  - Interpretation must be clearly documented in the report.
    - Epidurography
    - Discography
    - Myelography
    - Arthrography
    - Permanent image recording
    - Formal radiology report
2009 Outpatient Compliance Challenges
HIM versus CDM = Duplication

- **Areas of Risk Duplication = ($433,376)**
  - Gastrointestinal Lab (GI Lab)/45380
    - ($296) x 960 = ($284,160)
  - Wound Care/11042
    - ($90) x 100 = ($9,000)
  - Pain Management/64475
    - ($236) x 169 = ($39,884)
  - Blood Transfusion/36430
    - ($221) x 50 = ($11,050)
  - ESWL/50590
    - ($1,383) x 54 = ($74,682)
  - Interventional Radiology/36569
    - ($365) x 40 = ($14,600)

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2010 Proposed APC Rules

- **Incident to Outpatient Therapeutic Services**
- **Reiterates its statement from CY 2009 OPPS Final Rule**
  - That it has been its expectation all along that “hospital outpatient therapeutic services are provided under the direct supervision of a physician in the hospital and all (provider based departments) of the hospital, specifically, both on-campus and off-campus departments of the hospital.”
Direct supervision for services furnished on campus means that the supervising physician must be present on the same campus, in the hospital or in the on-campus provider-based department of the hospital, and immediately available to furnish assistance and direction throughout the procedure. This physician may not be located in any other entity, including a physician’s office, an independent diagnostic testing facility, a co-located hospital, a hospital operated provider or supplier (e.g. a skilled nursing facility), or any other non-hospital space co-located on the hospital’s campus.

“In the hospital” means in the main building(s) of the hospital that are under the ownership, financial and administrative control of the hospital; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital’s CMS certification number.

“Immediately available” requires the supervising physician to be physically present “without interval of time” – the supervising physician could not be performing another procedure or uninterruptible service or so far away on the main campus that he or she could not intervene right away.

The supervising physician also must be able to step in and perform the services – not just respond to an emergency, as required under 42 C.F.R. § 410.27(f). This means that the supervising physician must have the ability to perform the service or procedure (in accordance with state-specific scope of practice and medical staff privileges).
2010 Proposed APC Rules

- For off-campus provider-based departments, direct supervision continues to mean that the supervising physician must be in the off-campus department and immediately available to furnish assistance and direction throughout the performance of the procedure. 42 C.F.R. § 410.27(f) will be revised as such.
- CMS also proposes in the CY 2010 Proposed OPPS Rule that nonphysician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives, may directly supervise all hospital outpatient therapeutic services that they may perform. The non-physician practitioner must satisfy their State law scope of practice and hospital granted privileges, and any additional requirements, including any applicable collaboration or supervision requirements.

2010 Proposed APC Rules

- Proposes to allow hospitals to bill for pulmonary and intensive cardiac rehabilitation services
- No composite APCs however not abandoning their commitment to “value based” purchasing
- Proposed payment for 2010 separately payable drugs ASP plus 4%
- Increase the separately payable drug packaging threshold to $65 (currently $60)
- Considering to pay rural providers for kidney disease education services to Medicare beneficiaries diagnosed with Stage IV chronic kidney disease
2010 Proposed APC Rules

- CY 2010 is third year of a four-year-phase in of the ASC payment rates calculated under the standard rate setting methodology and the first year for which CMS is authorized to apply an update to the conversion factor.
- HOP QDRP – hospitals that did not participate in the program or did not successfully report the quality measures will receive an update in CY 2010 equal to the annual payment update factor minus 2.0%
- CMS is proposing to continue to require HOP QDRP participating hospitals to report the existing seven emergency department and perioperative care measures, as well as the four existing claims-based imaging efficiency measures for the CY 2011 payment determination. Although it is not proposing to adopt any new measures for the CY 2011 update, CMS is seeking public comment on potential additional quality measures for consideration for future OPPS updates. The potential measures relate to a number of areas including cancer care, emergency department throughput, diabetes, stroke and rehabilitation, osteoporosis, medication reconciliation, respiratory, immunization, health information technology, cataract surgery, overuse/appropriate use, imaging efficiency, and surgical care.

- CMS is also proposing to phase in a new HOP QDRP validation requirement to ensure that hospitals are accurately reporting measures for chart-abstracted data, but the validation results will not have any impact on outpatient department payments in CY 2011. In addition, CMS is proposing to establish procedures to make quality data collected under the HOP QDRP for quarters beginning with the third quarter of CY 2008 publicly available.