Inpatient ancillary services: Are your costs covered?

As the current economic climate continues to constrict cash flow for consumers and payers alike, hospitals are struggling to generate appropriate reimbursement to cover patient care costs.

Many facilities may be overlooking a potential—and perfectly legitimate—revenue stream.

A March HCPro survey of Briefings on APCs readers found a wide range of charging practices for inpatient ancillary bedside services. (For more on the survey, see “Outpatient coding staff a key resource for inpatient line-item billing” on p. 3.)

That can result in lost revenue not only now, but in the future, says Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC. “Providers are allowed to charge inpatients for what are often considered ancillary bedside services provided by nursing staff,” Shah says.

Hospitals may believe these services are routine and part of their room and board charge, but in all likelihood, most hospitals probably haven’t reviewed their room and board charge to see whether specific services have been factored in, Shah says. Because facilities charge outpatients for services such as blood transfusions, foley catheter insertions, injections, and infusions, they should also be charging inpatients for these services because Medicare requires hospitals to charge all patients equally.

Hospitals can find the supporting language for this position in the Medicare Provider Reimbursement Manual and 2009 inpatient PPS final rule, and they can learn more during HCPro’s July 16 audio conference, “Charging Bedside Procedures Beyond the Room Rate: How, Why, and What It Means for Your Bottom Line.”

“Medicare went about as far as I’ve seen them go in the IPPS final rule in saying, ‘Yes, providers can charge for blood transfusions on its inpatients,’ for example,” Shah says. “It’s a classic outpatient service, but if performed in the inpatient setting, it can and should be charged for separately.”

Increased payments in the long run

Hospitals will not immediately see increased reimbursement from Medicare simply because they begin charging for additional services separately on their inpatient bills, unless, of course, an outlier status is triggered—in which case additional payment could be seen immediately. Hospitals will continue to receive the same DRG payment that Medicare would assign to a particular case, but by reporting all of the charges separately, hospitals will be providing more cost data to Medicare. CMS uses these data to develop future payment rates.

> continued on p. 2
Ancillary services

“So over time, if all hospitals begin reporting these allowable charges on their inpatient claims, then we should see the appropriate DRG payment rates go up over time,” Shah says.

Patients who received more bedside ancillary services would see those services reflected in the line-item bill, which would allow hospitals to more accurately report the costs associated with caring for a particular patient, says Valerie Rinkle, MPH, revenue cycle director at Asante Health System in Medford, OR.

“Collectively, we should start to see improved weights for the payment systems reflecting true higher-cost cases,” Rinkle says. “That’s the long-term benefit.”

More immediately, hospitals have an opportunity to improve their current reimbursement from commercial payers in cases where the payment system is based on a percentage of billed charges. By reporting charges for ancillary bedside services on inpatient claims, hospitals will be submitting more total charges and could see greater payments from their commercial payers. For example, consider the difference between being reimbursed for 80% of $5,000 in charges versus receiving 80% of a $5,800 bill that reflects charges for the ancillary services mentioned above.

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“By getting all charges on the bill today with your non-Medicare payers, hospitals are likely to see an immediate increase in revenue,” Shah says.

Even for managed care payers that pay a per diem or DRG for inpatient care, the charges for ancillary services provide information to your contracting manager on the mix of higher-cost patients treated by your hospital that can be used in contract negotiations.

Reporting all of the ancillary nursing services as line items on a patient’s bill provides an additional benefit for hospitals by clarifying the number of services a particular patient receives, says Denise Williams, RN, CPC-H, director of revenue integrity services at Health Revenue Assurance Associates in Plantation, FL. Not all patients receive the same ancillary services in the same quantity for the same amount of time for each admission.

Upcoming audio conference
CMS allows facilities to line-item report what are traditionally thought of as outpatient nursing services, such as injections, infusions, and transfusions, on inpatient claims.

Learn how facilities can break out inpatient room-related procedures by line item in compliance with CMS standards during HCPro’s July 16 audio conference “Charging Bedside Procedures Beyond the Room Rate: How, Why, and What It Means for Your Bottom Line.”

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"It actually allows the hospital to drill down and ascertain the actual cost of care per individual patient," Williams says.

**One facility’s success story**

Asante Health System had been charging for some ancillary bedside services, such as lumbar punctures, for several years. However, until last fiscal year, it did not have systems in place for nurses to effectively document IV stop times to capture charges for drug administration, Rinkle says.

The health system has been reporting drug administration charges for about 18 months. Its commercial payers have started to audit some of those cases, and Rinkle has successfully defended her organization’s charging practices using the Medicare statute that requires all patients to be charged the same.

“We have been extremely successful,” she says. “In fact, I would say we have been almost 100% successful in defending our charge practices with those audits by citing language from the Medicare hospital manual and the 2009 IPPS final rule.”

Rinkle has also successfully defended her charging practices to the Oregon Medicaid agency on outlier cases. Some Medicaid managed care plans used a defense firm to dispute charges in outlier cases to reduce the outlier payment.

“We had to appeal to the state, and the state upheld the charge practices as well,” Rinkle says. “In addition, our Medicare contractor released a FAQ that said it is appropriate to charge drug administration on inpatients.”

**Importance of documentation**

Rinkle has one other thing going for her when she defends Asante Health System’s charging practices: accurate documentation.

“We don’t charge if we don’t have the documentation,” she says.

Although Asante is now successfully billing for ancillary bedside services for inpatients, Rinkle faced opposition in the beginning, especially when it came to drug administration. “It was hard to convince nursing about the IV stop times,” Rinkle says.

Fortunately for Rinkle, Asante was rolling out its electronic medical record system for documenting drug administration at the same time it started billing for drug administration.

“We were able to actually build in capture of the stop times in the electronic medical record,” she says.

The economic downturn ended up being an even bigger help in getting staff members on board with the...
Ancillary services  < continued from p. 3

charging practice. Like all hospitals, Asante saw its margins shrink and had to do a lot of belt tightening.

“When nursing realized they controlled much of the financial success based on documenting certain things, they really got on board,” Rinkle says.

Challenges of line-item billing

If billing ancillary bedside services for inpatients is an appropriate and legitimate practice, why aren’t more hospitals doing it?

Many hospitals believe they have already factored these ancillary services into their room and board charges, says Shah.

Williams compares outpatient services to an à la carte system, in which services are reported and mostly reimbursted individually. Inpatient services are more like a buffet, in which reimbursement is based on a flat rate regardless of the number of services provided.

“In the past, the room rate has been the catchall for reporting nursing services,” Williams says. “Hospitals believe, and I think it’s a valid belief, that they have already accounted for bedside services in the cost and charge for that room rate and they don’t want to double dip by reporting additional services separately.”

However, hospitals must carefully review their existing room and board charges because staff members may not be sure what originally was involved in creating the room rate.

In many cases, the room rate may have remained the same for a long time, and there may not be anyone at the facility who was around when it was created.

In addition, annual updates to the room rate likely reflect inflation rather than a full-scale review and analysis of the charges. Hospitals may be assuming that the room rate already reflects charges for ancillary bedside procedures since routine nursing services are part of the rate, but it’s important to recognize the difference between routine nursing services and ancillary bedside procedures that are not considered routine.

“What I would say to hospitals is, do you really know what your room and board rate is made up of?” Shah says. “Are you absolutely sure that bedside ancillary services have been factored in and, if so, would it be more appropriate to pull them out and charge for them separately since they are not the same as routine nursing services?”

Rather than increasing room rates by the annual price increase, consider separately charging the ancillary services. This carves out the ancillary services from the room rate.

Allocation of hospital resources

Hospitals also have to determine how they can accurately and consistently capture these services. If a facility captures the charges accurately on some days but not others, it could end up billing patients in different ways.

“You end up with a breakdown in the process, which allows some patients to be billed with the appropriate line items and others not,” Williams says.

Individual hospitals must determine whether it is cost-effective for them to expend resources capturing and reporting these charges.

“Based on your patient population and payer mix, you are putting forth a lot of resources for something that doesn’t necessarily or immediately help your bottom line,” Williams says.

Consider standard charge practices

Some hospitals may remain wary of adding ancillary bedside services to patients’ bills, which could affect all of the hospitals in their state or region.

According to Medicare, if other hospitals in your region are line-item billing for these other services, then it is very appropriate for you to line-item bill as well, says Williams.

In the past, hospitals did not know what other facilities were charging because the information was proprietary. However, hospitals are now posting their charge
description masters and increasing the transparency of billing practices, making it easier to determine whether something is a standard charge practice.

**Future fixed payment contracts**

Even though hospitals won’t see immediate returns from government payers and commercial plans with fixed payment rates, they should still report ancillary services on patient bills, Rinkle says. That way, when they negotiate future contracts, they can use the information to justify increased reimbursement rates.

“If I know that 90% of one payer’s patients end up getting IV therapy, and another payer has 10% of their patients who have IV therapy, I’m going to negotiate each contract with information applicable to that specific payer,” Williams says. “Even though I’m going to be paid a flat rate, I’ll have complete cost information to be sure the negotiated rate covers the services that my facility provides.”

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Set the bar with outpatient coding productivity standards

*Get started with these six questions*

Editor’s note: The results of the survey discussed in this article are based on responses from 215 participants in the following settings:

- Acute care community hospital (nonteaching): 45%
- Acute care teaching hospital: 26%
- Clinic/physician office: 12%
- Critical access hospital: 7%
- Freestanding ambulatory surgery center: 5%
- Freestanding rehab: 2%
- Freestanding skilled nursing facility: 1%
- Long-term acute care hospital: 2%

Establishing coding productivity standards is a necessary and challenging part of running an efficient HIM department. Without standards, coders don’t know what directors and managers expect of them, and they don’t have a productivity goal to which they can aspire.

Seventy-three percent of the 215 respondents of HCPro’s April coding productivity survey reported having established a general coding productivity standard.

Although having standards is important, the one area in which directors or managers sometimes fail is in monitoring those standards, says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, senior consultant at QHR in Brentwood, TN. Outpatient standards, in particular, aren’t monitored as closely because inpatient cases tend to bring in more money, Krauss says.

Not revisiting outpatient productivity standards on a weekly or monthly basis for each coder could be a big mistake, he says, adding that if a coder is not performing up to par, it’s better to realize that early on and set realistic goals rather than to determine it during a six-month or annual evaluation.

What’s challenging about productivity standards is that there’s no one-size-fits-all solution, says Joe Rivet, CCS-P, CPC, CEMC, CICA, regulatory specialist at HCPro, Inc., in Livonia, MI.

“The problem is that people are looking for something that doesn’t exist,” Rivet says. “Every facility is unique. Facilities should really be looking at their operations, flows, and processes to create their own benchmarks for productivity.”

When monitoring outpatient coding productivity standards, directors and managers should routinely ask the following questions to ensure accurate and fair expectations:

- Do outpatient coders also code inpatient services? Inpatient and outpatient coding require two different skill sets, says Rivet.

“The rules between inpatient and outpatient are very different. Outpatient rules are unique, and you use CPT far more than you would on the inpatient side,” he adds. Because of these differences, productivity standards vary

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greatly between the two. In smaller facilities, coders typically code both types of records, Rivet says. But larger facilities may have more FTEs, allowing for specialization.

One advantage of separating coders according to record type is that it could increase productivity, he says.

“If you do something all the time, you’re going to get to know the types of diseases and procedures that represent the product line, and can move more quickly through the encoder or book,” Rivet says.

A disadvantage is that coders who code only one record type may become bored with the task and yearn for more variety, Krauss says.

It’s important to distinguish whether coders code inpatient records, outpatient records, or both because each record type has its own challenges. For example, inpatient coders must scour records in search of complications and comorbidities (CC) or major CCs. They must also assign the present-on-admission indicator and follow up with physicians regarding queries for added specificity.

On the outpatient side, coders struggle with medically unlikely edits, NCCI edits, modifiers, and verifying medical necessity, Krauss says. All of these factors affect coding productivity.

➤ **What type of outpatient records do coders code?** Outpatient productivity standards could vary greatly depending on the record type.

“[Interventional radiology] cases or any other type of invasive procedure is more complex than a straightforward ER or clinic visit,” Rivet says.

See “Outpatient coding productivity standards according to record type” at right for specific standards for ambulatory surgery, ED, outpatient testing reports (noninterventional), interventional outpatient testing reports (e.g., cardiac catheterizations and angiographies), clinic visits, and observation.

➤ **What other noncoding duties do outpatient coders perform?** Noncoding duties can greatly affect coding productivity, and you should take them into

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### Outpatient coding productivity standards according to record type

| Ambulatory surgery records per hour | |
|-------------------------------------|---|---|
| Fewer than 4                        | 5% | 8% |
| 4                                   | 6% | Greater than 8 | 7% |
| 5                                   | 16% | We don’t have a standard | 16% |
| 6                                   | 18% | We don’t code this record type | 17% |
| 7                                   | 9% | |

| ED records per hour | |
|---------------------|---|---|
| Fewer than 6        | 2% | 11% |
| 6                   | 2% | Greater than 12 | 29% |
| 7                   | 2% | |
| 8                   | 3% | We don’t have a standard | 16% |
| 9                   | 2% | We don’t code this record type | 23% |
| 10                  | 13% | |

| Outpatient testing reports (noninterventional) per hour | |
|--------------------------------------------------------|---|---|
| Fewer than 20                                          | 8% | Greater than 31 | 13% |
| 20–25                                                 | 19% | We don’t have a standard | 20% |
| 26–31                                                 | 12% | We don’t code this record type | 28% |

| Interventional outpatient testing reports per hour | |
|----------------------------------------------------|---|---|
| Fewer than 4                                        | 4% | 9% |
| 4                                                   | 6% | Greater than 10 | 9% |
| 5                                                   | 12% | |
| 6                                                   | 8% | We don’t have a standard | 18% |
| 7                                                   | 6% | We don’t code this record type | 27% |
| 8                                                   | 4% | |

| Clinic visits per hour | |
|------------------------|---|---|
| Fewer than 8           | 3% | 12% |
| 8                      | 5% | Greater than 12 | 17% |
| 9                      | 1% | We don’t have a standard | 20% |
| 10                     | 6% | We don’t code this record type | 44% |
| 11                     | 1% | |

| Observation cases per hour | |
|----------------------------|---|---|
| Fewer than 4               | 9% | 8% |
| 4                         | 10% | Greater than 8 | 6% |
| 5                         | 17% | We don’t have a standard | 21% |
| 6                         | 9% | We don’t code this record type | 21% |
| 7                         | 3% | |

Source: HCPro’s April coding productivity benchmarking survey.
account when establishing standards, Rivet says. For example, outpatient coders often perform data entry and loose filing, answer phones, order supplies, and retrieve records.

Of those respondents who reported that coders code outpatient records only, nearly 63% said they also answer calls and questions from the business office and patient financial services.

Fifty-six percent said outpatient-only coders obtain information to support medical necessity. Thirty-eight percent said they respond to RAC requests, and another 38% said they answer calls and questions from physician offices.

Coders who code for labs, x-rays, or other ancillary departments may need to go to the department to pick up the record, Rivet says. Often, they may need to alphabetize the records as well, and each of these tasks takes time.

➤ For which omissions do outpatient coders check? Omissions, such as a missing operative note or pathology report, are perhaps the biggest barrier to an outpatient coder meeting productivity expectations, Krauss says.

Of those respondents who reported that coders code outpatient records only, nearly 63% reported that these coders also check for omissions in ambulatory surgery/outpatient records.

Twenty-five percent said they check for omissions in ED records, and another 25% said they check for omissions in outpatient testing records.

“Is it missing, or did the physician not perform it? If it’s not documented, then it didn’t happen,” Rivet says, adding that outpatient coders must frequently track down missing signatures or attestations for teaching hospitals.

➤ What ED services do coders code? In some facilities, coders only code facility ED services, whereas in others, they code facility and professional services, Rivet says. When coders code both, adjust productivity standards accordingly.

Twenty-seven percent of respondents reported that coders assign diagnoses on the physician’s bill. Twenty percent said they assign procedures on the physician’s bill, and 27% said they assign the physician E/M level.

➤ What is the skill level of the individual coder? When setting productivity goals, take coders’ skill sets into account, particularly when the coder is new to the organization, Rivet says.

“Even if the person is seasoned, but new to the organization, there should be some ramp up. Set goals for one month, two months, three months, etc., into the employment.”

Although it’s important to consider a coder’s skill set when determining whether he or she can reasonably meet predetermined standards, directors and managers shouldn’t set standards solely based on skills, Krauss says.

“If you have too many standards, it defeats the purpose and is not a standard anymore,” he adds. “If someone is not meeting the standard, figure out what you can do to help that person get where he or she needs to be.”

“If someone is not meeting the standard, figure out what you can do to help that person get where he or she needs to be.”

—Joe Rivet, CCS-P, CPC, CEMC, CICA

Upcoming audio conference
Benchmark coder productivity
Learn the results of HCPro’s in-depth coder productivity benchmarking survey and find out what factors most affect coding productivity.

We’ll drill down into the effects that noncoding duties, record type, patient volume, and more have on staff members’ ability to maintain efficiency. Join HCPro on August 11 at 1 p.m. for the live audio conference “Benchmark Coder Productivity to Improve Efficiency and Justify FTEs.”

Register today by calling customer service at 800/650-6787 and mention source code NEWSAD.
Carefully review CMS’ national coverage analysis on PET scans

For years, it has been a challenge for healthcare facilities to determine whether Medicare will cover positron emission tomography (PET) scans for cancer patients.

However, that job just got easier. In April, CMS issued a final national coverage analysis (NCA) reconsidering coverage for several types of solid tumors. The NCA expands coverage for initial testing with PET scans for Medicare beneficiaries who are diagnosed with and treated for most solid tumor cancers.

The NCA should make it easier for facilities to determine when Medicare will cover the expensive scans, but there are still some caveats when it comes to coverage.

“Providers really need to read the final NCA ... when it comes out. They should review it very carefully and pay attention to the asterisks. There are still a lot of significant limitations.” —Kimberly Anderwood Hoy, Esq., JD, CPC

CMS made its decision to expand coverage based on evidence that PET scans are useful in helping physicians guide treatment when they first diagnose a patient’s cancer. The agency said scientific data show PET scans are “reasonable and necessary” for initial treatment decisions for most solid tumor cancers. CMS describes a PET scan as a minimally invasive diagnostic imaging process that uses a radioactive tracer to evaluate glucose metabolism in tumors and normal tissue. The test can provide important clinical information to guide initial treatment, such as helping physicians determine whether a growth is benign or cancerous, as well as determining staging or the extent of a tumor’s growth or metastasis. The scans are expensive, costing an estimated $3,000–$6,000, according to PETNET Solutions.

Simplifying the complex

CMS’ new NCA makes it clearer when Medicare will cover PET scans. “Hopefully, and that’s a big hopefully, it’s going to mean we are going to be smoothly and without interruption paid for PET scans for almost all of our solid tumors in initial staging, before treatment begins,” says Simmons.

The NCA should simplify the task for providers. “PET scan coverage previously has been a bear to understand,” says Hoy, with at least 11 different NCDs for cancer uses of PET scans.

Until now, it was difficult for hospitals to determine when and if Medicare would cover PET scans for certain diagnoses because it varied by cancer type and treatment stage.

For example, Medicare might not cover a PET scan for a patient with stage one breast cancer or stage four lung cancer.

Although the oncologist who ordered the PET scan would know the type and stage of cancer, as well as other treatments already tried, the hospital did not always have all the documentation needed to determine coverage from the physician’s order, says Hoy.
Without crucial information to determine coverage, facilities were sometimes forced to give patients an ABN informing them that Medicare might not cover the test, leaving cancer patients with the difficult decision of whether to go forward with an expensive test they might have to pay for out of pocket, Hoy says.

The new decision eliminates the need to know the stage of the cancer and presents two time frames when scans are performed—as initial treatment and subsequent treatment strategies, says Hoy. “In that way, they did simplify it, but I think it’s still a bit difficult to understand,” she says.

What can facilities do to prepare for the new NCA? Consider the following:

➤ Be sure you understand the NCD and its exceptions. Although the decision applies to PET scans used to support initial diagnosis and treatment for most solid tumor cancers, there are still limitations to coverage, so be sure to read the CMS decision, says Hoy. You can find CMS’ decision memo on its Web site at www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=2189.

CMS has a chart in Appendix A summarizing coverage of the decision memo. Some of the coverage exceptions are at the bottom of the chart. CMS made the changes to Section 220.6 of the Medicare NCD Manual.

The decision also expands coverage of PET scans for subsequent follow-up testing for Medicare beneficiaries who have cervical or ovarian cancer, or who are being treated for myeloma, a cancer that affects white blood cells, according to CMS.

Exceptions to the coverage for initial treatment include the following:

- To determine initial treatment in patients with adenocarcinoma of the prostate.
- For diagnosis and initial staging of axillary lymph nodes in breast cancer patients. Medicare will continue to cover PET imaging for male and female breast cancer only when used in staging distant metastasis.
- For initial staging of regional lymph nodes in melanoma. However, other uses to determine initial treatment strategy remain covered.
- Limitations on treatment of cervical cancer. Medicare will cover the scan only as an adjunct test for the detection of pretreatment metastasis, such as staging, in newly diagnosed cervical cancers following conventional imaging that is negative for extra-pelvic metastasis. All other uses will continue to be covered under CMS’ Coverage with Evidence Development as research. When not used as an adjunct test, Medicare will cover one initial PET study when a physician determines that the test is needed to inform the initial treatment strategy for newly diagnosed cervical cancer in a clinical study to collect additional information to assist in patient management.

➤ Keep an eye on your local FI or MAC. Watch closely what your local FI or MAC is putting out on its Web site and whether it is in tune with federal guidelines, says Simmons. Hopefully, regional FIs and MACs will implement the national guidelines quickly, she adds.

Until the FIs and MACs put those “mechanical pieces” in place and update their Web sites and databases to reflect the change, some PET scans may still not be covered, Simmons says.

Facilities may still be forced to give Medicare patients an ABN telling them they should be prepared to cover the cost for the scan until the new policy is implemented.

➤ Keep departments informed. There should be a partnership between the diagnostic imaging department and your patient access and billing personnel, Simmons says.

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PET scans  < continued from p. 9

says. “Make sure everyone is on the same page,” she cautions.

Take note that the NCA removes the clinical study requirement for PET scan use for initial testing for most solid tumors. “I think it will make it easier. This takes away the requirement that these things be sent into the National [Oncologic PET] Registry,” says Simmons. “It’s one less step for folks.”

Since 2005, Medicare coverage of PET scans has been tied to a requirement that providers collect clinical information about how the scans have affected physicians’ treatment decisions. The new NCA is based, in part, on those registry data and is the first time that CMS has reconsidered a coverage policy based on new evidence developed under this program.

However, clinicians still need to report data to the registry when using PET scans to monitor the progress of treatment or remission of cancer in some cases.

Although the data helped show scans are useful in guiding treatment when cancer is first diagnosed, scientific evidence is not as strong in showing PET scans are as useful in making subsequent treatment decisions for some types of cancer, CMS noted.

➤ Be sure providers inform patients about the new policy. Providers may want to caution cancer patients to have the initial PET scan done where their treatment will take place. If a patient gets a PET scan at one facility and then goes to a tertiary facility for treatment, it could be a problem, Simmons says, adding that Medicare beneficiaries will be covered for only one initial PET scan on their diagnosis.

Be sure the facility where the treatment takes place will have access to the PET scan itself, not just the report, Simmons says. Physicians often like to see the scan, and if computer software is not compatible, they may not have access to the initial test.

Physician supervision update: Organizations urge withdrawal or delay of recent policy change

A group of 12 healthcare organizations, including the American Hospital Association and Federation of American Hospitals, has urged CMS to withdraw or delay the recent policy change regarding physician supervision of hospital outpatient services. The organizations recommended that CMS suspend enforcement of the policy until the agency can address all related concerns.

The policy, which CMS announced in the 2009 OPPS final rule, requires the supervising physician to be physically present in the department of the hospital furnishing outpatient services for purposes of coverage under “incident to.” The policy applies to both on- and off-campus departments.

In an April 15 letter to CMS, the group says the policy “places a considerable burden on hospitals, requiring them to engage more physicians for direct supervisory coverage without a clear clinical need.” The group reiterated its call for CMS to withdraw the policy during a May 13 meeting with the agency.

The letter also states that “the impact will be particularly severe for small or rural hospitals, such as critical access hospitals, which are often the only source of outpatient hospital services within many miles and which are in locations which may have only one or two physicians in the entire community.”

Kimberly Anderwood Hoy, Esq., JD, CPC, director of Medicare and compliance at HCPro, Inc., in Marblehead, MA, says the letter is “a good start, because certainly hospitals have felt that this was an onerous burden.”

In the 2009 OPPS final rule, CMS stated that lack of direct physician supervision was a quality concern. The
letter responds that “beyond this statement, CMS offers no evidence to support the assertion that quality is affected at these sites of service when there is no direct supervision. If quality is one of the reasons for imposing this new requirement, then CMS must make available the data that supports this contention.”

Many of the services affected by the current policy, such as infusion and wound care, are also delivered by home health nurses in a patient’s home without a physician present. “It doesn’t make sense for CMS to limit coverage of these services without a physician present in the outpatient department when they are being done safely without a physician present by home health nurses in patient’s homes,” Hoy says.

CMS argued in the final rule that the policy was a clarification rather than a change. The letter draws attention to the confusion this position has caused within the industry: “CMS’ intent ... was not clear in the 2009 OPPS proposed rule. There was a clear lack of effective and adequate notice about the CMS policy change ... Therefore, many in the field missed the opportunity to address the substantial impact this policy change would have on providers and physicians.”

Even if opponents of the policy were to concede to CMS that this policy has always been its intent, that doesn’t mean that CMS shouldn’t take a look at how delivery of healthcare has changed in the past ten years. “They may need to reexamine the policy in light of the lack of safety concerns that have arisen,” Hoy says.

A strength of the letter is that many reputable associations without a common agenda back it, Hoy says. Although CMS could dismiss the concerns of individual hospitals as biased, a letter from the industry associations commands more attention.

The letter concludes with a call for CMS to hold a special Open Door Forum or town hall meeting to address the policy and the problems it is creating.

This, the organizations say, “would be an important first step ... to ensure it provides the hospital and physician community with the opportunity to provide full feedback on the new policy’s impact.”

Such a meeting would offer the industry an opportunity to discuss CMS’ basis for saying that the policy is necessary for quality, Hoy says.

During the May 6 Hospital & Hospital Quality Open Door Forum conference call, a CMS representative said the agency was working on the issue internally and declined to give a timetable for further discussion or clarification.

Editor’s note: Go to www.aha.org/aha/letter/2009/090415-let-coaltion-blum.pdf to view the group’s letter to CMS.

Hospital Open Door Forum
CMS discusses access hospital payments, RACs in Open Door Forum

CMS hosted a Hospital & Hospital Quality Open Door Forum (HODF) conference call May 6, in which it discussed several items of interest to OPPS hospitals.

Critical access hospital payments
A CMS representative discussed payments to critical access hospitals (CAH) for clinical diagnostic laboratory services.

The 2010 IPPS proposed rule implements a provision under Section 148 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), effective for services furnished on or after July 1, 2009. Current regulations state that in order for the CAH to receive 101% of reasonable costs for outpatient clinical diagnostic lab tests, the patient must be physically present in the CAH when the specimen is collected. Failing to meet this requirement generates payment under the clinical diagnostic laboratory fee schedule, rather than under the reasonable cost methodology.

> continued on p. 12
Open Door Forum  < continued from p. 11

In accordance with MIPPA, the provision would not require the individual to be physically present in the CAH during the specimen collection for payment under the reasonable cost methodology. However, the reasonable cost methodology would still require that the individual be an outpatient of the CAH to receive services directly from the CAH. For the individual to “receive services directly from the CAH,” he or she must receive other outpatient services from the CAH on the same day the specimen is collected, or an employee of the CAH must collect the specimen. Cost-based payment would also continue if the individual is physically present in the CAH (or a provider-based facility of the CAH) during specimen collection.

RAC update
A CMS representative provided an update on the RAC program. CMS and the RACs are currently conducting provider outreach in the first-wave states. An updated schedule is available at www.cms.hhs.gov/rac. CMS has also made available transcripts of the Special RAC Open Door Forum conference calls for Part A and Part B providers, which it held April 8 and April 14. Go to www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp to access these. CMS is accepting e-mailed RAC-related questions at rac@cms.hhs.gov.

ICD-10 update
A CMS representative discussed the agency’s efforts following its proposed rulemaking regarding ICD-10 adoption; CMS has proposed ICD-10 implementation effective October 1, 2013.

An ICD-10 Web site at www.cms.hhs.gov/icd10 includes a variety of ICD-10 resources, fact sheets, mapping tools, and transcripts of outreach calls that CMS has held regarding the ICD-10 transition.

5010 implementation
During the question-and-answer period, a caller asked about the processing of secondary diagnoses, noting that, currently, only eight of these are being processed. A CMS representative confirmed that the system is only able to process the first eight secondary diagnosis codes, but said this will be fixed with the implementation of Version 5010.

Editor’s note: The next HODF is scheduled for Thursday, June 25.