

Reimbursement, Cost & Regulatory Considerations - PCI & Cardiac Surgery

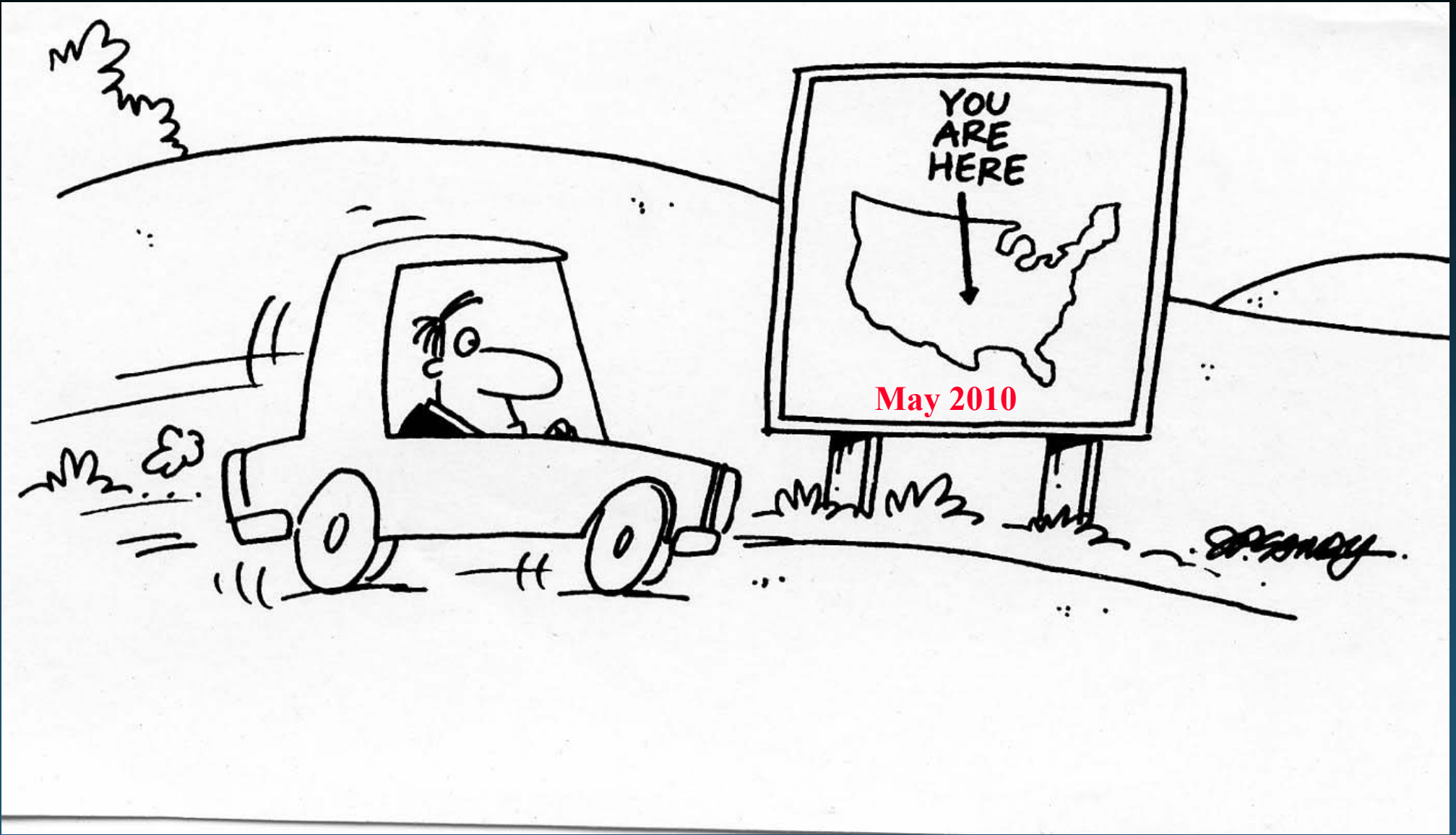
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AGENDA

- **Recent Changes**
- **Opportunities**
- **Special Issues:**
 - Recovery Audit Contractors – Update
 - OIG Specific Concerns for 2010
 - Staff & “Incident to”
 - Observation
 - Research
 - Records: EMR
 - Records : Changes
 - Reporting







SGR: Continuing Extension Act - 2010

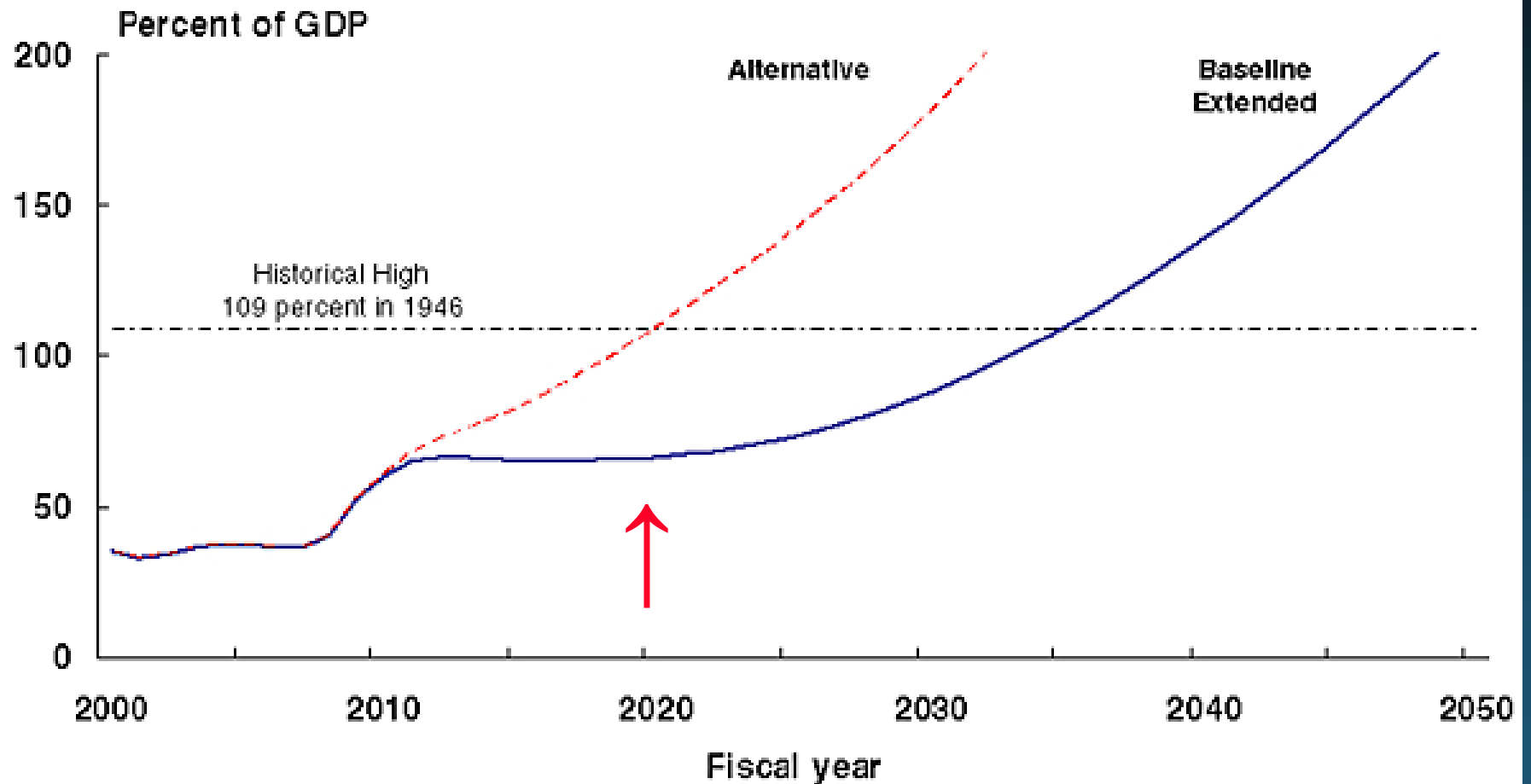
On April 15, 2010, President Obama signed into law the "Continuing Extension Act of 2010." This law extends through May 31, 2010, the zero percent update to the MPFS that was in effect for claims with dates of service January 1, 2010 through March 31, 2010.

Sustainable Growth Rate (SGR)

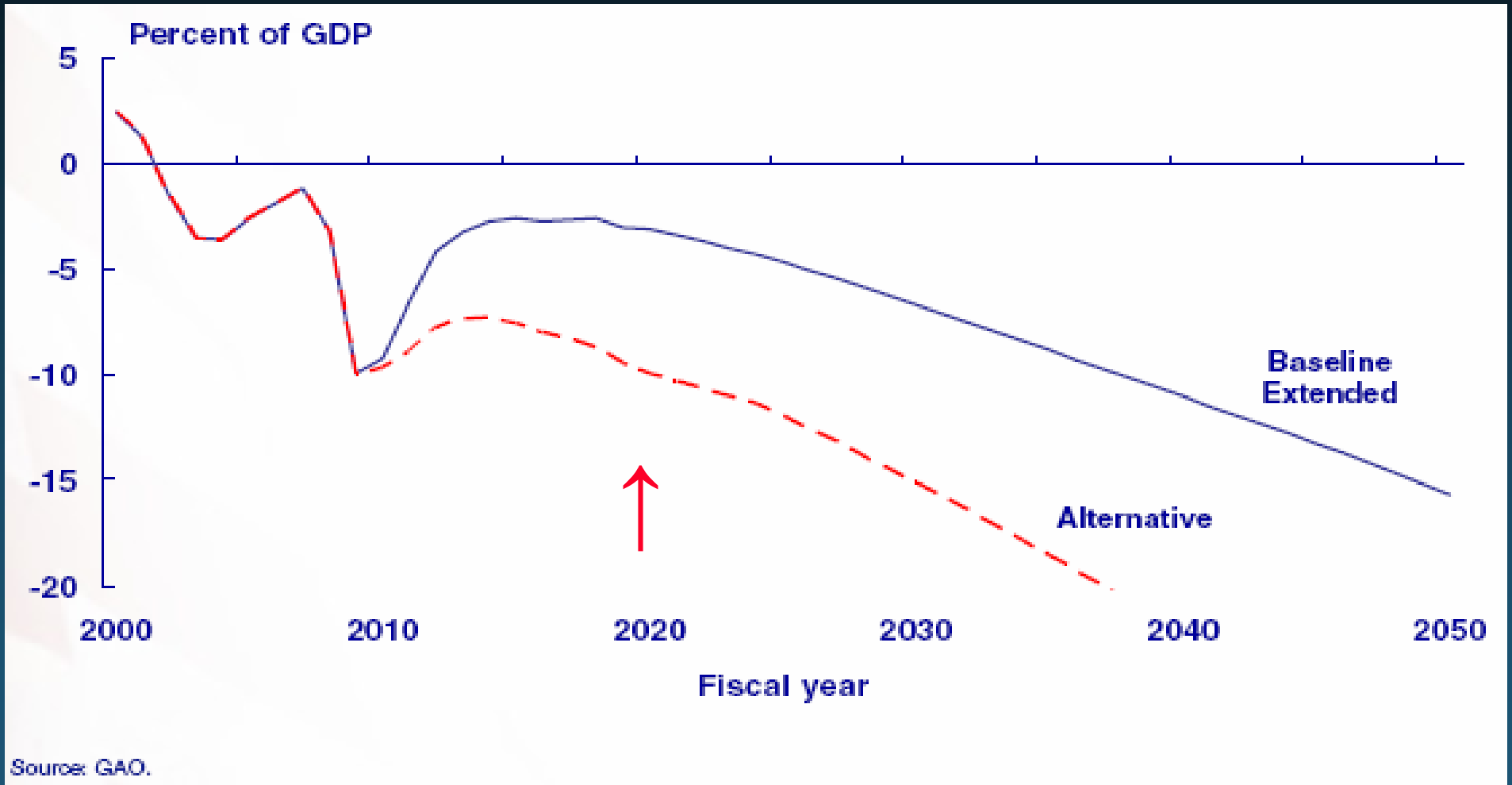
- 1980- 1991: Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6%
- New intermediate term (“**BAND-AID**”) fix
- RW: Congress will not – and can not – develop a more permanent “fix” to the SGR

<http://www.gao.gov/special.pubs/longterm/index.html>

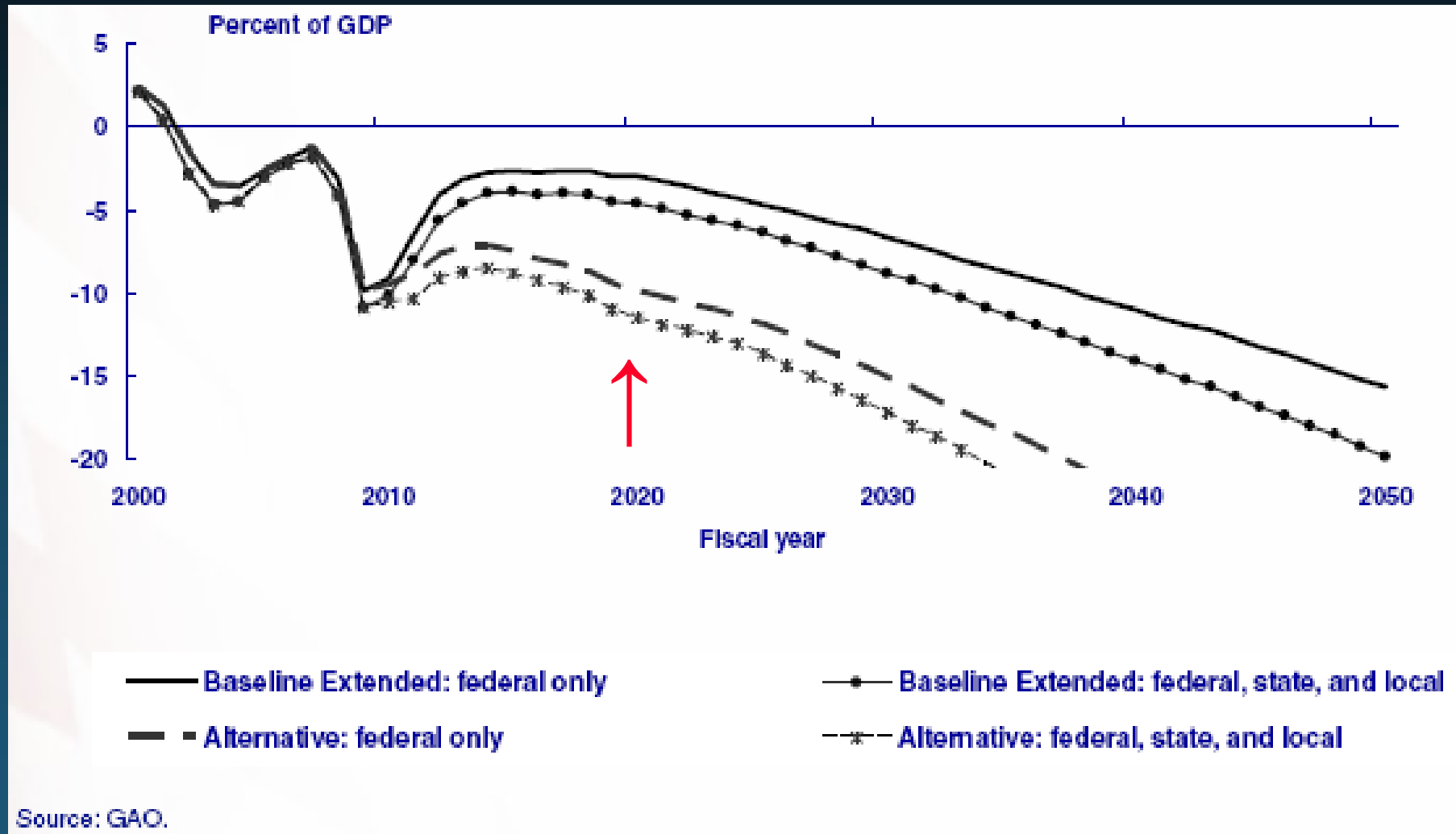
Debt Held by the Public Under Two Fiscal Policy Simulations



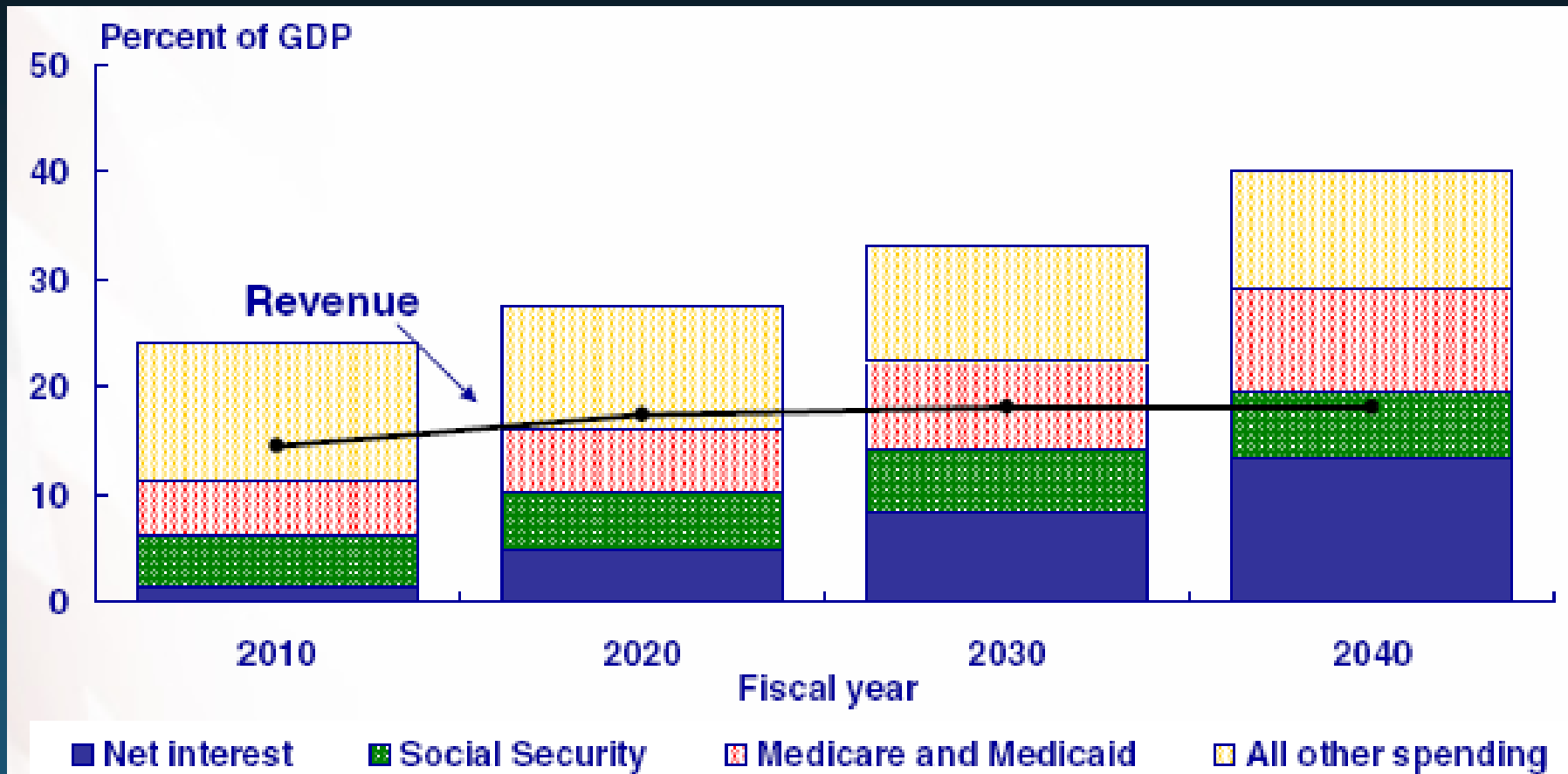
Federal Budget Surpluses & Deficits



Combined Federal, State & Local



Potential Fiscal Outcomes



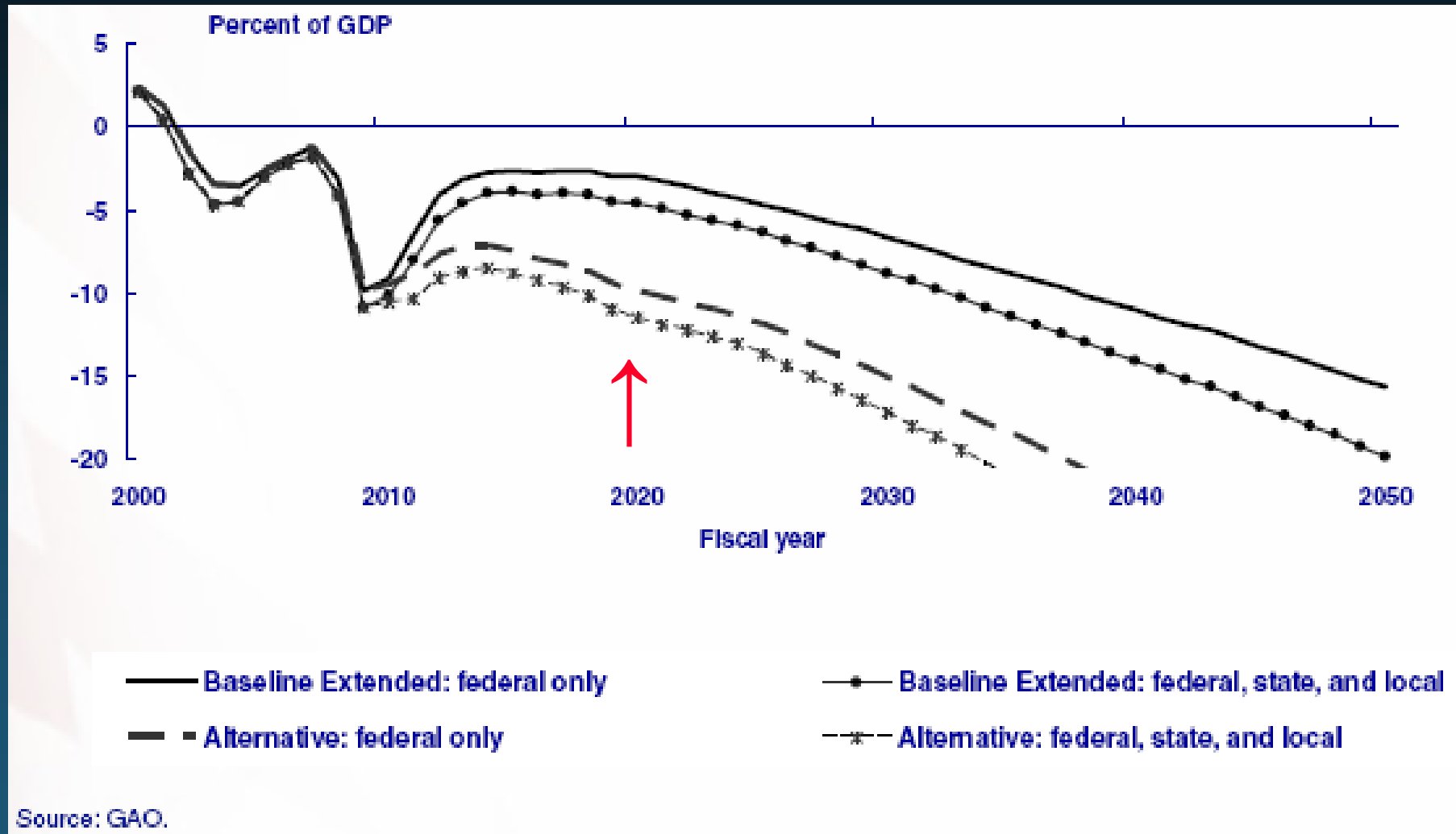
Source: GAO.

Federal Budget Near Term Challenges

2008	Oldest members of the baby-boom generation became eligible for early Social Security retirement benefits
2008	Medicare Hospital Insurance (HI) outlays exceeded cash income
2010	Social Security runs first cash deficit since 1984 ^a
2011	Oldest members of the baby-boom generation become eligible for Medicare
2014	45 percent of Medicare outlays funded by general revenue ^b
2016	Social Security begins running consistent annual cash deficits and redeeming trust fund assets (i.e., nonmarketable Treasury securities) in order to pay beneficiaries
2017	Medicare HI trust fund exhausted. Income sufficient to pay about 81 percent of benefits ^b
2020	Debt held by the public under GAO's Alternative simulation exceeds the historical high reached in the aftermath of World War II

Sources: GAO.

Combined Federal, State & Local



The White House

Office of the Press Secretary

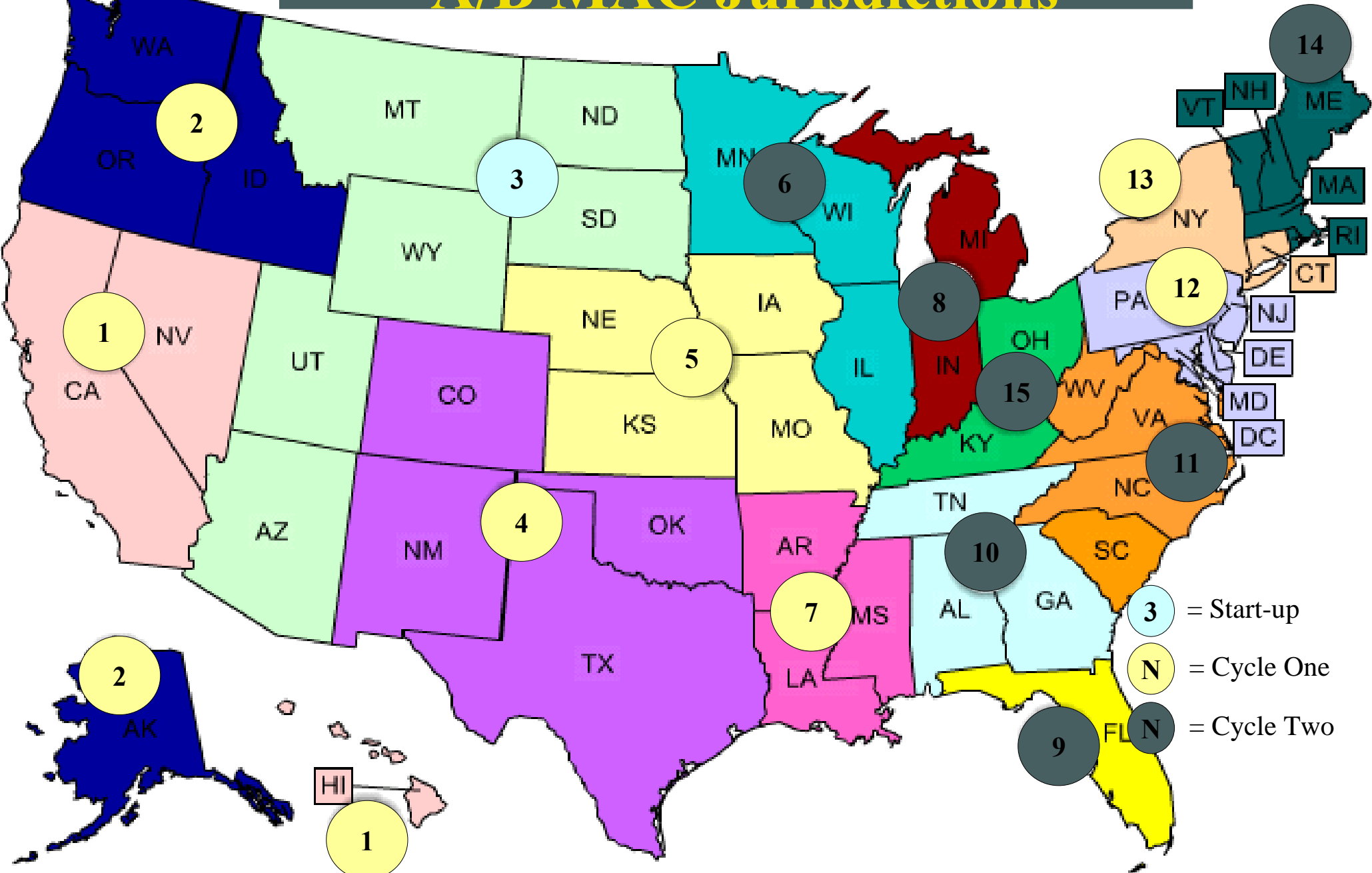
April 19, 2010

- President Obama Nominates Dr. Donald Berwick for Administrator of Centers for Medicare and Medicaid Services
- *“Today, President Obama nominated Dr. Donald Berwick to be Administrator of the Centers for Medicare and Medicaid Services, Department of Health and Human Services.*
“Dr. Berwick currently serves as President and CEO of the Institute for Healthcare Improvement, and is a professor at Harvard Medical School and the Harvard School of Public Health.”





A/B MAC Jurisdictions



3 = Start-up
N = Cycle One
N = Cycle Two

Drivers

- **Major variation** (cf: MedPAC, Dec. 2009 Report to Congress)
 - “...amount of services provided to beneficiaries with similar resource needs still varies substantially” -
 - “...in higher use areas (90th percentile) is about 30 percent greater than lower use areas (10th percentile). The range shows an almost twofold difference...”
 - “...varies at all geographic levels, including within states and among providers within MSAs”

2010 Patient Protection & Affordable Care Act (PPACA)

- **New Quality & Cost Incentives**
- **Accountable Care Organizations (ACOs)**
- **Acute Care Demonstration**
- **Medical Home**
- **Other Alternative Reimbursement Programs**

Physician Quality Reporting Initiative (PQRI)

- **2% payment bonus**
- **EHR reporting method for 10 measures**
- **22 new reporting measures**
- **7 measures deleted**

CMS New Information

- **CMS created an alternative process that providers may request 2007 Re-Run and 2008 PQRI feedback reports:**
 - <http://www.cms.hhs.gov/MLNMArticles/downloads/SE0922.pdf>

Accountable Care Organizations

- **Concept long present**
 - Health Maintenance Organizations (HMOs)
 - Physician-Hospital Organizations (PHOs)
- **Accountable for 100% of all care & of all costs of a defined population**
- **Document longitudinal outcomes - both health & costs**
- **Distribution if costs < targeted budget**

ACOs per MedPAC

- **Consist of primary care physicians, specialists, and at least one hospital**
- **Formed from integrated delivery system, physician–hospital organization, academic medical center, multi-specialty group or IPA**
- **Spending target set in advance**
- **Formal organization and structure**
- **Large share of patients in the ACO**
- **Continuity & therefore primary care, essential**

My Conclusions

- **No permanent “fix” to the SGR**
- **Rapidly increasing pressure to reign in costs and to demonstrate improved health outcomes**
- **Need for more & better outcome data**
 - Longitudinal – longer term
 - More comprehensive – measurable outcomes
 - More comparisons – evidence for effectiveness
 - More comprehensive – all providers

Implications for COAP

- **Longitudinal outcome data**
- **More emphasis on comparative effectiveness**
- **Initially shared with and later including other providers**

Special Issues

- **RACs**
- **OIG**
- **Staff & “Incident to”**
- **Observation**
- **Research**
- **Records: EMR**
- **Records : Changes**
- **Reporting**



Recovery Audit Contractors

<http://www.cms.hhs.gov/rac>

RAC Review Process

- RACs review claims on a post-payment basis
- RACs use the same Medicare policies as Carriers, FIs and MACs
 - NCDs, LCDs, CMS Manuals
- Two types of review:
 - Automated (no additional documentation needed)
 - Complex (additional documentation required)
- RACs not to review claims paid prior to October 1, 2007
 - Maximum look-back period is 3 years
- RACs required to employ staff consisting of nurses or therapists, certified coders and physician CMD

Recovery Audit Contractors

- Paid on contingency basis – *but* only net recoveries
- Normal five levels of appeals – USE THEM!!
<http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf>
- Non-participating physicians still subject to RAC audits for assigned claims
- Watch ACP, ACS, ACC, STS, SIR & other specialty societies

RACs & their CMDs

A - Diversified Collection Services, Inc., Livermore, CA

Richard Pozen, MD – *Cardiologist*

Eugene J. Winter, MD - *Internist*

B - CGI Technologies and Solutions, Inc., Fairfax, VA

**Percival Seaward, MD, CMSA (FCS), FACS –
*General Surgeon***

C - Connolly Consulting Associates, Inc., Wilton, CN

James Lee, DO, R.Ph - *Emergency Med & RPh*

D - HealthDataInsights, Inc., Las Vegas, NV

Ellen R. Evans, MD - *Geriatrics & Family Medicine*

Other RAC Contractors

Subcontractors

- **PRG-Schultz**

Earl Berman, MD, FACP, MALPS-L

- **Viant - Alpharetta, GA**

Stephen T Peake MD, DPH

RAC Validation Contractor

- **Provider Resources, Inc.**

Dennis E. Agostini, DO, PhD, FACEP

Approved RAC Targets

- **Blood transfusions-CPT 36430, 36440, 36450, 36455**
- **Untimed codes**
- **IV hydration therapy-CPT 96360 (replaced 90760 in 2009)**
- **Bronchoscopy services-CPT 31625, 31628, 31629**
- **Once in lifetime procedures**
- **Pediatric codes exceeding age parameters**
- **J2505 (injection, Pegfilgrastim, 6 mg)**

RAC Documentation Limits - 2010

- **Institutional Providers**
 - 1% of Medicare claims submitted for the previous calendar year (2008), divided into eight periods (45 days).
 - Based on TIN and Zip Code
- **Professional Services and DMEPOS Suppliers**
 - Limits have not yet been established
- **Two Caps in FY 2010**
 - Through March 2010, the cap will remain at 200 ADRs per 45 days for all providers/suppliers.
 - From April through September 2010, those in excess of 100,000 claims to Medicare (per TIN) have a cap of 300 ADRs per 45 days

Future RAC Targets

- RAC proposes to add 73 new issues
- May 12, 2010 1:00pm - 2:30pm EST:
Nationwide RAC 101 Call for Physicians
1-877-251-0301, meeting ID: 66529242

CMS RAC Information

- **CMS Web Site: www.cms.hhs.gov/RAC**
- **CMS RAC Email: RAC@cms.hhs.gov**

Office of
Inspector
General

Work
Plan

FISCAL YEAR
2010



OIG

Department of Health and Human Services
Office of Inspector General

http://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf

OIG 2010 Workplan (excerpts)

- “We will identify whether physicians double-billed hospice services to Part A and Part B”
- Physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments
- E&Ms billed during global surgeries
- Appropriateness of Medicare payments for sleep studies

OIG 2010 Workplan (excerpts)

- **Part B imaging services**
- **Medicare payment for unlisted procedure codes**
- **Medicare billings with modifier GY (statutorily excluded)**
- **Compliance with Assignment rules**
- **Transforaminal Epidural Injections**
- **Increased use of Observation**

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

PREVALENCE AND QUALIFICATIONS
OF NONPHYSICIANS
WHO PERFORMED
MEDICARE PHYSICIAN SERVICES



Daniel R. Levinson
Inspector General

August 2009
OEI-09-06-00430



OIG August 2009 Report

Physicians who do not personally perform a service billed must assure:

- a. Licensed physician personally performs, or
- b. Non-physician performing has necessary training, certification and/or licensure

And supervision level is appropriate

Pursuant to state law and to state & Medicare regulations.

<http://www.oig.hhs.gov/oei/reports/oei-09-06-00430.pdf>

Some Examples

- **Injections**
- **Infusions**
- **Venous access**
- **Arterial access**
- **Radiologic technical services**
- **Ultrasound technical services**
- **Respiratory Rx**
- **Ear lavage**
- **Diabetic teaching**

Examples - continued

- **Catheterizations**
- **EKG and ETT tech**
- **Surgical Assist**
- **Topical dermal & ophthalmic applications**
- **Visual fields & eye exams**
- **Simple vital signs**

Requirements: Direct Supervision

- “Immediately available” to furnish assistance and direction and throughout the performance of any procedures **AND** during any hours of Observation
 - For on-campus be present on the same campus
 - For off-campus be present in the provider-based department
- The physician or NPP does not have to be in the room when the procedure is performed or in the observation area **BUT** “must be immediately available to assist”

Drug Compendia Listings (Unchanged from 2009)

- American Hospital Formulary Service (AHFS)
- NCCN Drugs and Biologics Compendium
- Thompson Micromedex DrugDex
- Clinical Pharmacology
- USP Drug Information (USP DI) *no longer valid*
- American Medical Association Drug Evaluations
no longer valid

Observation Services

- “Outpatient” assessment & treatment, 24 - 48 hours
- Observation services DO NOT include:
 - Provided for convenience of patient/family/physician
 - Inpatient admission would have been appropriate
 - Standard preparation for or monitoring related to other services
 - Post-op monitoring during standard recovery period
 - More than 48 hours, in most circumstances

Inpatient/Outpatient: Why Status Matters

- **Basis of Hospital Coverage and Payment**
- **Impact on coverage for SNF care**
- **Patient Co-payment Obligations**
- **Focus of Recovery Audit Contractors (RACs)**
- **Potential False Claims Exposure**
 - **Saint Joseph's Health System (Atlanta) \$26million Settlement (Dec. 2007)**
 - **Kyphoplasty Investigations and Settlements**

OBSERVATION: Medical Determination

- **Observation is a Medical Decision**
 - Decision at the point of entry to care
 - Can I Dx and Rx this patient in 24-48 hours and without the need for highly specialized and intensive services
- **“Referral to Observation”:** Physician’s order
- **Change to Inpatient:** Physician’s order
- **Change to outpatient:** Physician’s order
- **Discharge:** Physician’s order

Default Determination: Utilization Review Rules

- Normal UR committee rules allow decisions to be made either:
 - (1) by one member of the UR Committee and the “practitioner or practitioners responsible for the care of the patient” or
 - (2) by two members of the UR Committee without the concurrence of the treating physician(s).

Causes of Patient Status Assignment Errors

- Unclear Orders
 - “Admit” = Inpatient
 - “Admit as inpatient” = Inpatient
 - “Admit for observation” = Outpatient
 - “Admit to observation” = Outpatient/Observation
 - “Place in observation” = Outpatient/Observation
 - “Admit to Case Management Protocol” = Neither an order for Inpatient Admission nor Observation services



Department of Justice

FOR IMMEDIATE RELEASE

Wednesday, September 2, 2009

WWW.USDOJ.GOV

AAG

(202) 514-2007

TDD (202) 514-1888

Justice Department Announces Largest Health Care Fraud Settlement in Its History

Pfizer to Pay \$2.3 Billion for Fraudulent Marketing

WASHINGTON – American pharmaceutical giant Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc. (hereinafter together "Pfizer") have agreed to pay \$2.3 billion, the largest health care fraud settlement in the history of the Department of Justice, to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products, the Justice Department announced today.

Medical “Research”

- Is there a “tying” relationship...?
- Is my research input substantive?
- Marketing vs. Research Departments?
- Is \$\$ return appropriate to effort & time?
- “Front Page” test!! – Be careful!



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

National Medicare Fraud Alert

Distribution of this Fraud Alert is Limited to the Following Audience:
CMS Regional Offices, Medicare Contractor Benefit Integrity Units, Program Safeguard Contractors, Medicare Integrity Program (MIP) Units, Quality Improvement Organization (QIO), Medicaid Fraud Control Units, the Office of Inspector General, the Defense Criminal Investigation Service (DCIS), the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Medicaid Program Integrity Directors.

SUBJECT:

Use of medical documentation software programs in a manner that results in the upcoding of Office Evaluation and Management Services.

Caution: Changing a Record

- Never “amend”, “fix”, “clarify”, “improve”or otherwise change a record after an audit request!
- But, *may* send a currently-dated translation, clarification, explanation or companion note
- Must be able to document the original record, even when a needed clinical correction made.

Office of Inspector General Reporting

- Phone: 1-800-HHS-TIPS (1-800-447-8477)
- Fax: 1-800-223-2164
(no more than 10 pages please)
- E-Mail: HHSTips@oig.hhs.gov
- Mail: Office of the Inspector General
HHS TIPS Hotline
P.O. Box 23489
Washington, DC 20026





All I really need
to know I learned in
kindergarten





Thank you. Comments/questions welcome:

*Please remember to 1st check both website &
your contractor's Provider Call Center*

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CONSULTATIONS

Specific Points of Confusion

Consultation effective 1/1/2010

- eliminate all consultation codes (inpatient and office/outpatient codes for various places of service) for Medicare except for telehealth consultation G-codes
- bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes

Consultation eff. 1/1/ 2010

- New modifier (“AI”) to identify the admitting physician of record for hospital inpatient and nursing facility admissions (vs. “consultations”)
- Admitting physician of record will be required to append the specific “AI” modifier
- Subsequent care visits by all physicians and qualified NPPs reported as subsequent hospital care codes and subsequent nursing facility care codes

Consultations – eff. 1/1/2010

- physicians will use the office and hospital visit codes in place of consultations and will not have to determine whether the requirements to bill a consult are met
- determination of the appropriate visit code should be made solely on the basis of the existing rules and guidelines for the use of the relevant visit codes (for example, office visit or inpatient visit), without any reference to the guidelines that have been employed for the use of the consultation codes

Consultations – eff. 1/1/2010

Q: asked to see a current patient for (what would otherwise have been) an office consultation, is the “new patient” rule waived?

A: No, if the patient does not meet criteria as a “new” patient (not seen by self or same-practice/same-specialty in past 3 yrs), then cannot bill as “new”

Consultations – eff. 1/1/2010

Q: Asked to see a patient in Observation status for a consultation, what is billed?

A: Treated as if an office (outpatient) service; therefore will bill as New Patient: Office or Other Outpatient services.

Note: ER – same answer

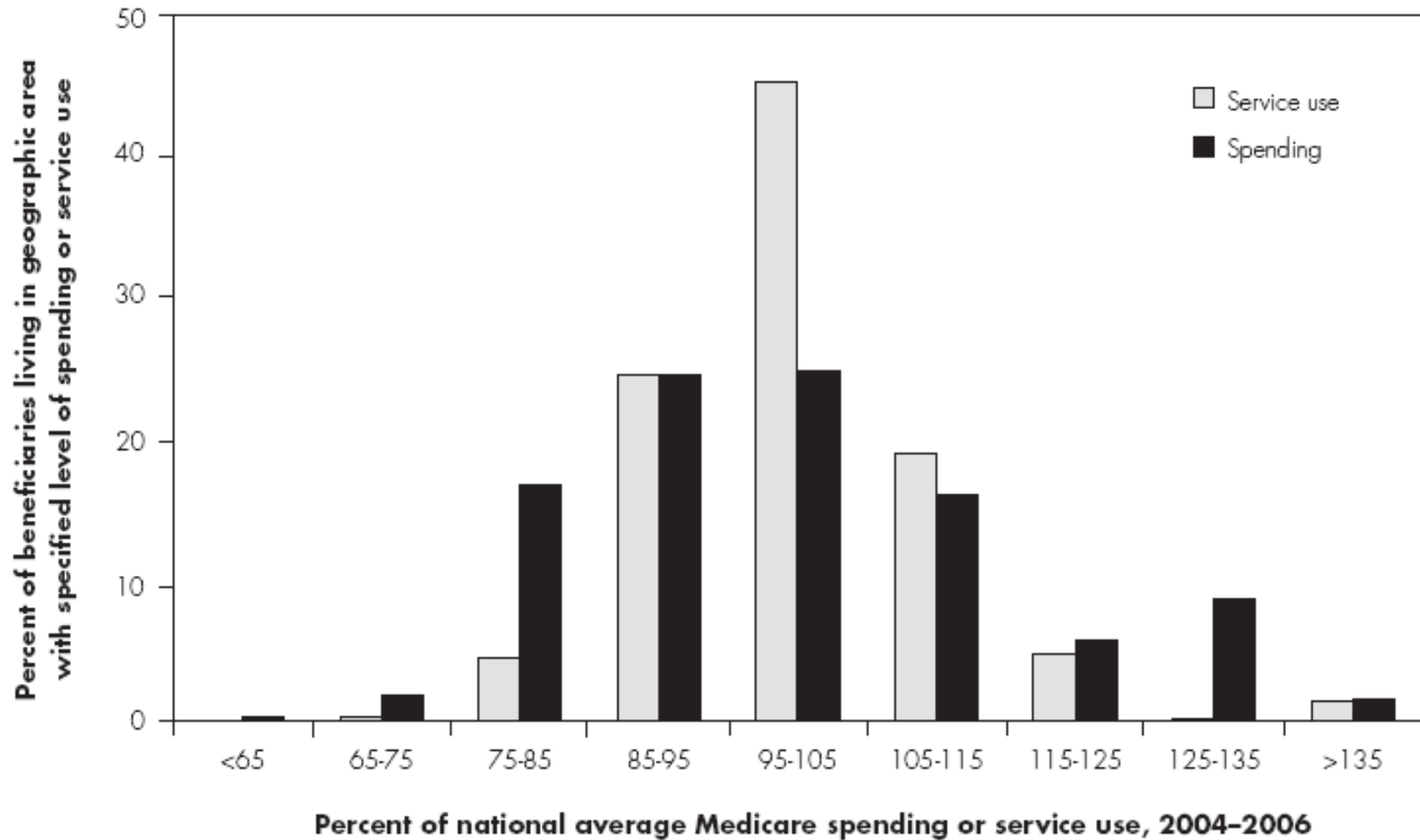
Consultations – eff. 1/1/2010

Final Rule says: determination of the appropriate visit code should be made solely on the basis of the existing rules and guidelines for the use of the relevant visit codes (for example, office visit or inpatient visit), without any reference to the guidelines that have been employed for the use of the consultation codes

Q: May an inpatient consultation therefore now be a “shared service”

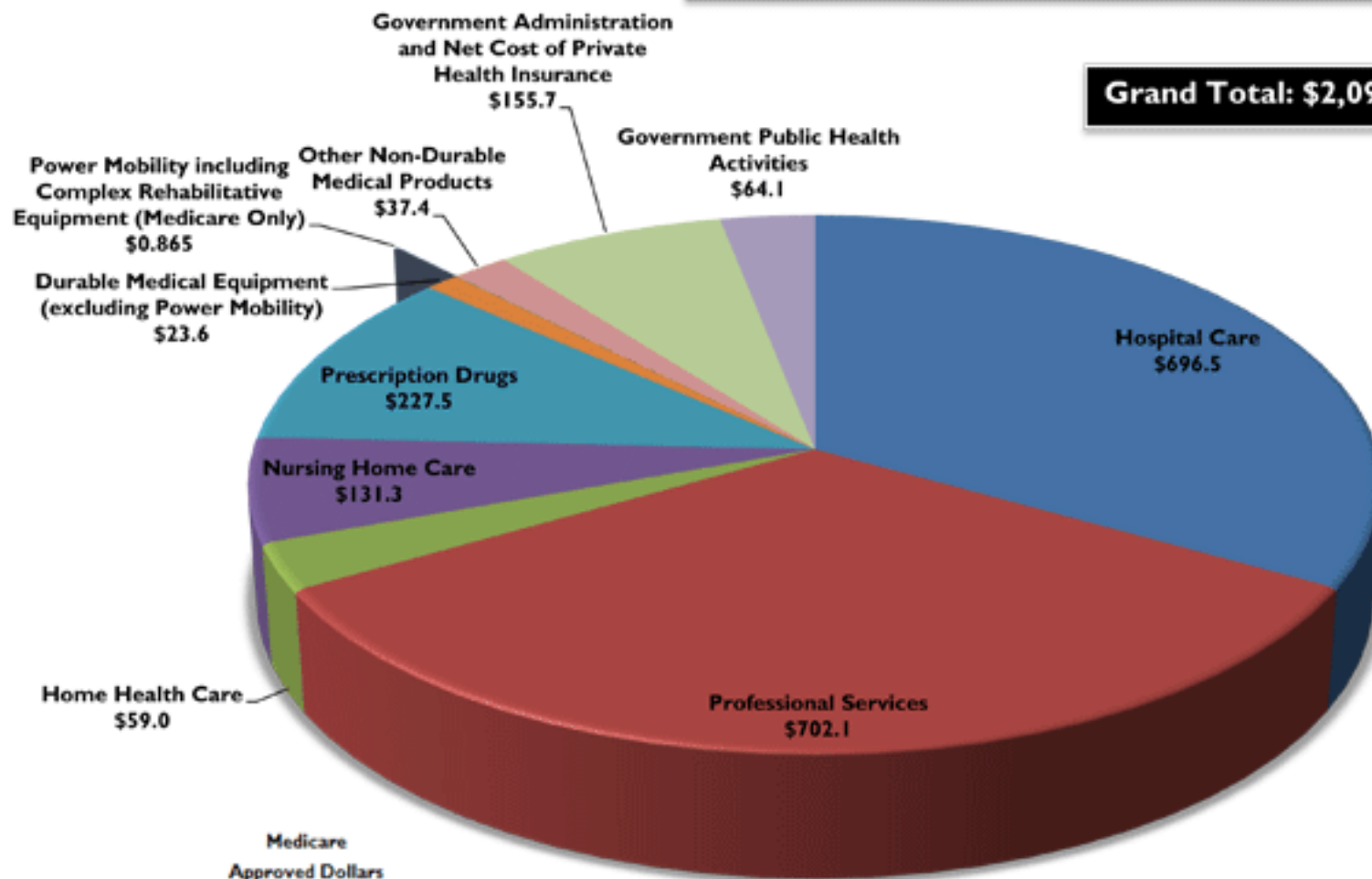
A: Yes! Follow existing rules and guidelines for the use of the relevant visit codes

Service use varies less than raw spending per beneficiary, but substantial variation remains



Expenditures for Health Services and Supplies, 2007 Public and Private Spending (Billions of Dollars)

Grand Total: \$2,098.1 Billion

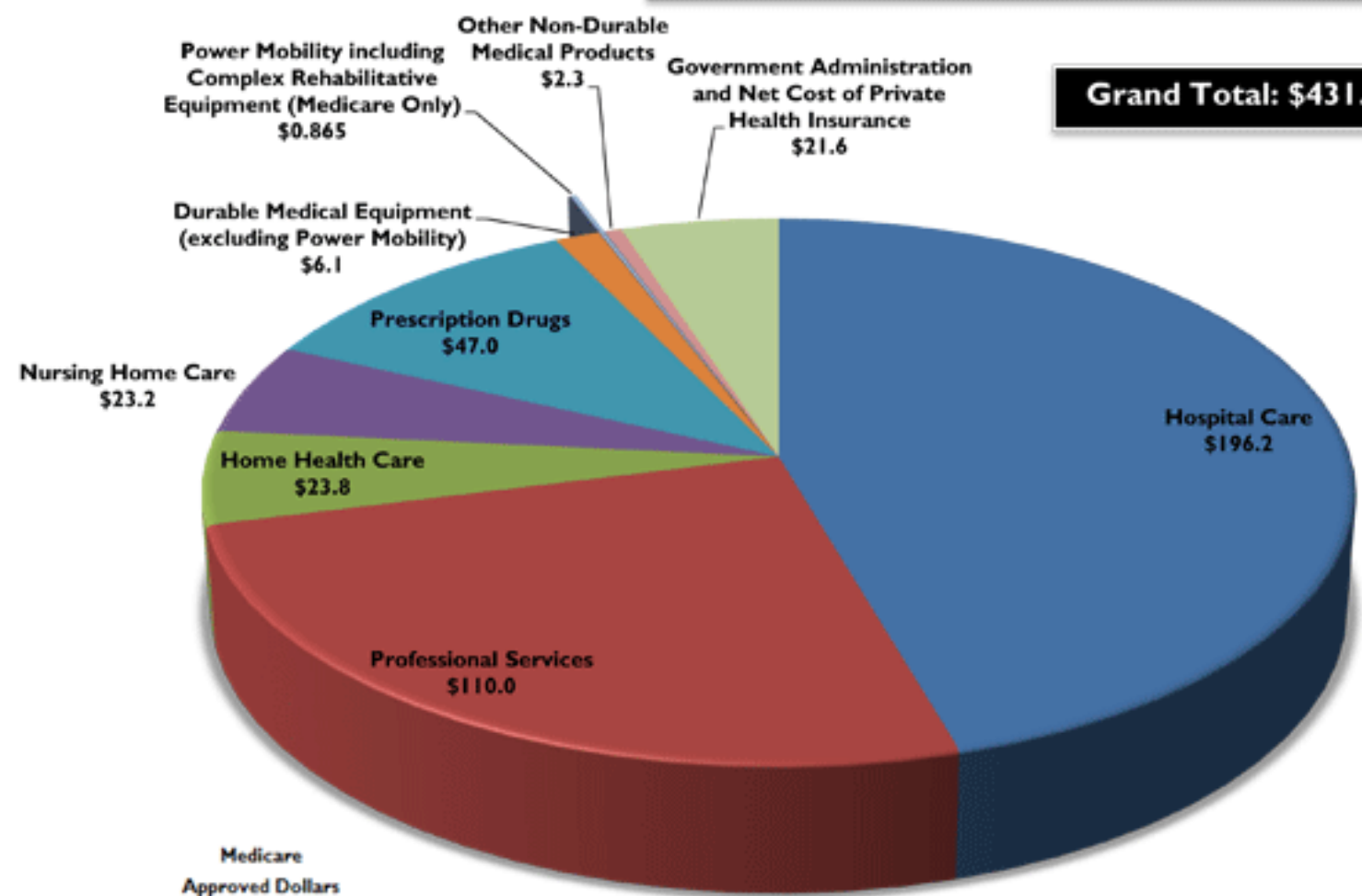


**Medicare
Approved Dollars
(includes beneficiary
20% co-pay)**

Standard Power Wheelchair	\$ 577,490,074
Power Mobility Accessory	\$ 143,078,189
Complex Rehab Accessory	\$ 75,477,556
Complex Rehab	\$ 45,717,921
POV/Scooter	\$ 23,277,462
Grand Total	\$ 865,041,202

Expenditures for Health Services and Supplies, 2007 Medicare Spending (Billions of Dollars)

Grand Total: \$431.1 Billion



Medicare Approved Dollars (includes beneficiary 20% co-pay)

Standard Power Wheelchair	\$	577,490,074
Power Mobility Accessory	\$	143,078,189
Complex Rehab Accessory	\$	75,477,556
Complex Rehab	\$	45,717,921
POV/Scooter	\$	23,277,462
Grand Total	\$	865,041,202

Source: NHE Fact Sheet
http://www.cms.mhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.aspx#TopOfPage

Fanny Foxe



She was the stripper and he was the powerful chairman of the Ways and Means Committee. When park police stopped a car near the Tidal Basin in Washington driven by the Honorable [Wilbur Mills](#), the stripper jumped out of the car into the water.

Oh no, nothing happened, said the chairman. But then Larry Krebs, WMAL-TV camera man, caught it all on tape. This incident in 1974, between Mills and Annabella Batista, aka Fanne Foxe, set the stage for modern Washington scandal. Didn't help Wilbur's reputation when they showed up on a Boston stage a week later, drunk as a skunk. Wilbur doesn't remember any of it. Probably best that way. They guy actually wanted to be President of the U.S.

Outpatient Psychiatric Payment Increase

- **To eliminate the 62.5% reduction, payment increase phases in by 2014**
 - For 2 years (CY 2010 and CY 2011) same:
 - Medicare pays 55%
 - Patient pays 45%
- **Conversion continues until 80% (Medicare pays) and 20% (Patient pays)**
- **Diagnosis triggers psychiatric reduction**
- **CR 6686 effective January 1, 2010**