



New Codes, Provider-Based Rule, Direct Physician Supervision and Charge Compression

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Auditing Injections, Infusions and Chemotherapy

For CY2009 the American Medical Association (AMA) has decided to renumber all of the CPT codes for hydration, injections and infusions. Chemotherapy codes will remain the same. The newly renumbered codes will be placed in CPT just before the chemotherapy codes. While there do not appear to be changes in the coding logic, the coding and auditing staffs will need to carefully study the coding guidance in CPT for hydration, infusions, injections and chemotherapy. The wording has been revised to some extent.

CPT is clearly distinguishing the coding process in this area between physician coding and facility coding. For facilities, such as hospitals, a strict hierarchical approach, as described in CPT, is to be used in selecting codes. For physicians the primary-secondary approach is still to be used. This means that auditors will need to distinguish between freestanding physician-based operations and provider-based hospital operations. The coding could be slightly different.

Auditors actually face a bigger challenge. Each year for the last five years or more there have been significant changes for coding, billing and reimbursement for injections, infusions and chemotherapy. Thus, auditors will need to establish a specific context within the given year or years for any audits. Not so very long ago we had per-session HCPCS Q-codes, then various HCPCS C-codes and now we have progressed to the regular CPT codes. Even within CPT the numbering has changed and guidance has been altered from year to year.

Given the significant changes from year-to-year, hospitals' written policies and procedures have been constantly altered and updated. Almost continuous training of all staff involved in coding and billing has taken place. Auditors will need to use all of this documentation as metrics to judge whether coding, billing and reimbursement has been correct for a given provider.

On the reimbursement side, there have been significant variations in payments along with all the changes in coding. Chemotherapy, in particular, has been on a roller-coaster ride during the early years of APC implementation. For CY2009, APCs are reducing the number of drug administration categories from six down to five APC categories. The actual change in reimbursement due to this change must be carefully monitored.

the formalization of the PBR starting with the April 7, 2000 *Federal Register*.

Over the years, several thousands of pages of *Federal Register* entries, training materials and other documents have been provided by CMS. When this formalization process started, it was anticipated that gaining provider-based status would be an affirmative process involving a request to the MAC (Medicare Administrative Contractor) with formal approval. As the PBR was more fully developed during the several years following 2000, the requirements under this rule morphed somewhat into a much more voluntary program in which hospitals needed to assure that the criteria were met and then possibly file a simple attestation to confirm compliance.

The one main exceptional case is with off-campus provider-based clinics. There are

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The Provider-Based Rule and Hospital-Owned Physician Clinics

In the OIG 2009 Work Plan the related issues of hospitals meeting the requirements of 42 CFR §413.65 (the provider-based rule) and the hospital ownership of physician clinics are being investigated. The provider-based rule (PBR) has been developed over the past fifteen years. The first set of criteria to establish provider-based (or hospital-based) status was enunciated in Program Memorandum A-96-7. These criteria were then brought forward and modified for

three special obligations with off-campus provider-based clinics:

- Notice of Two Copayments
- Special EMTALA Policies
- Direct Physician Supervision

For off-campus provider-based operations either an attestation with supporting documentation should be filed or, to be completely safe, a formal application should be filed to affirmatively gain approval.

Hospitals can also own and operate freestanding clinics. These clinics file only

a 1500, professional claim as opposed to split-billing with both a 1500 and UB-04. The place-of-service indicator on the 1500 is typically 11 for these freestanding clinics. Note that a hospital may elect to have a freestanding clinic physically located right in the hospital itself. Care must be taken to adjust cost-reporting processes in this type of case. Note also, that such owned clinics do trigger the DRG Pre-Admission Window.

Considering the OIG activity, hospital and clinic auditing staffs should anticipate that reviews will be needed to verify compliance. Because there continue to be unanswered questions involving certain requirements of the PBR (e.g., prohibition against under arrangements), auditors will have to take extra caution and time to carefully study and assess organizational structuring.

Just What Is 'Direct Physician Supervision'?

The issue of what constitutes physician supervision has now spanned more than two decades. This issue has arisen again relative to provider-based clinics. The specific issue involves provider-based clinics or outpatient departments of the hospital that are on-campus or in the hospital itself.

When the provider-based rule was initially formalized through the April 7, 2000 *Federal Register*, CMS (then HCFA) was quite adamant that a special obligation for off-campus provider-based clinics is that of direct physician supervision for services. For in-hospital or on-campus operations, physician supervision was simply assumed. This seemed to be based on the concept that there would be a qualified practitioner some place close by on the hospital campus.

In both the July 18, 2008 and the November 18, 2008 *Federal Register*¹ entries updating the APC payment system, CMS is now stating that direct physician supervision is expected for in-hospital and on-campus operations as well. Because this issue has not been discussed since 2000, this guidance appears to be new, but CMS maintains that this is simply a reiteration.

Note also that CMS is now carefully distinguishing diagnostic supervisory requirements from therapeutic

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supervisory requirements. For diagnostic services, the different levels of supervision come from guidance relating to the Medicare Physician Fee Schedule (MPFS). The current discussions are directed more toward therapeutic service supervision.

Chargemasters, Cost-to-Charge Ratios and Cost Reports

Both APCs (Ambulatory Payment Classifications) and DRGs (Diagnosis Related Groups) use charge data from claim forms in developing the relative weights for the APC and DRG categories. This charge data is converted into cost data using hospitals' cost-to-charge ratios (CCRs) from the Medicare cost report.

CMS has discovered significant problems with hospital chargemaster charging formulas generating what is known as *charge compression*. Charge compression occurs mainly with supply items and pharmacy items that use a tiered pricing structure in which inexpensive items are marked up more than expensive items.

Auditors should be prepared to examine this issue when reviewing chargemasters, chargemaster pricing formulas, use of revenue codes and the interface of this information into the Medicare cost report preparation process. While there do not appear to be any easy solutions, CMS is working on making changes to the cost reporting structure. **NP**

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¹ See Section XII. A., Physician Supervision of HOPD Services in both Federal Register entries.