

Reimbursement Management update

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VOLUNTARY USE OF ABNs: CMS Issues New Modifier to Accommodate

By Patrick D. Harkins

The Centers for Medicare & Medicaid Services (CMS) have announced several changes related to the **voluntary** use of advance beneficiary notices of noncoverage (ABNs). Transmittal 1840 (October 29, 2009, change request 6563) is far-reaching, impacting the UB-04 institutional claim and its electronic equivalent as well as the Part B CMS-1500 claim and its electronic equivalent. The changes take effect on April 1, 2010.

In the transmittal, CMS modified the description of the GA modifier and added a new GX modifier. It updated these two HCPCS Level II modifiers to allow the **voluntary** use of liability notices to be distinguished from the **required** use of them. The agency also made significant changes (such as deleting old sections and adding new sections) to several chapters in the *Medicare Claims Processing Manual*.

Modifier GA

This modifier has been redefined as “waiver of liability statement issued, as required by payer policy.” Providers should only use modifier GA when they issue a required ABN for a service. The modifier should not be reported in association with any other liability-related modifiers (see below) and should continue to be submitted with covered charges.

Note that Medicare systems will automatically deny (as a beneficiary liability) lines submitted with modifier GA and covered charges on *institutional claims* (rather than subjecting them to possible medical review). The beneficiary will have the right to appeal this determination. When denying lines due to the presence of the GA modifier, Medicare contractors will use claim adjustment reason code 50, which states, “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”

Note also that Medicare processing of *professional claims* with this modifier is not changing.

Modifier GX

The definition of this new modifier is “notice of liability issued, voluntary under payer policy.” Providers may use the GX modifier to provide beneficiaries with a voluntary notice of liability regarding services excluded from Medicare coverage by statute. In these cases, report the modifier on the same line as certain other liability-related modifiers. (See below.) Note that the GX modifier must be submitted with noncovered charges **only**, and the fiscal intermediary or A/B Medicare administrative contractor (MAC) will deny the claim as a beneficiary liability.

Medicare systems will return the claim if the GX modifier is used on any line reporting covered charges. But they will allow modifier GX to be reported on the same line as the following modifiers that indicate beneficiary liability:

- GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit); and
- TS (follow-up service).

Medicare also will return the claim if the modifier is reported on the same line as any of the following liability-related modifiers:

- EY (no doctor’s order on file);
- GA, GL (medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN);
- GZ (item or service expected to be denied as not reasonable and necessary);
- KB (beneficiary requested upgrade for ABN, more than four modifiers identified on claim);

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- QL (patient pronounced dead after ambulance is called);
- TQ (basic life support transport by a volunteer ambulance provider);

Finally, Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the GX modifier and non-covered charges and will assign beneficiary liability to claims automatically denied when this modifier is present.

Finally, Medicare systems will recognize and allow the GX modifier on claims, but will return the claim if the GX modifier is used on any line reporting covered charges.

The Bottom Line

On and after April 1, 2010, there will be four modifiers related to the use or non-use of beneficiary liability notices in various cases where an item or service may or may not be covered.

GA Modifier: Use this *mandatory* modifier when you, as provider, know that an item or service will not be covered for a medical necessity reason and you have obtained a signed ABN from the patient.

GX Modifier: Use this *voluntary* modifier when a test is not covered (never covered) for statutory reasons, and you have issued an ABN informing the patient of his/her financial liability.

GY Modifier: Use when an item or service is not covered (never covered) for statutory reasons, but no ABN has been issued to the patient.

GZ Modifier: Use when the service provider knows that an item or service will not be covered for medical necessity reasons and did not issue an ABN to the patient.

Information Source: *The program memo summarized above can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1840CP.pdf>.*

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NO NDCs REQUIRED ON MEDICAID CLAIMS: Hospitals Free of Costly Reporting Burden

Hospitals are now, or will soon be, free from a federal requirement to include national drug codes (NDCs) on Medicaid claims for physician-administered outpatient drugs. The only stipulation is that the drugs must not be billed for more than their purchasing cost, as defined by each state's Medicaid plan.

This good news is a result of a recently settled lawsuit filed against the Centers for Medicare & Medicaid Services (CMS) in August 2008 by Safety Net Hospitals for Pharmaceutical Access (SNHPA) and University Medical Center of Southern Nevada. The lawsuit reverses the implementation of a July 2007 Medicaid regulation requiring hospitals to report the NDCs.

The drugs for which CMS was demanding NDCs included infusion products and injectables, which are liquid products or compounds of different drugs that do not lend themselves easily to the mandated reporting.

In addition, said the SNHPA, the requirement would have cost hospitals "millions of

dollars to implement." Specifically, the American Society of Health-System Pharmacists estimated that the reporting requirement would require hospital systems to make changes that would add costs of \$10 per prescription. Not only would it have been costly, it also would have been very difficult to implement.

CMS agreed to issue a memo to Medicaid agencies clarifying that they may exempt hospitals from this federal mandate. It also will advise the agencies that if a hospital drug qualifies for the exemption, it is not subject to a rebate under the Medicaid drug rebate program.

SNHPA President and General Counsel William von Oehsen urged states to take advantage of the CMS clarification to eliminate a difficult and costly administrative burden on all hospitals, especially those participating in the 340B drug-discount program by virtue of serving large numbers of uninsured and underinsured patients.

Information Source: *The full SNHPA press release can be found at http://www.snhpa.org/public/documents/news_release_10_8_09.cfm.*

MEDICARE BILLING GUIDELINES FOR 2010: CMS Issues Two Transmittals to Summarize

On December 11, the Centers for Medicare & Medicaid Services (CMS) issued two transmittals related to the changes made to the hospital outpatient prospective payment system for 2010. Transmittal 1871 (change request [CF] 6751) updates the Medicare Claims Processing Manual, and Transmittal 116 does the same for the *Medicare Benefit Policy Manual*.

Transmittal 1871 describes changes to and billing instructions for various payment policies related to the January 2010 OPPS update. Changes summarized cover the gamut and include the following:

- Changes to device edits;
- Billing for "sometimes therapy" services;
- Payment for multiple imaging composite APCs;
- Cardiac and pulmonary rehabilitation services;
- Outpatient observation services;

- Billing for allogeneic and autologous stem cell transplant procedures;
- Brachytherapy sources;
- Drugs, biologicals, and radiopharmaceuticals; and drug administration services.

In Transmittal 116, you will find highlights related to hospital outpatient diagnostic and therapeutic services as well as requirements for diagnostic x-ray, diagnostic laboratory, and other diagnostic tests.

Finally, CMS reminded providers that the January 2010 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer would reflect additions, changes and deletions made to HCPCS codes, APCs, modifiers, and revenue codes.

Information Source:

- *Provider-information memo MM6751, which is available at <http://www.cms.hhs.gov/MLN/MattersArticles/downloads/MM6751.pdf>, summarizes key points from both of the above transmittals and provides links to them as well.*

UNDER THE RAC MICROSCOPE:

Medical Necessity of Services

By Barbara Vandegrift RN, BSN, MA

When it comes to recovery audit contractors (RACs), hospital leaders continue to ask: Where should we focus our time and attention? The answer is medical necessity—a key RAC target.

Medical necessity lies within the case management scope of practice. Utilization review (UR) is an operational function that occurs within that department to determine the appropriateness of treatment and setting.

Focus on Case Management

Review this department's policies, procedures and protocols, and be sure they align with the Medicare manuals.

The hospital conditions of participation require all hospitals to have a UR plan. A hospital must ensure that all the utilization management (UM) requirements of 42 CFR 482.30 are fulfilled.

(Go to the following web site and search for the above section: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl>.)

For example, a RAC-ready organization will have a supportive structure to help case management personnel adhere to regulatory compliance standards, such as the following:

- A UM committee consisting of two or more practitioners to implement the assigned tasks; and
- A UM plan that provides for review of Medicare patients with respect to the medical necessity of admissions to the institution, duration of stays, and professional services furnished.

The Department of Health and Human Services Office of Inspector General's (OIG) Supplemental Compliance Program Guidance for Hospitals states the following: "Often, the status of patients at the time of admission or discharge significantly influences the amount and method of reimbursement hospitals receive. Therefore, hospitals have a duty to ensure that admission and

discharge policies are updated and reflect current CMS rules."

A case management structure that is RAC-ready will have processes in place to monitor risk areas and a UM program to report potential exposure for recoupment. Performance-improvement activities will assist in the development of programs to address areas not meeting regulatory compliance.

Create a UM Plan

To get started, develop a UM plan, and consider a further drill-down on your internal utilization practices to determine what care setting needs attention. It doesn't matter whether the patient enters the facility through the emergency department (ED), endoscopy, cardiac cath lab, surgery or as a direct admission; it's important to know how the determination is made for an outpatient or inpatient status and whether medical necessity is a consideration.

Also be sure the following questions can be answered.

- What protocol is used for outpatient observation?
- Have medical staff received any education to ensure that they are current with regulatory and compliance issues as they pertain to medical necessity?
- Does the ED physician understand admission criteria?
- When was the last time the case management staff received training on admission criteria?
- What monitoring is occurring to assure the application and appropriateness of the screening criteria?

Other Key Areas

If your hospital has fallen short, it is not too late to focus on a few key areas related to medical necessity. These are provided below along with brief guidelines for implementation.

Short-Stay Admissions. Review all short-stay cases to identify whether they were medically appropriate for an inpatient admission. In the documentation, look for clinical signs

and symptoms that indicate the patient's condition and treatment response.

When the patient recovers quicker than was anticipated and is discharged within a one-day stay, has the policy for condition code 44 been followed? Specifically, when a Medicare patient's status is changed from inpatient to outpatient, the following conditions must be met:

- The status change must be made before discharge or release, while the individual is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission; and
- A physician concurs with the UR committee's decision and documents the agreement in the medical record.

23-Hour Observation. If this term is used in your facility, exam the protocol and the medical staff's understanding of the use of this outpatient level of service. Observation is no longer limited to 23 hours and may extend longer. The documentation should clearly reflect the level of care needed—that is, outpatient observation versus inpatient admission.

Socioeconomic Admissions or SNF Placements. Medicare pays for up to 100 days of skilled nursing or rehabilitation if it precedes a three-day acute care hospital stay. Medical necessity will need to be met on all three days. Monitor and audit all three-day hospital stays with a skilled nursing facility (SNF) admission, evaluate the need for an acute care admission and determine whether each day of the stay was medically necessary.

Medically Unnecessary Admissions. For admissions to be considered medically necessary under the Medicare program, the patient must have a condition requiring treatment that can only be provided in an inpatient setting. If the patient can safely receive treatment in a less intensive setting, such as outpatient observation, the patient should not be admitted. A RAC-ready hospital has a process and system in place for taking care of patients who do not require acute care hospitalization, every day of the week, 24 hours per day.

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INDUSTRY NEWS:

Latest on Payments, Policies and Practices

Correct Use of PA, PB and PC Modifiers. These three modifiers are often being submitted incorrectly on claims, which can cause incorrect denials. In Transmittal 1867 (December 4, change request 6718) and MM6718, CMS directs contractors on handling incorrect claims in order to alleviate the issue. It also provides detailed instructions on the proper uses of the three modifiers, which hospital billing staff should follow.

Previous transmittals have covered the topic of “wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.” These transmittals summarized billing procedures for these adverse events.

In this latest transmittal, the Centers for Medicare and Medicaid Services (CMS) says that it has come to its attention that the new modifiers announced for these situation are, in many cases, being submitted incorrectly by the providers. In particular, some are using the PC modifier to represent the professional component (PC) of a service, which is incorrect. The PC modifier is defined as “wrong surgery on a patient.” The incorrect use of this modifier results in claims being incorrectly denied.

In Transmittal 1867, CMS gave Medicare contractors instructions about how to prevent claims from being processed with modifiers incorrectly submitted on them.

For the transmittal, go to <http://www.cms.hhs.gov/transmittals/downloads/R1867CP.pdf>. For the provider-information memo, go to <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6405.pdf>.

Lab NCD Edit Changes Issued. The Centers for Medicare & Medicaid Services (CMS)

have announced the quarterly changes that will be made to the Medicare edit module for the clinical diagnostic laboratory national coverage determinations. The changes, which take effect for services provided on and after January 1, 2010, relate to serum iron studies and gamma glutamyl transferase (GGT). A second group of changes relates to an effective date that was inadvertently changed in the quarterly update that took effect on July 1, 2009. The effective date listed should have been October 1, 2007, instead of July 1, 2009, for numerous codes listed in Transmittal 1847 (November 9, change request 6717), which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1847CP.pdf>.

HFMA Issues Patient Friendly Billing Report. What are the characteristics of revenue cycle high performers? That’s the question the Healthcare Financial Management Association (HFMA) investigated and published its findings of high-performance strategies in the areas of people, processes, technology, metrics, communication and culture. In general, the report highlights good practices for hospitals. For more on this, go to http://www.hfma.org/library/revenue/PatientFriendlyBilling/High_Performance_Revenue_Cycle.htm.

FDA Approves Six More CLIA-Waived Tests. The U.S. Food and Drug Administration (FDA) has approved six more waived tests under the Clinical Laboratory Improvement Amendments (CLIA). Remember that these tests, including those below, are valid as soon as they are approved and that most of the CPT codes for the new tests **must** include modifier QW to be recognized as a waived test. (CMS gives the following as exceptions to that rule: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651.) Details about this can be found in Transmittal 1857 at <http://www.cms.hhs.gov/Transmittals/downloads/R1857CP.pdf>.

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