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News & Analysis on Part B Reimbursement & Regulation

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2009 BUDGET

Proposed Budget Cuts ASC, Outpatient Hospital and Hospice Pay

▶ *Plus, Bush's proposal makes beneficiaries pay more*

When **President Bush** proposed $178 billion in Medicare cuts over the next five years in his 2009 federal budget, healthcare practitioners braced themselves for the source of those cuts. Although Bush's budget hasn't yet been approved, the U.S. House of Representatives released a report outlining where those cuts would hit — and they will impact the wallets of almost everyone.

According to the **House Budget Committee**'s Summary and Analysis of the President's 2009 Budget, released on Feb. 7, the $178 billion will be culled from various aspects of the Medicare program over the next five years, with Part B providers impacted most as follows:

- Cut inpatient and outpatient hospital update: saves $70.3 billion
- Cut SNF update: $11 billion
- Cut hospice update: $5.1 billion
- Cut ambulatory surgical center update: $1.3 billion
- Competitive bidding for clinical lab services: $2.3 billion
- Limit oxygen rental to 13 months: $3 billion
- 60-Month end-stage renal disease (ESRD) Medicare secondary payer status: $1.1 billion
- Establish income-related Medicare Part D premiums: $3.2 billion
- Eliminate indexation of income-related Part B premium thresholds: $2.6 billion
- Create 13-month power wheelchair rental period: $0.7 billion

In a Feb. 15 statement, **Sen. Edward Kennedy (D-Mass.)** said, "The Administration has trumped up a phony crisis in Medicare to justify proposing deep cuts in quality health care for seniors while giving massive subsidies to HMOs and other insurance companies."

Healthcare practices may find their Medicare patients complaining as much as the physicians, thanks to the new income-based premium increases for both the Part B and Part D programs.

"The system may work if it graduates the premium based on where you (the beneficiary) live, but they don't indicate they're doing that," says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, president of **CRN Healthcare Solutions**. A geographic indexing system is crucial to any income-based budget reform, Cobuzzi says, "because someone in Alabama and someone in New York City may make the same amount, but it doesn't mean they have the same disposable budget." ■

BILLING

New Software May Be the Answer to Your Medicare Secondary Payer Woes

▶ Consider downloading additional software from your carrier or clearinghouse if necessary

If you're wrangling with your carrier to accept your electronic Medicare secondary payer claims, you're not alone.

Approximately two years ago, several Medicare carriers told practices that they would no longer process Medicare secondary claims unless practice's submitted the claims electronically. Most billing software systems can't handle Medicare secondary claims data, however, making the process cumbersome.

Unfortunately, payers haven't streamlined their systems too much since then, and practices are still struggling with how they can collect when Medicare is the secondary payer.

"We are not having luck filing these claims," says **Vicki Williamson** of **Carrollton Ear, Nose and Throat** in Carrollton, Ga. "I was told by Medicare if my practice management system and clearinghouse did not have the capability to send these electronically, then the only way to submit them is through a program you download from their Web site." And although her payer only accepts Medicare secondary claims electronically, other carriers accept only paper claims from her. "I just think we need some consistency with the requirements," she says.

One solution: "Our electronic clearinghouse was able to help us with this issue," says **Ben Willis** of **Accurate Medical Billing**. "We had to add something in the user note in our system that allowed the clearinghouse to pick it up."

Unfortunately, Willis says, "I also have to manually add the primary insurance's allowable, date of payment, how much they paid, how much they put to the patient's responsibility and for what reason, and how much the primary adjusted off and for what reason," Willis says. He then enters that information into software that his clearinghouse gave him. "It takes a little bit of time, but that seems to be the solution for us currently," Willis says.

When is Medicare secondary? According to Chapter 10 of Medicare's *Internet Only Manual* (IOM), "When a primary plan's payment for Medicare covered services is less than the provider's, physician's, or other supplier's charges for those services and less than the gross amount payable by Medicare, and the provider, physician, or other supplier does not accept and is not obligated to accept the primary plan's payment as full payment, then contractors can process Medicare secondary payment as appropriate."

To read the IOM's section on Medicare secondary payments, visit www.cms.hhs.gov/manuals/downloads/msp105c01.pdf ■

COMPLIANCE

Kickbacks Still Stir Up the OIG's Interest

▶ *The Office of Inspector General's latest report shows that Stark laws haven't curbed some habits*

Despite the recent buzz regarding new OIG targets, the agency's most recent report shows that kickback schemes still dominate their share of audits and sanctions.

The **HHS Office of Inspector General** (OIG) recently released its Health Care Fraud and Abuse Control Program report for 2006. The report touted the program's $2.2 billion in judgments and settlements in fiscal year 2006, adding that "in addition to these enforcement actions, numerous audits, evaluations and other coordinated efforts yielded recoveries of overpaid funds, and prompted changes in federal health care programs that reduce vulnerability to fraud. In financial year 2006, HHS collected more than $378.4 million in HHS/OIG recommended recoveries."

The report covers several highlights of the OIG's 2006 recoveries, which deal with everything from physicians getting patients addicted to narcotics to practices submitting fake charges to unlicensed personnel operating as physicians (*see "Peruse This Breakdown of the OIG's Report on page 44 for more on the recoveries*).

Throughout the report, the OIG refers to instances of anti-kickback violations, occurring among insurers, hospitals, equipment suppliers, physician practices, medical device manufacturers and clinics. In addition to the higher-profile cases, smaller practices are more likely to encounter some basic arrangements.

One of the more common anti-kickback arrangements involves space-sharing agreements. "This is an area where the OIG issued a specific Fraud Alert on the subject of physicians who sublease space to therapy practices, the principles of which are generally applicable to various arrangements between tenants and subtenants," says **Howard L. Sollins, Esq.**, of **Ober Kaler** in Baltimore.

"Certain common arrangements that are ordinarily customary in a general business context can be problematic in the physician context," Sollins says. "For instance, in some commercial lease agreements, a landlord gets a percentage of the revenues of the subtenant. You may see that in a retail location, but if you had two referring healthcare providers, one taking a percentage of the other's revenues, that could be a problem."

The OIG's February 2000 Fraud Alert addresses various rental agreements that it deems questionable, such as rental amounts that vary based on the number of referrals, or rental agreements on unoccupied spaces. The Fraud Alert also offers "safe harbor" criteria to protect legitimate arrangements.

Avoid this misstep: One practice's medical director recently contacted the *Insider* to explain that he requires the physical therapist (PT) who rents space from him to pay *more* in rent than he would charge other tenants because he wants to make sure the OIG doesn't view him as providing a referral inducement.

"If a physician practice has determined the fair market value of the space rental for a PT subleasing space, there is no reason to have any variance — up or down — from the fair market value," says **David C. Harlow, Esq.**, of **The Harlow Group** in Newton, Mass. "Overcharging may be just as problematic as undercharging, given the right set of circumstances," he says.

For example, the practice in the example above "seems to be focused entirely on steering clear of providing impermissible remuneration to a referral source," Harlow says. "However, one must also consider the very real possibility that some referrals flow in the other direction (physician to PT). In that case, the overpayment of rent by the PT to the physician practice may be viewed as an inducement to refer patients to the PT."

In addition, such arrangements often include more than just office space. For example, the sublessee — the PT in the example above, "is likely also receiving utilities and building services, which are likely covered by the lease and sublease payments, and may also be receiving other goods and services whose value has not been quantified, such as physician practice front office staff assisting with the day-to-day operations of the PT office practice on an ad hoc basis, linens,other consumables, etc.," Harlow says. "All of these goods and services must be quantified, priced and paid for in order to steer clear of prohibited inducements to refer." ■

COMPLIANCE

Peruse This Breakdown of the OIG's Report

▶ *No entities were spared by the OIG in 2006*

If you want to know who got caught in the OIG's net in 2006, we've got a breakdown for you.

The **HHS Office of Inspector General**'s (OIG's) recently-released Health Care Fraud and Abuse Control Program report for 2006 offers examples of several OIG recoveries. The following breakdown can show you just what the government discovered so you can avoid facing the same fate:

Physician fraud:	One physician hired an unlicensed practitioner, referred to that practitioner as "doctor" and allowed the practitioner to treat patients and write prescriptions. The physician billed insurers for the practitioner's services, but claimed that the physician personally performed the services. Both practitioners pled guilty and were sentenced to two months of imprisonment and asked to repay $160,000. One dermatologist was sentenced to 20 years in prison and asked to pay $880,000 in restitution for providing kickbacks that weren't always monetary — some kickbacks involved medically unnecessary prescriptions for addictive substances. The physician would offer the prescriptions to induce patients to return to the practice and would then bill insurers for the visit, even though the physician provided no services.
Nonphysician practitioners:	One audiologist faced 78 months in prison and $868,000 in restitution for billing Medicare for hearing aids, speech therapy and other services, despite the fact that the audiologist had no physician referral for the services and no license to render them.
Device manufacturers:	Medtronic Inc. paid the government $40 million to settle allegations that it paid kickbacks (in the form of lavish trips, sham consulting agreements and other types) to physicians to induce them to use Medtronic's spinal products.
Podiatrists:	One podiatrist faced 78 months in prison and $528,000 in restitution for billing services under other podiatrists' names without their permission because the podiatrist had been excluded from Medicare for defaulting on student loans. In addition, the podiatrist billed Medicare for complex procedures when in fact only nail-trimming took place.
Chiropractors:	One chiropractor was sentenced to more than 12 years in prison and ordered to pay $1.5 million in restitution for handing out $100 back braces to senior citizens at group presentations and billing federal programs $1,300 per brace for the products.

To read the OIG report in its entirety, visit www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2006.pdf. ■

READER QUESTION

Don't Count on Patient for WTM Data

Question: *Recently, we've been faced with several "Welcome to Medicare" appointments that we end up not getting paid for because the patient didn't fit the strict guidelines. How can we prevent this?*

Answer: Beneficiaries receive coverage for the new "Welcome to Medicare" (WTM) exam (G0344, *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment*), only once in their lifetime — and only within the first six months after joining Medicare. Experts offer these three good practices to help keep track of your new Medicare patients and ensure you get paid for these services:

1. Ask patients to sign an advance beneficiary notice (ABN). Practices often have no way to keep track of whether the patient has already received the WTM exam somewhere else. A signed ABN guarantees that the patient will pay out-of-pocket if Medicare denies the claim.

2. Add a note to patients' files when they've had the exam already. This simple act will prevent you from accidentally performing the WTM exam again for patients who have already had it.

3. Inquire about the patient's exam status multiple times. When the patient makes his appointment, you should ask if he's just enrolled in Medicare, when that enrollment became effective, and if he's had the WTM exam anywhere else. Then when the patient comes in for his visit, the front-desk staff, as well as the doctor, should ask the same questions.

4. Check the patients' eligibility with Medicare to make sure they don't have Medicare Managed Care. Additionally, you should check the patients' Medicare cards to confirm their eligibility date, and make sure they're still within the window of when they can get their WTM exam.

5. Ensure that the patient also undergoes a screening EKG. If you don't have this component, the carrier will deny payment for the WTM exam.

How: If the physician performs the EKG in the office using his own equipment, you can report G0366 (*Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination*) in addition to G0344.

If he only performs the EKG tracing, report G0367 (*Tracing only, without interpretation and report, performed as a component of the initial preventive examination*) with G0344. When the physician supplies interpretation and report only, report G0368 (*Interpretation and report only, performed as a component of the initial physical examination*) with G0344. ■

Part B Coding Coach

4 Questions You Should Ask Before Choosing Debridement Codes

▶ *FAQ addresses coding conventions for wound care*

Patients who present to your practice for debridement pose a challenge for coders because there are misconceptions floating around about how to properly assign active wound care management (AWCM) codes 97597-97598.

Add to that the confusion regarding selective versus surgical debridement, and you have a potential coding challenge on your hands.

Check out this wound care coding FAQ, and be sure to refer to it before choosing a code for your provider's services.

Question: *Who can provide the 97597-97598 service?*

Answer: Nonphysician practitioners (NPPs) licensed to perform these procedures (for example, physician assistants, nurse practitioners, enterostomal therapy nurses, wound care nurses, physical therapists) typically report 97597-97598. CPT designed 97597 (*Removal of devitalized tissue from wound[s], selective debridement, without anesthesia [e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], with or without topical application[s], wound assessment, and instruction[s] for ongoing care, may include use of a whirlpool, per session; total wound[s] surface area less than or equal to 20 square centimeters*) and 97598 (*... total wound[s] surface area greater than 20 square centimeters*) for reporting by licensed nonphysician professionals.

Because licensure and state laws vary from state to state, you'll have to check your individual policies to see what "qualifies" an NPP to perform these debridements.

Note: Most physicians do not directly perform these debridement services as part of their typical service. But if they do, check your contracts to make sure the payer accepts 97597-97598 when the physician performs the service.

Remember to use 97597-97598 only for encounters during which the provider meets the codes' parameters, says **Sharon Richardson, RN**, compliance officer with **Emergency Groups' Office** in Arcadia, Calif.

Question: *What are the parameters for 97597-97598 service?*

Answer: When the wound management provider performs selective debridement on a patient, you would code the service with 97597, says **Jeffrey Linzer, MD, MICP, FAAP, FACEP**, associate medical director of compliance and business affairs for the division of pediatric emergency medicine Department of Pediatrics at **Children's Healthcare of Atlanta** at Egleston.

Selective debridement means removing devitalized tissue from the wound, Richardson says. During selective debridement, the provider does not treat any healthy tissue, only the devitalized tissue.

Check out this definition from **Diversified Clinical Services**, a consulting firm in Jacksonville, Fla. Note how the definition specifies "devitalized tissue":

"Selective debridement is the removal of devitalized tissue (including fibrin, exudates, crusts, and other non-tissue materials) from wounds, without general anesthesia (e.g., high-pressure water jet with/without suction, sharp selective debridement with scissors, scalpel, or forceps), with or without topical applications."

"It's basically removal of dead tissue that is sitting on top of the wound and keeping it from healing," Richardson says of selective debridement. Remember that your provider might use aggressive means of tissue removal for this

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service, including scissors, curettes, water pressure, etc.

No matter the tools of removal, the service is still a selective debridement as long as the provider is not treating healthy tissue, Richardson says.

Consider this example from Linzer:

A patient who recently underwent treatment for a 2-cm x 2-cm infected carbuncle on the back of his hand reports to the wound care clinic for a checkup on the injury. The provider examines the wound and removes some devitalized tissue and fibrin from the wound margin with a high-pressure waterjet, and then dresses the wound.

This is an example of a 97597 service. On the claim, report the following:

- 97597 for the wound care
- 680.4 (*Carbuncle and furuncle; hand*), V58.49 (*Other specified aftercare following surgery*) and V58.31 (*Encounter for change or removal of surgical wound dressing*) linked to 97597 to prove medical necessity for the service.

ICD-9 explanation: In this example, the first ICD-9 code represents the patient's carbuncle. "The V codes show care for the residual state of the infection," Linzer says.

Question: *Who can provide 11000-11044 service?*

Answer: Either a physician or a qualified NPP can report services using debridement codes 11000 (*Debridement of extensive eczematous or infected skin; up to 10% of body surface*) through 11044 (*Debridement; skin, subcutaneous tissue, muscle and bone*). If the performing NPP is qualified and the visit meets the parameters for 11000-11044, you can report these codes, Richardson says.

Question: *What are the parameters for a 11000-11044 service?*

Answer: When the physician or NPP performs surgical debridement, you should report the service with a code from the 11000-11044 series, Linzer says. Surgical debridement means cutting outside the margins of the wound's width or depth into healthy tissue just outside the wound. "So if the debridement is getting down to healthy tissue, then you'd use the 11000-11044 codes," Richardson says.

Here's a definition from Diversified Clinical Services — note how the definition does not specify "devitalized tissue":

"Surgical debridement is defined as removal of all tissue necessary to establish a viable margin."

Example: A 46-year-old patient with type II uncontrolled diabetes presents to the emergency department (ED) with diabetic ketoacidosis. During a level-four service, the ED physician discovers cellulitus of the left leg with small areas of necrotic tissue surrounding several wounds. The physician performs significant debridement of the infected tissue while starting high-dose antibiotics.

In this scenario, the physician performed surgical debridement. On the claim, report the following:

- 11000 (*Debridement of extensive eczematous or infected skin; up to 10% of body surface*) for the debridement service
- 99284 (*Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity*) for the E/M
- Modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 99284 to show that the E/M and debridement were separate services
- 682.6 (*Other cellulitus and abscess; leg, except foot*) linked to 99284 and 11000 for the patient's wound
- 250.12 (*Diabetes with ketoacidosis; type II or unspecified type, uncontrolled*) linked to 11000 and 99284 to represent the patient's diabetes. ■

PHYSICIAN NOTES

Some Practices Still Aren't Ready for NPI

Despite CMS' frequent reminders, many Medicare-participating physician groups have not yet acquired National Provider Identifier (NPI) numbers.

During a recent Medicare NPI conference, CMS officials noted that 99.87 percent of all Part A claims now have an NPI, but that Part B providers haven't caught up just yet.

Starting March 1, "you will not be able to get paid for any Medicare services you provide until you begin using your NPI," CMS stressed in a recent e-mail message to providers.

The other key deadline is May 23. By that date, you must be able to submit Medicare claims with only the NPI in the primary fields. If your carrier has asked you to resubmit information on its 855 enrollment form, proceed with particular caution.

Here's why: If you haven't yet submitted a new 855, your intermediary may be paying your claims by virtue of a "temporary crosswalk match" that links your legacy number and NPI. But the intermediaries' upcoming maintenance of the provider enrollment system may soon throw a wrench into that temporary fix, leaving you in a situation with all claims suddenly rejecting.

To avoid this tripping point, get the 855 form in — and communicate with your intermediary to ensure the system picks up the corrections in a timely manner.

"Only correct information in the Medicare provider files will ensure that a match remains on the crosswalk, so we urge all providers to make the necessary corrections to their data," coached CMS during the call.

Simply turning in the corrected 855 — without following up with your Medicare carrier,— may not be enough. CMS has warned that the process of revising the enrollment data "can take a number of months to accomplish."

Resource: More information about NPIs is at www.cms.hhs.gov/NationalProvIdentStand.

In other news…

You can curb a confusion that you had regarding the Zostavax vaccine for shingles. Empire Medicare, a Part B payer in New Jersey and New York, recently disseminated a clarification that reminds practices that Zostavax is "excluded from Medicare Part B coverage," but may be payable under Medicare Part D.

If you still have claims for dates of service in 2007, you can still submit them to your Part B payer using G0377 (*Vaccine administration for Part D drug*), but 2008 claims should go to Part D.

You can read Empire's clarification at http://www.empiremedicare.com/news/nynews08/021808zos.htm. ■

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