Eli's Rehab Report

Ensure Proper APC Pay Up For Physical Therapy in ED

The outpatient prospective payment system (OPPS) and its ambulatory payment classifications (APC) regulations Aug. 1 will take thousands of HCPCS codes used for hospital outpatient services and consolidate them into a smaller group of 451 APCs. Physiatrists need to be ready to provide thorough documentation to ensure hospitals and other outpatient facilities receive full reimbursement for the services provided and can continue to support such services.

According to the Health Care Financing Administrations (HCFA) April 7 final rule, the OPPS will increase Medicare outpatient payments to hospitals by an average 0.2 percent (this is a positive change from the highly-publicized -5.7 percent average stated in HCFAs June 1999 proposed rule). Use of the APCs will be required for hospital outpatient services.

Physical Medicine Practices Should Be Interested

Jack Turner, MD, PhD, medical director for documentation, coding and compliance with Team Health, a physician staffing company in Knoxville, Tenn., says that although the OPPS will not directly impact the way physiatrists, therapists, chiropractors and other Part B providers code and bill for services for Medicare patients, there are definite ways in which these clinicians may be affected. Turner says that if hospitals and outpatient facilities begin to lose money on certain procedures, they may no longer make them available, and that will affect physiatrists potential earnings and their ability to provide the best possible care to their patients.

What we have to recognize is that what we write on a chart and what medications and tests we order and what procedures we perform will now greatly influence the bottom line of the hospital, Turner says. The physician who is performing outpatient procedures needs to consider the well-being of the hospital as well as the well-being of the patient. If the hospital doesnt get paid, theyre going to suffer, and ultimately, that affects where were going to perform our procedures and what procedures we may perform.

Departments Must Work Together

Catherine A. Brink, CMM, CPC, president of Healthcare Resources Management Inc., a practice management and reimbursement consulting firm in Spring Lake, N.J., reports that physician documentation will have to be extremely accurate and extensive for the hospital coders to bill properly.

According to Brink, the APCs will require hospitals and outpatient facilities to code and bill in an entirely new way. In essence, when a physician performs a procedure in a hospital or outpatient facility for a Medicare patient, he or she will continue to bill for the professional component of that procedure with the Medicare Part B HCFA 1500 form, exactly as before.

Under the APCs, however, all of the hospital or outpatient facilitys bills for the technical component of the procedure have to be consolidated into one, meaning the bill cannot be submitted for reimbursement until every department submits its portion of the entire bill to central billing, and that bill is itemized and correctly coded. All applicable nursing services, x-rays, medications and treatments performed by hospital staff (such as injections), along with charges for the room itself, equipment, disposable items, etc., are listed all at once on the Medicare Part A UB92 form. Further, the hospital or outpatient facility coder will have only one opportunity to submit a bill; Medicare will not accept late or ancillary billing. Now, more than ever, the hospital needs the help of the physical medicine provider with precise and comprehensive chart note documentation.

Chart Notes Must Be Clear

Because APCs will require that hospital coding is remarkably accurate, physiatrists chart notes must reflect the exact service that was performed or reimbursement will be incorrect. For example, one of the most common surgical procedures that physical medicine and rehabilitation (PM&R) patients undergo is the carpal tunnel release (29848). If the physician simply indicates carpal tunnel release on his or her chart notes, the hospital coder may erroneously bill this as a 64721 (neuroplasty and/or transposition; median nerve at carpal tunnel), and the bill will be placed under APC 220, which pays $676.88. The correct code, 29848, is part of APC 041, which pays $1191.33. The physiatrist who does not indicate clearly the exact service performed may, in this case, cause a loss in reimbursement of $514.45.

According to a June 2000 report to Congress by the Medicare Payment Advisory Commission (MedPAC), the new payment system gives hospitals an incentive they previously lacked to code visits accurately. This is because codes that seem similar in scope may belong to different APCs. For example, a physiatrist performs an electromyogram (EMG) on a patient with weakness in her left arm, leg and shoulder. The EMG is conducted on three extremities, but instead of coding it properly using 95863 (needle electromyography, three extremities with or without related paraspinal areas), the coder erroneously assigns 95860 (needle electromyography, one extremity with or without related paraspinal areas). Because 95863 is grouped into the APC 0216, it pays $139.16. Since the coder erroneously assigned 95860, which is in APC 0215, it only pays $55.76.

The Emergency Room

APCs will make coding for emergency room visits more complex. HCFAs April 2000 Transmittal A-00-23 states, formerly, hospitals could report CPT code 99201 (office or other outpatient visit, new patient) to indicate a visit of any type. Under OPPS, 31 codes are used to indicate visits, with payment differentials for more or less intense services. These codes, however, translate into only seven APC codes for outpatient or emergency department care.

HCFAs Transmittal A-00-23 also states, hospitals should be advised that every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPPS. The transmittal recommends that hospitals report Condition Code G0 for multiple medical visits occurring on the same date at the same revenue center for distinct and independent visits. For example, if a patient went to the emergency room in the morning for a fractured finger (816.00), and later in the day for shortness of breath (786.05), the coder would report the appropriate procedure codes, along with condition code G0.

News Update:
HCFA Allows Carriers to Decide Coverage for AAC Devices

The Health Care Financing Administration (HCFA) will no longer allow private Medicare carriers to decide locally whether to cover augmentative and alternative communication (AAC) devices, according to an April 26 decision memorandum. Prior national policy considered these devices personal convenience items that were not covered as a Medicare benefit, but HCFAs decision classifies the devices as durable medical equipment.

AAC devices can be extremely helpful to patients with severe speech impairments, allowing them to communicate with the aid of products such as speech synthesizers. These products will be particularly helpful to physical medicine and rehabilitation (PM&R) patients, especially those with speech-limiting conditions such as amyotrophic lateral sclerosis (335.20), stroke (436), multiple sclerosis (340), cerebral palsy (343.0-343.9), among other diagnoses.

For years, various Medicaid programs have classified AAC devices as covered prosthetic devices because they correct the malfunctions of speech organs or the nervous system that led to the patients loss of speech, but HCFA did not concur.

HCFAs new coverage policy (CAG-00055) asserts that as many as 4.5 million Americans suffer from speech impairment, but states that it cannot make a national determination to cover AAC devices without more information about the products, the conditions that may be covered, and how it will determine which patients suffer from severe speech impairment, versus mild speech loss, which will be excluded from coverage.

HCFAs coverage decision asks a lot of questions that need to be looked into, and it appears as though a lot of research and analysis is still needed to satisfy HCFAs requirements that they must meet to make a national coverage decision, says **Leslie Stein, JD,** regulatory counsel in the reimbursement and regulatory policy department at the American Occupational Therapy Association in Bethesda, Md. HCFA specifically said that they are seeking input from the health care community regarding this issue.

HCFAs coverage memorandum states that criteria on coverage of these devices will be published by the end of June, and that the effective date for this decision will be no later than January 1, 2001.

Currently, HCFA provides coverage for items such as artificial larynges (L8500), but AAC devices such as speech synthesizers are classified as A9190 (personal comfort item). As Medicare carriers decide how to implement the new ruling, more specific codes most likely will become available. According to **Mark Kander,** director of healthcare regulatory analysis at the American Speech-Language-Hearing Association (ASHA) in Bethesda, Md., There are no codes yet, but ASHA and other organizations are making a proposal to the HCPCS advisory group for consideration of new codes to cover several different types of AAC devices. We hope to ensure that by Jan. 1, when this new policy takes effect, there will be some new HCPCS codes.

Two CPT codes that will be useful for evaluating and modifying AAC devices are 92597 (evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech) and 92598 (modification of voice prosthetic or augmentative/alternative communication device to supplement oral speech).

The Coverage Policy can be accessed at the HCFA Web site at www.hcfa.gov/quality/8b3-s2.htm.