Eastern Michigan Chapter

HEALTHcents

hfma: it's personal

November 2003
Correction

Volume 1,Issue 15

Editor's correction

I would like to apologize for confusing everyone by including October newsletter material in the November newsletter. I am sending this correction since the following articles were sent to me for inclusion in the November newsletter. I apologize for the confusion. I appreciate your patience.

Thank you

Maryanne

Medicare Therapy Caps Finally Effective

Submitted by Maria Abrahamsen, 248/203-0818 or mabrahamsen@dykema.com

After numerous delays, Medicare has finally implemented the caps on the amount of outpatient therapy services covered each year for a single beneficiary. Effective September 1, 2003, Medicare will cover for each beneficiary only $1,590 per year for physical therapy (including speech therapy) and $1,590 per year for occupational therapy. Key facts regarding the limits include:

- The *full* amount of each cap may be used for therapy furnished between 9/01/03 and 12/31/03. In other words, the 2003 caps will *not* be prorated.
- Medicare will pay up to 80% of these limits; the remaining 20% of the cap amount is covered through beneficiary co-pays.
- The caps apply in all **non-hospital** settings where therapy services are paid on the basis of Medicare's physician fee schedule, such as CORFs, rehab agencies, physician's offices, and therapists in private practice.
- CMS has published a list of CPT codes which define the services that are subject to the caps. However, this list of covered codes was revised in August to exclude certain codes from the caps when they are not provided under a therapy plan of care and they are billed by physicians.
- Non-hospital providers should notify beneficiaries of the limits on therapy coverage by means of a Notice of Exclusion from Medicare Benefits. Advance Beneficiary Notice (ABN) forms should *not* be used for statutory exclusions from coverage, such as the therapy caps.
- CMS is establishing mechanisms by which providers and beneficiaries can determine the amount of therapy each beneficiary has received year-to-date.

CARDIAC REHAB SERVICES SINGLED OUT BY THE OIG

Submitted by Maria Abrahamsen, 248/203-0818 or mabrahamsen@dykema.com.

The Office of Inspector General announced in its 2003 Work Plan that it would be evaluating whether cardiac rehabilitation services furnished in hospital outpatient departments meet Medicare coverage requirements. The OIG has followed through on its announced plan and recently published the results of reviews of hospitals located in different parts of the country (including CMS Region V). The studies identify a number of problems in billing for cardiac rehab. Now that the OIG has focused attention on the topic, hospitals can expect greater scrutiny of cardiac rehab compliance by fiscal intermediaries, U.S. Attorneys and *qui tam* relators. Key findings of the OIG studies include:

- **"Incident to" Requirements.** Cardiac rehab, like most hospital outpatient therapeutic services, is covered by Medicare as a benefit that is "incident to" the services of a physician. This means that the hospital service is "furnished as an integral, though incidental, part of the physician's professional service." (*Medicare Intermediary Manual* § 3112.4) Furthermore, a physician "must personally see the patient periodically and sufficiently often to assess" and manage the course of care. The OIG found no face-to-face physician services to which the cardiac rehab was incidental and directed the fiscal intermediary to evaluate whether this requirement for coverage was satisfied. Interestingly, the OIG commented only on the failure of the cardiac rehab Medicare Director to provide face-to-face care, and did not discuss the role of the patient's attending physician.

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Proposed Regulation Significantly Impacts Medicare Bad Debt Payment

Kenneth R. Marcus

A pending proposed Medicare regulation, issued on February 10, 2003, would significantly impact Medicare bad debt payment by:

(1) Removing the cap on allowable Medicare bad debt for end-stage renal disease (ESRD) facilities,
(2) Expanding the application of a 30 percent reduction in bad debt reimbursement to other Medicare providers currently eligible to receive bad debt reimbursement, and
(2) "Clarifying" that bad debts are not allowable for entities paid under reasonable-charge or fee schedule methodologies.

ESRD Payment

Removal of the cap on bad debt payment for ESRD facilities belatedly recognizes that the cap was invalidated five years ago in the case of *Kidney Center of Hollywood v. Shalala,* 133 F.3d 78 (D.C. Cir. 1998). While this proposed regulation clearly would result in increased Medicare bad debt payment for ESRD facilities, thus improving payment for those providers, it adversely impacts all other providers. Note, however, that the 30% reduction, discussed below, also would apply to ESRD facilities.

30% Reduction

The 30% reduction in bad debt reimbursement for hospitals was mandated by the Balanced Budget Act of 1987, as subsequently amended by the Benefits Improvement Act of 1999 which decreased the reduction from 45% to 30%. The Centers for Medicare and Medicaid Services ("CMS") has now proposed to extend this reduction to all providers eligible for bad debt payment, which include, among other providers, skilled nursing facilities, critical access hospitals, ESRD facilities and rural health plans. While clearly Congress intended to impose the payment reductions on hospitals, the Medicare Act is silent regarding other providers. Accordingly, this provision, if and when it is issued in final form, is subject to challenge, and likely will be challenged.

Elimination of Bad Debt for Reasonable Charge or Fee Schedule Methodologies

CMS now "clarifies" that bad debt payment is not available for entities paid under reasonable-charge or fee schedule methodologies. If this provision is issued in final form, hospital providers will not be eligible for bad debt reimbursement for outpatient therapy services or other outpatient services for which payment is made on a fee schedule. The rationale of CMS is stated as follows in the preamble to the proposed regulation:

> Medicare has never made payments to account for bad debts for services paid under a fee schedule or reasonable charge methodology, such as services of physicians or suppliers. Under a fee schedule or reasonable charge methodology, Medicare reimbursement is not based on costs and, therefore, the concept of unrecovered costs is not relevant. Fee schedules, which are either charge-based or resource-based, relate payments to the price the entity charges. Historically, these prices have reflected the entities cost of doing business, including expenses such as bad debt.

A serious flaw in the underlying rationale expressed by CMS is that the payment rates established for these services did not include recognition of bad debt. Moreover, the use of the term "clarify" signals that CMS is concerned that this shift in policy will be interpreted as retroactive rule making, which is prohibited absent statutory authority. Katie Walker, who is identified in the proposed regulation as the CMS contact person, advised the author that to her knowledge the fiscal intermediary is not instructed to conduct reopenings to implement this provision. Ms. Walker further advised, however, that the fiscal intermediary is instructed to apply this "clarification" to current audits. Thus, although the actual final regulation has not been published, apparently it is already being implemented. Of course, Providers are required to comply with published CMS policy. At the same time, however, Providers impacted by this change in policy have the right to take steps to preserve the issue for appeal.

Conclusion

With the nearly full implementation of the Medicare prospective payment system, bad debt is one of the remaining vestiges of the cost reimbursement system. Clearly it is the agenda of CMS to reduce this payment. To the extent CMS is authorized to do so by the Medicare Act, providers have little recourse other than to petition their legislative representatives for relief. To the extent such action is not supported by the Medicare Act, however, providers can and should file appeals. Critical to the appeal process is taking appropriate steps to preserve the appeal and to avoid a jurisdictional challenge by the fiscal intermediary.

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CARDIAC REHAB SERVICES
SINGLED OUT BY THE OIG

- **Physician Direct Supervision.** Cardiac rehab must be performed under the "direct" supervision of a physician, *i.e.*, the supervising physician must be in the exercise program area and immediately available in case of emergency. The *Intermediary Manual* states that the physician supervision requirement is "generally assumed" to be met when services are performed on hospital premises. The OIG acknowledged this assumption, but nevertheless expressed discomfort regarding hospital cardiac rehab programs which operated without a physician on-site and relied on emergency department response teams in the event of emergency. Such programs were directed to confirm with the fiscal intermediary that the physician supervision provided was adequate. (Note that cardiac rehab programs conducted in a medical office *must* be directly supervised by an on-site physician.)
- **Covered Diagnoses.** Medicare covers cardiac rehab for patients who have at least 1 of 3 covered diagnoses: (1) documented diagnosis of acute myocardial infarction within last 12 months, (2) past coronary bypass surgery, or (3) *stable* angina pectoris. The OIG studies emphasize that *unstable* or *variant* angina or *unspecified* angina is not a covered diagnosis. One study also indicates that a medical record is inadequate if it does not indicate that stable angina pectoris *continued* after angioplasty or stenting and *throughout* the program of cardiac rehab.
- **Physician Referral.** The hospital's file must contain a signed written referral from the patient's attending physician, which specifies the diagnosis.
- **Units of Service.** All cardiac rehab services furnished during a single session must be billed as a single visit. Absent special approval, Medicare will cover only 36 cardiac rehab sessions, provided over a period of up to 12 weeks. Hospitals should have in place procedures that prevent billing for visits in excess of these limits.
- **Initial Assessments.** Initial assessments of patients (which do not include an outpatient cardiac rehab session) may not be billed as cardiac rehab. Furthermore, initial assessments performed by an RN or exercise physiologist do not qualify for payment under an E&M code because they are not performed by a physician.

While the OIG studies focus on hospital outpatient cardiac rehab programs, the same (or more stringent) Medicare coverage requirements apply to cardiac rehab performed in physician offices. The studies provide a helpful checklist of potential problem areas.

New Member Information Correction

The correct address for Brian Brady:

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See page 4 for a corrected list of Board of Directors, Officers and Committee Chairpersons.

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