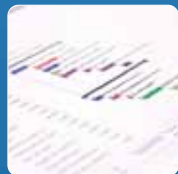


“ACE” IN THE (BLACK) HOLE: HOW EMERGENCY PHYSICIANS CAN PREPARE FOR PAYMENT BUNDLING

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

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As part of a three-year demonstration that began May 1, 2009, the Acute Care Episode (ACE) is a program from the Centers for Medicare & Medicaid Services (CMS) that strives to improve efficiency and quality while allowing patients to share in the cost savings. It is designed to align incentives and provide flexibility to hospitals and physicians by bundling all related Part A and B patient services into an episode of care with a single global payment.

Essentially ACE changes how Medicare pays for healthcare services, with CMS bundling payments into a lump sum instead of paying the hospital and physicians separately. ACE is also intended to change how providers are “incentivized” for quality of care and cost reductions and to reward providers when patient outcomes are deemed by CMS to be better than the norm, for example, a hip replacement patient who is discharged in two inpatient days versus four or more. The one payment will cover the patient’s entire course of treatment, rather than each individual service. Currently, the demonstration is being held in Medicare Administrative Contractor (MAC) Region 4, also known as Trailblazer and includes Colorado, New Mexico, Oklahoma and Texas. By 2012, there will be nationwide demonstrations on payment bundling, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA).

It is notable that before CMS institutes a new national demonstration or regulation, it often tests it on a smaller group. Demonstration projects essentially allow other facilities that are not involved in the project to learn from their peers. A recent example of this is the Recovery Audit Contractors (RAC) demonstration. These demonstration projects identify weaknesses in the new rules and allow CMS to make necessary changes to the program. Most notably, weaknesses in the system stem from skewed economies of scale for high-volume services such as those seen in an emergency department environment. While ACE could also have a large effect on case management and coordination of care, it is too early to know if CMS is likely to change the range of Diagnosis Related Groups (DRGs) subject to the ACE demonstration now in the nationwide program mandated by PPACA.

The biggest question surrounding the bundling of payments for these services is who stands to win or lose. From a big picture standpoint, the program: 1) allows CMS to continuously link inpatient payment rates with “quality indicators” to reverse the fee-for-service mindset of “doing more to get more,” 2) allows retention of inpatient profit margins and “gain-sharing” among hospital-based specialists assuming step-wise cost reductions and, 3) facilitates one payment for all Part A and B services to reduce Medicare program transaction costs while maintaining clinical quality. On a smaller scale, the program greatly impacts emergency physicians, how they are paid, and how they operate. This white paper will define ACE and discuss its implications, specifically addressing how emergency physicians can prepare for the impact.

GETTING SERVED

All services provided to the Medicare beneficiary from the date of admission through the date of discharge at the demonstration facility includes services provided off site, including professional or technical lab, or other diagnostic services. There are four places of service (POS) included:

- › Inpatient = POS 21
- › Outpatient = POS 22
- › Emergency department = POS 23
- › Independent lab = POS 81

SERVICE ELIGIBILITY, Too

Not all services are included either. The demonstration covers a very specific list of MS-DRGs related to orthopedics and cardiovascular procedures. There are 28 cardiac and 9 orthopedic inpatient surgical services and procedures included in the demonstration. Some of the procedures include:

- › Hip and knee total joint replacements
- › Revisions of hip and knee total joint replacements
- › Cardiac valve replacement (with and without catheterization)
- › Defibrillator implantation (with and without catheterization)
- › Coronary bypass surgery (with and without catheterization)
- › Permanent pacemaker implantation

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PROJECT SCOPE: ORTHOPEDIC MS-DRGs

MS-DRG	Description
461	Bilateral or multiple major joint procedures of lower extremity w/ MCC
462	Bilateral or multiple major joint procedures of lower extremity w/o MCC
466	Revision of hip or knee replacement w/ MCC
467	Revision of hip or knee replacement w/ CC
468	Revision of hip or knee replacement w/o CC/MCC
469	Major joint replacement
470	Major joint replacement
488	Knee procedures w/o primary diagnosis of infection w/ CC/MCC
489	Knee procedures w/o primary diagnosis of infection w/o CC/MCC

PROJECT SCOPE: CARDIAC MS-DRGs

MS-DRG	Description
216	Cardiac Valve and other Major Cardiothoracic Proc. w/ Cardiac Cath w/ MCC
217	Cardiac Valve and other Major Cardiothoracic Proc. w/ Cardiac Cath w/ CC
218	Cardiac Valve and other Major Cardiothoracic Proc. w/ Cardiac Cath w/o CC/MCC
219	Cardiac Valve and other Major Cardiothoracic Proc. w/o Cardiac Cath w/ MCC
220	Cardiac Valve and other Major Cardiothoracic Proc. w/o Cardiac Cath w/ CC
221	Cardiac Valve and other Major Cardiothoracic Proc. w/o Cardiac Cath w/o CC/MCC
226	Cardiac Defib Implant w/o Cardiac Cath w/ MCC
227	Cardiac Defib Implant w/o Cardiac Cath w/o MCC
231	Coronary Bypass w/ PTCA w/ MCC
232	Coronary Bypass w/ PTCA w/o MCC
233	Coronary Bypass w/ Cardiac Cath w/ MCC
234	Coronary Bypass w/ Cardiac Cath w/o MCC
235	Coronary Bypass w/o Cardiac Cath w/ MCC
236	Coronary Bypass w/o Cardiac Cath w/o MCC
242	Permanent Cardiac Pace. Implant w/ MCC
243	Permanent Cardiac Pace. Implant w/ CC
244	Permanent Cardiac Pace. Implant w/o CC/MCC
246	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents
247	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent w/ MCC
248	Percutaneous Cardiovascular Procedure w/ Non Drug-Eluting Stent w/ MCC or 4+ Vessels/Stents
249	Percutaneous Cardiovascular Procedure w/ Non Drug-Eluting Stent w/o MCC
250	Percutaneous Cardiovascular Procedure w/o Coronary Atrery Stent or Acute Myocardial Infarctoin w/ MCC
251	Percutaneous Cardiovascular Procedure w/o Coronary Atrery Stent or Acute Myocardial Infarctoin w/o MCC
258	Cardiac Pacemaker Device Replacement w/ MCC
259	Cardiac Pacemaker Device Replacement w/o MCC
260	Cardiac Pacemaker Revision ex. Device Replacement w/ MCC
261	Cardiac Pacemaker Revision ex. Device Replacement w/ CC
262	Cardiac Pacemaker Revision ex. Device Replacement w/o CC/MCC

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PATIENT ELIGIBILITY

Not all patients are included in the demonstration. Eligible beneficiaries must be enrolled in both Medicare Part A and Part B. While patients cannot be enrolled in Medicare Advantage or another Medicare health plan, they must have Medicare as their primary insurance. Patients may not be receiving Medicare due to Railroad Retirement or United Mine Workers of America, however. There also must be one lifetime reserve day at the time of admission. Dually eligible patients partaking in Medicaid will not be able to participate in shared savings from CMS.

Regarding patient admission, a facility completes the Notice of Admission (NOA) for Medicare A/B MAC (Medicare Part A and B contractor, f/k/a as the Medicare Part B Carrier) submission and approval. The hospital is also responsible for paying all professional services rendered during the acute care episode from bundled payment, which includes surgeons, hospitalists and anesthesiologists, to name a few. Reimbursement by the hospital of the Part B providers may be achieved by the hospital establishing a wholly owned subsidiary, e.g. LLC or C corporation, that receives the bundled Part A and B reimbursement from the Medicare A/B MAC.

In effect the hospital becomes the “fiscal intermediary” of the Part B providers’ reimbursements—meaning that these providers must enter into a participation agreement with the wholly owned hospital LLC. In contrast, the A/B MAC receives the Part B providers claims and issues a Medicare remittance advice (R/A) code indicating that no reimbursement will be made directly to the providers as the claim is subject to the ACE demonstration.

One of the perplexing and outstanding issues under the ACE demonstration is the current CMS regulation that guarantees reimbursement to the Part B providers for clean claims on 14-day turnaround. It is unknown how CMS will modify this regulation when the nationwide ACE project begins as there are claims in the demonstration that are not being reimbursed to the Part B providers within the mandated timeframes under current regulations.

BILLING, DEMONSTRATED

How does this affect physician billing? Payment for professional services provided by the physician will be paid by the hospital. Billing professionals must follow the same process they currently do with Medicare billing and in addition send a duplicate bill to the designated agent, e.g. the hospital owned LLC or subsidiary.

The common working file (CWF) will check for notice of admission (NOA) and if a notice is on file, it will then check for the National Provider Identification (NPI) and date of service. If these items match the record then it will process the claim as a “no pay” to the Part B provider and remittance advice will be sent with an “N67” notice.

The hospital knows to pay through two ways. First, the Part B provider will send a duplicate bill to the designated agent. Medicare will also prepare a weekly report of Part B claims related to the demonstration and processed as “no pay.” The report will include CPT codes, patient and physician information, and reimbursement of what would have processed as a traditional Part B claim. If Medicare pays and the claim should have been paid by the hospital, Medicare will reprocess the claim as a “no pay” and implement its normal automatic adjustment process and existing remittance advice through “correction/reversal” procedures in order to adjust the fee for service payment and establish the debit. Additionally, it will notify the patient the claim has been auto adjusted.

The patient’s Part B deductible is waived for the demonstration procedures. While they will pay an established Part B coinsurance to the hospital, they will also receive a combined Medicare Summary Notice (MSN) stating they are eligible for an incentive payment from CMS. Seniors with basic Medicare coverage could be eligible to receive incentive payments of up to \$1,157, the maximum annual Part B premium.

STICK TO THE CLAIMS RULES IF YOU WANT REVENUE

Claims submission are submitted as they normally would be to MAC. Physicians are not required to report the demonstration code number on the claim. The site where the service was provided, the facility NPI, name and address must be reported on the

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1500 form, and duplicate claims must be made to the hospital for processing. If the site of service NPI is not reported, the claim will be rejected with a message stating that the NPI is required. A claim will also be denied due to demonstration involvement, meaning it receives a “no-pay” designation from MAC with remark code “N67” on the remittance and with payment/denial code “D.” Otherwise, claims should typically follow all Local Coverage Determination (LCD) guidelines, National Correct Coding Initiative (NCCI) guidelines and Medically Unlikely Edits (MEUs) rules as usual.

PAYMENT: PART “B” FOR BUNDLING

Bundled payments to facilities are based on previously established rates with CMS. All claims for professional services from the date of hospital admission through the date of hospital discharge are also included in bundled payment rates. Any preadmission services, which would normally be included on the inpatient claim, would be reimbursed by the hospital facility. The facility also pays the physicians, which includes full Medicare allowable that is not reduced by patient’s coinsurance amount and provides detailed remittance advice. Part B coinsurance will be included in Part B payment from the facility to the physician. No Part B deductible, blood deductible, or coinsurance will be applied. The facility is not responsible for reimbursing any Part B service that would not be covered in the absence of the demonstration, but it is responsible for collecting the Part B coinsurance from the patient.

If claims were processed under traditional Medicare and then identified as part of the project, Medicare will re-adjudicate. Medicare will also follow normal accounts receivable processes when it is adjusting claims. Remark code “N68” will appear on the reversal remittance advice on claim line level, and Medicare will then notify the patient that the claim was auto-adjusted. The MAC provides a weekly report of any physicians processed for services rendered at the facility. The report includes patient, CPT detail and payment detail as if the claim was traditionally processed as fee for service. The ACE director is the party responsible for reconciling physician payments to the MAC report.

The patient receives a payment from CMS with 50 percent of the Medicare savings, not to exceed their annual Part B premium of \$1,157. The patient will also receive one MSN with beneficiaries and Part A and Part B liability; however, no Part B deductible, blood deductible, or coinsurance will be applied.

POSITIVES AND NEGATIVES

ACE encourages physician and hospital alignment – most likely to lower the costs of delivering healthcare. Hospitals are keen on physicians sharing concerns to reduce unnecessary utilization and supplies while improving patient safety. Physicians are happy because they can gain-share; however, physicians are also skeptical that the lump sum allows the hospital too much control over physician rates and possibly encourages hospitals to withhold certain services to keep costs down. Each side has concerns about control and the degree of cooperation they will face in a partnership, and specifically independent hospital-based emergency department (ED) practices.

For one, the notion of gain-sharing may be easier for specialists to implement than ED physicians, particularly for certain MS-DRG patient classes that are being used for the ACE demonstration. To illustrate, how would gain-sharing be used to substantively change the ED physician’s patient care for a hip fracture patient who will be treated and cared for in anticipation of hospital admission? Put another way, how should ACE change the way in which ED physicians do hip fracture work-ups? If ED physicians are really the beginning of the “episode of care” and so early in the process, it begs the question of whether they should be excluded from nationwide rollout in the future. The program definitely spawns important questions and offers altruistic positives with some individually-driven negatives that impact emergency groups in a far greater way, as listed below.

POSITIVES:

- › Potential quality of care improvements
- › Better practice/hospital relations
- › Potentially decreased equipment and supply costs
- › Increase to site volume
- › Improved facility reputation as value-based care center
- › Gain-sharing for specialty physicians
- › 100 percent Medicare fee schedule reimbursement without deductibles and co-payments from the beneficiary

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NEGATIVES:

- › Skewed economies of scale for high-volume ED services
- › Longer days in Medicare A/R due to bundled payment to the hospital and obtaining reimbursement from the wholly owned hospital LLC
- › Undetermined gain-sharing for ED physicians
- › Lessened independence of physician-owned structure
- › Concerns over “cook-book” medicine for complicated MS-DRGs that may not fit neatly into the streamlined episode of care processes
- › Possibility of loss of independence from the hospital as reimbursement timelines are lengthened
- › Serious concerns over how ACE would be coordinated across multiple payors when the patient has other insurance, whether “dual eligible” under Medicaid or Medigap coverage
- › Most common presentations to the ED were not included in the MS-DRG list including AMI, abdominal pain, syncope and trauma; it is unknown how these presentations could be included for “episodes of care” cost reduction strategies, but one reason could be that they are not neatly described into one monolithic patient care model

PAY ME NOW, NOT LATER

The ACE demonstration lends the notion that all care providers are on one team and not billing per ticket or per service, with an incentivized payment of treating the patient in one episode of care. To make the division of payments easier, hospitals are able to set up limited liability companies in an effort to bundle payments under the ACE demonstration and then divvy out payments after they are submitted to Medicare and then returned, typically after 60 to 90 days.

This ACE payment methodology may not fare well for independent emergency physician practices, which must constantly make inquiries to the LLC for payment. If an emergency physician practice is hypothetically working from a 30 percent Medicare predominant payor mix, it will have a hard time adjusting to receiving payments at 60 to 90 days out when previously payments would have been received at 14 to 30 days. To prepare for the possible impact, emergency physicians might consider the following options:

- › Consider selling the practice to the hospital. One approach would be to become a “captive PC” with physicians maintaining certain aspects of ownership and control, but it should be noted that experienced healthcare counsel should be consulted in considering this and many of these options.
- › Become a hospital employee directly.
- › Approach the hospital with the notion that the ED practice cannot survive on payments 60 to 90 days out and insist on reimbursement in no less time than is currently called for in the Medicare payment regulations, e.g. 14 days on clean electronic claims and 30 days on a paper Medicare claims.
- › Go to the nearest state ACEP chapter including representatives of the ACEP Council and ask that CMS carve emergency physician services out of the demonstration.
- › Understand the program, prepare for it, and view it for what it is: a per-service modality to a care team, including determining how ED physicians might be able to participate in the gain-sharing that the hospital may enjoy as part of the ACE demonstration.

The ACE demonstration has implications beyond what Medicare claims is the purpose of the project – implications that could run counter to providing better care, reducing financial impact, lowering government costs and increasing physician/hospital alignment. Can emergency physicians withstand the wait or get in on the incentives without diminishing their practices? As Dr. Lynn Massingale, Executive Chairman of Team Health stated at the 2010 EDPMA Solutions Summit, “You are either at the table or on it.” Emergency physicians should pull up a chair as they make preparations for the impact of payment bundling.

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References:

Visit Medicare's website at <http://www.cms.hhs.gov>

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Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a provider of billing and practice management services to emergency medicine physicians. It currently serves more than 70 emergency medicine practices with more than 1000 emergency physicians combined. MMP’s flexible solutions range from billing-only services to full-practice management services. For more information about MMP, visit www.cbizmmp.com.

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