

2014 CGS Medicare Update

Akron, Ohio | Vanessa Williams & Annie Scriven | June 27, 2014



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Objectives

Provide an overview of recent Medicare policy updates and changes that will affect your reimbursement in 2014:

- Incarcerated Beneficiary Claim Denials
- 2-Midnight Provision and A/B Rebilling
- Inpatient Prospective Payment System (IPPS) Updates
- July 2014 Outpatient Prospective Payment System (OPPS) Updates
- Medicare Secondary Payer (MSP) Audits
- Top Claim Submission Errors
- Beneficiary Eligibility

Incarcerated Beneficiary Claim Denials

- Denials occurred in the summer of 2013
- Medicare Enrollment Data Base was restored as of October 28, 2013
- A check, along with a letter and spreadsheet to identify the claims processed in error, were sent at the end of December 2013
- Claim adjustments occurred in April 2014
- Approximately 10,000 erroneous IURs were not identified by HIGLAS
- Dedicated CMS web page: <http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/2013-Claim-Denials-Due-to-Beneficiary-Incarceration-Status.html>

Two-Midnight Provision and A/B Rebilling

Two-Midnight Provision Timeline

Date	Publication or Update
August 2, 2013	Inpatient Final Rule CMS-1599-F was published; modifies CMS' longstanding policy on how Medicare Contractors review inpatient hospital (and CAH) admissions for payment purposes.
September 5, 2013	Prior Guidance on the Physician Order and Certification for Inpatient Hospital Admissions published.
January 27, 2014	MLN Matters article SE1403 published; describes a focused pre-payment medical review strategy for MACs to conduct pre-payment review of inpatient hospital claims with dates of admission October 1, 2013, through March 31, 2014.
January 30, 2014	Additional Clarification of Guidance on the Physician Order and Certification for Inpatient Hospital Admissions published.
April 1, 2014	The President signed the Protecting Access to Medicare Act of 2014; Section 111 extends the MAC Probe and Educate process through March 31, 2015, and prohibits Recovery Auditors from conducting inpatient hospital patient status reviews on claims with dates of admission October 1, 2013, through March 31, 2015.

Resources

- FY 2014 IPPS Final Rule:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html>

- CMS Hospital Center web page:

<http://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

- MLN Matters article SE1403:

<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1403.pdf>

- CMS Inpatient Hospital Reviews web page:

<http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

FY 2014 IPPS Final Rule Questions

- Two-midnight provision for admission and medical review:
IPPSadmissions@cms.hhs.gov
- Part B inpatient billing and clarifications regarding the physician order and certification should be sent to the subject matter staff listed in the final rule.
- To suggest an addition to the rare and unusual circumstances in which the two-midnight benchmark would not apply, email SuggestedExceptions@cms.hhs.gov, with “Suggested Exceptions to the 2-Midnight Benchmark” in the subject line.

A/B Rebilling Timeline

Date	Publication or Update
January 1, 2012 – March 14, 2013	A/B Rebilling Demonstration Project
March 13, 2013	CMS Ruling 1455-R is effective; terminated the demonstration project and established an interim process for A/B rebilling.
July 1, 2013	MLN Matters article MM8185 implemented; revised the billing instructions and allowed for automatic processing of A/B rebilling claims.
August 2, 2013	Inpatient Final Rule CMS-1599-F was published.
October 1, 2013	MLN Matters article SE1333 implemented; allows hospitals to submit A/B rebilling claims when they conduct a self-audit and determine that an inpatient stay was not medically reasonable and necessary after the patient was discharged. MLN Matters articles MM8666 and MM8445 implemented; revised the policies and timely filing limit for submitting A/B rebilling claims.

Prior to March 13, 2013

- A limited set of Part B inpatient services may be paid in the following circumstances:
 - The patient is not entitled to Medicare Part A
 - The patient exhausted benefits prior to the admission
 - The day(s) of the otherwise covered stay during which the services were provided was not reasonable and necessary
 - The admission was disapproved as not reasonable and necessary
- Services were submitted on a 12X Type of Bill (TOB) claim.
- Outpatient hospital services provided prior to the point of admission (i.e., the admission order) were separately billed on a 13X TOB claim.
- Timely filing limit is one calendar year from the “through” date of service.

March 13, 2013

Temporary instructions per CMS Ruling 1455-R:

- Applies as long as the denial was made:
 - While the Ruling is in effect
 - Prior to March 13, 2013; timeframe to file an appeal not expired
 - Prior to March 13, 2013; appeal is pending
- TOB 12X (Part B inpatient services); TOB 13X (Part B outpatient services)
- Treatment authorization code = SPN65
- Remarks = the Document Control Number (DCN) of the denied inpatient claim, last adjudication date, and CMS1455R
- The timely filing limit is within 180 days of the inpatient claim denial, final appeal decision, or dismissal notice.

July 1, 2013

Revised instructions for claims submitted on or after July 1, 2013:

- Applies as long as the denial was made:
 - While the Ruling is in effect
 - Prior to March 13, 2013; timeframe to file an appeal not expired
 - Prior to March 13, 2013; appeal is pending
- TOB 12X (Part B inpatient services); TOB 13X (Part B outpatient services)
- **Condition code W2**
- Treatment authorization code = **A/B Rebilling**
- Remarks = **ABREBILL**, the DCN of the denied inpatient claim, and the last adjudication date
- The timely filing limit is within 180 days of the inpatient claim denial, final appeal decision, or dismissal notice.

Admissions On and After October 1, 2013

Instructions for inpatient stays determined to be not medically reasonable and necessary through self-audit:

- If a Part A 11X TOB claim was submitted, cancel it.
- Submit a provider liable claim:
 - TOB 110
 - Occurrence span code M1 and dates of service
 - Non-covered days and charges for all services rendered
- Submit A/B rebilling claims.

Admissions On and After October 1, 2013

- FISS must reflect either a denied inpatient claim or a no-pay provider liable claim.
- A/B rebilling claim must include:
 - TOB 12X (Part B inpatient services); TOB 13X (Part B outpatient services)
 - Condition code W2
 - Treatment authorization code = A/B Rebilling
 - Remarks = **ABREBILL and the DCN of the denied inpatient claim**
- The timely filing limit is one calendar year from the “through” date of service.

IPPS Updates

MM8761

- Updates the FY 2014 IPPS PRICER due to the Protecting Access to Medicare Act of 2014, signed on April 1, 2014
- Certain provisions of the Affordable Care Act are extended through March 31, 2015:
 - Section 105 – Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals
 - Section 106 – Extension of the Medicare-Dependent Hospital Program
 - Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014
 - Reinstatement of Medicare-Dependent Hospital Status

MM8546

- Section 3008 of the Affordable Care Act – FY 2015 Hospital-Acquired Condition (HAC) Reduction Program
- Section 3133 – Uncompensated Care Payment (UCP) for Disproportionate Share Hospitals
- Medicare EHR Incentive Program – FY 2015 payment adjustment for acute care hospitals that are not meaningful users of certified EHR technology
- Model 1 of the Bundled Payments for Care Improvement (BPCI) initiative – provides a discount that will be phased in over the performance period of three years

July 2014 OPPS Updates

July 2014 OPPS Updates

- MLN Matters article MM8776, “July 2014 Update of the Hospital OPPS”:

<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8776.pdf>

- MLN Matters article MM8764, “July 2014 I/OCE Specifications Version 15.2”:

<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8764.pdf>

Summary of Changes

- Changes to Device Edits:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/device_procedure.html

- New Brachytherapy Source Payment: HCPCS code C2644
- Category III CPT Codes: 17 of the 27 new codes are separately payable under the OPSS
- Billing for Drugs, Biologicals, and Radiopharmaceuticals

Laboratory Test Payment and Billing

- Effective January 1, 2014, payment for most clinical diagnostic laboratory tests or services (except molecular pathology tests) will be packaged.
- Expansion of the use of the 14X Type of Bill (TOB):
 - Required for non-patient laboratory specimen tests
 - Used when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other outpatient hospital services during the same encounter
 - Used when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other outpatient hospital services, and the laboratory test is ordered by a different practitioner who ordered the other outpatient hospital services. Other outpatient hospital services are billed on a 13X TOB claim.

Laboratory Test Payment and Billing

- MLN Matters article SE1412, “Update to 2014 Hospital Outpatient Diagnostic Laboratory Test Payment and Billing”:
<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>
- Effective July 1, 2014, lab tests that meet the requirements of exception 2 or 3, will be billed on a 13X TOB claim with HCPCS modifier L1, rather than on a 14X TOB claim.

Laboratory Test Payment and Billing

Condition	Claims with dates of service on or after January 1, 2014, and received prior to July 1, 2014	Claims with dates of service on or after January 1, 2014, and received on or after July 1, 2014
Non-patient (referred) specimen	TOB 14X	TOB 14X without HCPCS modifier L1
Only outpatient lab tests are furnished on a given date of service	TOB 14X	TOB 13X with HCPCS modifier L1
Outpatient lab tests are clinically unrelated to other outpatient services furnished on the same day	TOB 14X	TOB 13X with HCPCS modifier L1

Hospital Part B Inpatient Labs

- Clarification of payment policy for patients who are treated as inpatients and are:
 - Not eligible for, or entitled to, coverage under Part A
 - Entitled to Part A, but have exhausted their Part A benefits
- The limited set of inpatient Part B services that are separately billable and payable under Part B, and are excluded from OPPS packaging, IF the primary service with which the service would otherwise be bundled is NOT a payable Part B inpatient service.
- Claims processing logic for lab tests will be updated.

MSP Audits

Common Findings

- Obligated to Accept Assignment (OTAF) calculation errors:
 - Failed to verify amounts entered as MSP CALC OTAF and value code 44
 - Value code 44 and OTAF amount out of balance
- Non-completion of an MSP questionnaire
- Improper utilization of condition codes
- No date on the MSP questionnaire
- Reported incorrect policyholder name and patient relationship on MSP claims

Recommendations

- Resolve any discrepancies with the MSP questionnaire and the Common Working File (CWF) **prior** to claim submission.
- Educate staff on the proper utilization of condition codes.
- Create a process to identify those claims with a value code 44 and an OTAF amount **prior** to billing Medicare, and ensure calculations are correct.
- Ensure all applicable questions pertaining to the beneficiary's entitlement is documented.
- Update office reference material(s).
- An MSP questionnaire **MUST** be completed on Medicare patients **prior** to submitting the claim.
- Value code 44 **SHOULD NOT** appear on the same claim as condition code 77.

Opportunities for Process Improvements

- Rely on MSP information from the questionnaire, instead of the physicians' offices.
- Ensure internal software edits for balancing the OTAF are in working order.
- Make staff aware of the requirement of completing the MSP questionnaire upon admission.
- Policy/process in place to obtain other possible primary payers.

Top Claim Submission Errors

Ohio – May 2014

Return to Provider (RTP)

Reason Code	Description
32402	Revenue/HCPCS code combination error; the revenue code reported is not billable with the HCPCS code.
19301	A principal procedure code or a surgical CPT/HCPCS code is present, but the operating physician's National Provider Identifier (NPI), last name, and/or first initial is either missing or invalid.
30905	There is no record of processing an original claim for this adjustment.
38119	Inpatient Skilled Nursing Facility (SNF) and non-Prospective Payment System (PPS) hospital bills must be processed in the same sequence in which the services were furnished. The claim immediately preceding the dates of service on this claim has not yet processed.
32206	The revenue code reported is invalid for the Type of Bill (TOB).

Rejections

Reason Code	Description
39934	All lines on the claim are denied as non-covered and one or more lines are reported as beneficiary liability.
U5233	The services on the claim fall within or overlap a Medicare Advantage enrollment period.
38200	This claim is an exact duplicate of a previously submitted claim.
C7010	The service dates on this claim overlap a hospice election period and condition code 07 is not present.
U5200	The beneficiary is not entitled to Medicare coverage for the services billed.

Denials

Reason Code	Description
5J504	Item/service is not medically reasonable and necessary.
52MUE	All line items on the claim have units of service in excess of the medically reasonable daily allowable frequency.
55503	Claim did not meet the medical necessity guidelines outlined in CGS' Local Coverage Determination (LCD) policy.
5FRTB	The documentation submitted to the Recovery Auditor did not justify payment; therefore, therapy services have been denied.
56900	We are unable to determine medical necessity of the services since the requested medical records were not received within the 30-day time limit.

Beneficiary Eligibility

Termination of CWF Part A Provider Queries

- MLN Matters article MM8248:
<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8248.pdf>
- Effective date to be announced approximately 90 days prior to termination
- HIPAA Eligibility Transaction System (HETS) 270/271:
<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html>
- myCGS Web portal: <http://www.cgsmedicare.com/parta/index.html#>

Other Benefits of myCGS

- Access and view claims data
- View and print remittance advices
- Check your payment floor status and determine recent checks issued to your facility
- Submit redetermination requests and determine appeals status
- Request offsets

CGS Resources

- CGS website: <http://www.cgsmedicare.com/>
- CGS ListServ registration:
http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp
- CGS Part A PCC: 1.866.590.6703
- CGS Part A IVR: 1.866.289.6501
- myCGS web portal: <http://www.cgsmedicare.com/parta/index.html#>

EDI Resources

CGS Electronic Data Interchange:

<http://www.cgsmedicare.com/parta/index.html#>

- EDI enrollment
- Electronic Remittance Advice (ERA)
- PC-ACE Pro32 software
- Direct Data Entry (DDE) software

Questions?

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Thank you for attending!