

CGS Medicare Update

Aurora, OH | Annie Scriven & Vanessa Williams | September 11,
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Objectives

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

- 2-Midnight Provision and A/B Rebilling
- Other Types of Review
- Hospital Updates
- 2015 Updates
- Top Claim Submission Errors
- General Updates

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.

Administrative Agreement

On August 29, 2014, CMS announced it is now offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount).

- CMS Inpatient Hospital Reviews Web page:

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

Facility Types

- Facility types eligible to submit a settlement request:
 - Acute care hospitals (including those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and Maryland waiver)
 - Critical Access Hospitals (CAHs)
- Facility types NOT eligible to submit a settlement request:
 - Psychiatric hospitals paid under the Inpatient Psychiatric Facility (IPF) PPS
 - Inpatient Rehabilitation Facilities (IRFs)
 - Long-Term Care Hospitals (LTCHs)
 - Cancer hospitals
 - Children's hospitals
 - Certain hospitals may be excluded based on pending False Claims Act litigation or investigations

Eligible Claims

- Currently pending appeals of inpatient status claim denials by Medicare contractors on the basis that services may have been reasonable and necessary, but treatment on an inpatient basis was not
- Dates of admission prior to October 1, 2013
- Patient was not a Medicare Part C enrollee
- Hospitals may not choose to settle some claims and continue to appeal others
- Requests must be sent to CMS by October 31, 2014

Other Types of Review

Claims That Are Related

Effective September 8, 2014:

- Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs) have the discretion to deny other “related” claims submitted before or after the claim in question.
- If documentation associated with one claim can be used to validate another claim, those claims may be considered “related”.
- MACs and ZPICs must receive CMS approval prior to initiating these reviews.

Reference:

- CMS Change Request (CR) 8802: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R540PI.pdf>

Comprehensive Error Rate Testing (CERT)

- “Task Force Scenario: Documenting Therapy and Rehabilitation Services”:

<http://cgsmedicare.com/articles/cope26285.html>

- SE1419, “Medicare Signature Requirements – Educational Resources for Health Care Professionals”:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1419.pdf>

Recovery Auditors

- Due to the continued delay in awarding new Recovery Auditor contracts, CMS is initiating contract modifications to the current contracts to allow the restart of some reviews.
- Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS.
- Work continues on the procurement process and CMS remains hopeful that the new round of Recovery Auditor contracts will be awarded this year.

Hospital Updates

FY 2015 Inpatient Hospital Updates

- FY 2015 IPPS Final Rule:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html>
- MM8889, “Update – IPF PPS FY 2015”:
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8889.pdf>
- MM8788, “IRF Annual Update: PPS Pricer Changes for FY 2015”:
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8788.pdf>

October 2014 Hospital Outpatient Updates

- MM8873, “October 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)”:
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8873.pdf>
- MM8879, “October 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.3”:
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8879.pdf>

2015 Updates

Medically Unlikely Edit (MUE) Program

Effective January 1, 2015:

- MUE Adjustment Indicator (MAI):
 - MAI 1 = claim line edit
 - MAI 2 = absolute date of service edit
 - MAI 3 = date of service edit based on clinical benchmarks
- MUE changes are not retroactive unless the change is to update with a retroactive date
- MUE denials may be appealed, but MACs may only pay in excess of an MUE that has an MAI indicator of 1 or 3
- MUE denials are coding denials, not medical necessity denials; therefore, it is not appropriate to issue an Advance Beneficiary Notice of Noncoverage (ABN) to shift liability to the beneficiary

MUE Program

- Bilateral surgical procedures should be reported on a single claim line with CPT modifier 50 and one unit of service
- Use anatomic modifiers and report procedures with differing modifiers on individual claim lines when appropriate

References:

- MM8853: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8853.pdf>
- SE1422: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1422.pdf>

Distinct Procedural Services

Effective January 1, 2015:

- Four new HCPCS modifiers to define specific subsets of HCPS modifier 59:
 - XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
 - XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
 - XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
 - XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
- Continue to report the most specific modifier

Distinct Procedural Services

References:

- MM8863: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf>
- SE1418: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf>

Automation of the Claims Reopening Process

Effective for claims received on and after April 1, 2015:

- Type of Bill (TOB) XXQ
- Reopening condition code (R1-R9)
- Adjustment condition code
- Condition code W2 (Attestation that there is no appeal in process)
- Adjustment reason code (R1-R3 for DDE claims only)
- Reopenings that require “good cause” to be documented must include a specifically formatted statement in Remarks

References:

- MM8581: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8581.pdf>
- SE1426: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf>

Top Claim Submission Errors

Ohio – July 2014

Return to Provider (RTP)

Reason Code	Description
31164	The line item modifier is invalid, or the line item date of service is not within or equal to the modifier effective and termination dates.
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.
32402	Revenue/HCPCS code combination error; the revenue code reported is not billable with the HCPCS code.
U5452	Therapy claim with a different functional G-code set and the posted reporting episode has not been discharged.
39132	The OPPS reimbursement is greater than the covered charge on the bill line.

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.
W7027	Only incidental services are reported on the claim.
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.
U5200	The beneficiary is not entitled to Medicare coverage for the services billed.

Denials

Reason Code	Description
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.
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.
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.

General Updates

Termination of CWF Part A Provider Queries

- 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
- Submit Part B claim reopenings

CGS Website Enhancements

- Direct Data Entry (DDE) Manuals:
<http://cgsmedicare.com/parta/edi/dde.html>
- Top Claim Submission Errors Web page
- Online Computer Based Training (CBT) courses
- Forms

CGS Calendar of Events

http://cgsmedicare.com/medicare_dynamic/wrkshp/pr/parta_report.asp

Event	Date
Two-Midnight Rule Ask-the-Contractor Teleconference (ACT)	October 8, 2014
Outpatient Therapy Services	October 14, 2014
SNF Billing and Payment for BPCI Model 2 Beneficiaries Without a 3-Day Hospital Qualifying Stay ACT	October 15, 2014
ESRD Updates ACT	October 29, 2014
MSP Audits: Lessons Learned ACT	November 12, 2014
Top Billing Errors ACT	November 19, 2014

CGS Resources

- CGS website: <http://www.cgsmedicare.com/>
- CGS electronic mailing list:
http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp
- CGS Part A PCC: 1.866.590.6703
 - Option 1: Billing, claims, eligibility, and payment inquiries
 - Option 2: Electronic Data Interchange (EDI)
 - Option 3: Provider Enrollment (PE)
 - Option 4: Overpayment Recovery (OPR)
- CGS Part A IVR: 1.866.289.6501
- myCGS web portal: <http://www.cgsmedicare.com/parta/index.html#>

Questions?

CGS Medicare Update

Thank you for attending!