Hospital Medicare Outpatient Reimbursement

March 13, 2007

Medicare Outpatient Reimbursement

- History
- Overview of Ambulatory Payment Classifications (APCs)
- How CMS determines reimbursement amounts
- Calculating payments
- Calendar 2007 updates
- OPPS Billing Compliance
  - Compliance challenges
  - General and specific compliance concerns

History of Medicare Outpatient Reimbursement

- Ambulatory payment classifications (APCs) became effective August 1, 2000
- Prior to APCs hospitals were reimbursed cost of a blend of cost and fee schedule amounts
- Some services still paid at cost or fee schedule

Overview of APCs

- Rates are based on national payment amounts adjusted for geographic wage differences
- Covers supplies and services integrally related to performing the service
- Certain drugs, biologicals and devices qualify for separate reimbursement
- Clinical lab, ambulance and certain therapies are excluded from APCs
  - Paid on a fee schedule
- Additional payments are made for outliers in certain circumstances

How CMS Determines Reimbursement Amounts

- National Conversion Factor established by CMS
  - Takes into account:
    - Group weights
    - Volume of services in each group
    - Expenditure target
    - Adjusted as needed to ensure budget neutrality
- Each APC has an assigned weight
  - Derived from median hospital costs of the services in the group relative to the median hospital cost for a mid-level clinic visit
  - Mid-level clinic visit chosen because it is one of the most frequently performed service in the outpatient setting
  - Based on hospital cost reports
- Wage adjustment factor
  - Based on area wage index specific to geographic area

Calculating the Total Payment Amount

- The APC Weight is applied to the APC Conversion Factor.
- The wage index adjustment is applied to the labor related portion of the APC group
- The wage adjusted labor portion is added to the non-labor portion.
- This calculates the total payment due the provided, the Medicare/beneficiary split is determined by the National Co-payment Amount

Sample APC Payment Calculation

Calendar Year 2006

		CT Scan - Body	Ultrasound	Minor Surgery	
1	Revenue Code	352	402	361	
2	CPT code	71250	76770	20610	
3	APC that CPT maps to	0332	0266	0204	
4	APC Conversion Factor	$ 59.5110	$ 59.5110	$ 59.5110	*Per Federal Register*
5	APC Weight	3.1608	1.5883	2.2667	*Per Federal Register*
6	Number of units	1	1	1	
7	Unadjusted APC Payment Amount	$ 188.10	$ 94.52	$ 134.89	(L.4xL.5xL.6)
8	Labor portion	0.60	0.60	0.60	*Per Federal Register*
9	Unadjusted wage portion	112.86	56.71	80.94	(L.7xL.8)
10	Wage Index	1.1551	1.1551	1.1551	*Per Federal Register*
11	Wage adjusted portion	130.37	65.51	93.49	(L.9xL.10)
12	Non-wage portion	75.24	37.81	53.96	(L.7-L.9)
13	Total payment amount *	$ 205.61	$ 103.32	$ 147.45	(L.11+L.12)

* Medicare/beneficiary portion is dependent on the National Copay Amount

Calendar Year 2007 Update Highlights

- Conversion factor increasing from $59.511 to $61.551
- Outlier payments
  - Final dollar threshold is $1,825
  - Outlier payment to be made at 50% of the amount by which the cost of furnishing services exceeds 1.75 times the APC amount
- Devices
  - Reduced payment rates when a device is replaced without cost (recalls), beneficiary coinsurance also reduced
- Drug and Biologicals
  - Paid at 106 percent of average sales price
  - Radiopharmaceuticals paid at hospital specific cost to charge ratio
- E/M services
  - New APCs implemented for evaluation and management

OPPS Billing Compliance

- Challenges
- General Concerns
- OPPS Specific Concerns
- The Near Future

Compliance Challenges

- Keeping Current
  - New Regulations, National, and Local Coverage Determinations
  - Changes to Regulations, National and Local Coverage Determinations
  - Probe Findings, Alerts, and Bulletins
  - OIG Work Plan, Reports, and Publications
  - List-Serves, Conferences, and Trade Publications
- Identifying What is Relevant
  - Regulatory Updates Process
- Identifying and Educating Appropriate Staff

Compliance Challenges

- Monitoring
  - Evaluating *Your* Risk Areas (Annually)
    - Performing *Your* Risk Assessment
    - Evaluating Internal Audit's Findings
    - Reviewing The OIG Work Plan
    - New Systems, New Regulations, and New Vendors
    - Articles in the Trade Press
    - Findings from CMS, FI, Carrier, MAC, and Other Payers
    - Allegations Received
    - Soliciting Requests

Compliance Challenges

- Monitoring
  - Assuring That *Your* Process Controls are Functioning
    - Establishing *Your* Work Plan
    - Conducting Reviews, Interviews, and Monitors
    - Checking-in (Quarterly)
    - Producing Findings / Rating Them
    - Reporting Your Findings
    - Acting Upon Your Findings
    - Following Up on Significant Findings

Compliance Challenges

- Accessibility
  - Can Issues Reach You?
  - Will Issues Reach You?
- Documentation
  - Thoughts and Considerations
  - Guidance
  - Research
  - Work Product

General Compliance Concerns

- Policies & Procedures
  - In its Various Compliance Program Guidance Publications, the OIG Recommends Policies and Procedures for an Effective Program:
    - Billing Standards of Conduct (on future slides)
    - Employee Educational Requirements
    - Risk Areas (Fraud, Abuse and Waste)
    - Integrity of Information
    - Resolution of Ambiguities
    - Coding

General Compliance Concerns

- Documentation and Coding
  - Assignment of Codes
  - Billing Only for Services Documented
  - Billing Only for Services That are Medically Necessary
  - Following the National Correct Coding Initiatives
  - Proper Use of Modifiers
    - -25 Significant, separately identifiable Evaluation and Management Service by the same physician on the same day of the procedure or other service
    - -57 Decision for surgery
    - -59 Distinct procedural service

General Compliance Concerns

- Charge Capture and the Charge Description Master
  - New, Edited, and Deleted CPT/HCPCS Codes
  - Tighter Implementation Deadlines (01/01 vs. 04/01)
  - AMA CPT vs. CMS HCPCS Requirements
  - Education

General Compliance Concerns

- Medicare as Secondary Payer
- Charges on a Fee Schedule / Not OPPS
  - Ambulance Services
  - Screening & Diagnostic Mammography
  - End Stage Renal Disease / Chronic Kidney Failure
  - Professional Services
  - Clinical Laboratory
  - Durable Medical Equipment / Prosthetic and Orthotics
  - Outpatient Skilled Nursing Facility Services
  - Organ and Corneal Tissue Acquisition Costs
  - Others...

Specific Compliance Concerns

- Outpatient Services Treated as Inpatient Services Rules
  - Outpatient Services Followed by an Admission Before Midnight of the Following Day
  - Preadmission Diagnostic Services (Revenue Code)
  - Preadmission Non-Diagnostic Services (Diagnosis)
    - Are you holding claims long enough to prevent inappropriate billing?
    - Late charge process?

Specific Compliance Concerns

- Duplicate Billing
  - New Processes
  - Redundant Processes / Shadow Systems
- Bundled Services
  - Use of Individual Codes Rather Than Aggregate Codes (Lab: BMP, CMP, HFP)
- Inpatient-Only List
- Charges Covered by Research / Clinical Trials

Specific Compliance Concerns

- Facility Evaluation & Management Leveling
  - No Guidance from CMS Other than to Develop Your Own System and Follow It
- Provider-Based Clinics
  - Ability to Charge a Facility Fee and Professional Fee
- Observation Services
  - Requires a Directed Order to Admit to Observation
  - Not for Routine, Post-Surgical Recovery
  - Condition Code 44 (Inpatient to Observation)
- Partial Hospitalization Program
  - Used by Outpatient Psych Facilities
  - Stringent Documentation / Care Requirements

Specific Compliance Concerns

- Pass-Through Payments for Drugs, Biologicals, Devices, and New Technologies
- Outlier Payments
  - For Unusually Costly Services
  - 1.75x Over APC Payment and Dollar Threshold
- Resolution of Overpayments
  - Often Result from MSP or Duplicate Billing Issues
  - Quarterly Credit Balance Report to Medicare
  - Reimburse within 60 Days

Future Compliance Concerns

- Medically Unlikely Edits (v2 on 04/01/2007)
  - No Published MUE List
  - Monitor Return to Provider Errors
- Services Performed Outside of the US
  - Tele-Radiology Services (for example)
  - No Facility or Professional Payment Made
  - Implementation Date: 04/02/2007
  - Retro-effective Date: 11/13/2006
    - Thursday in April – Next CMS Hospital Forum
    - Tuesday; April 17, 2007 Next CMS Provider Forum

Future Compliance Concerns

- Medicare Administrative Contractor Conversion
  - Coordination Between Fiscal Intermediaries and Carriers
  - Consolidation of Local Coverage Determinations
  - Standardization of Systems
- Data Mining
  - Expect More of It
  - With Increased Accuracy
  - Sharing of Medicare Findings with Medicaid Integrity Program
- Research / Clinical Trials Billing
- FY08 CMS OPPS Proposed / Final Rule

Resources

- Hospital Outpatient Prospective Payment System and CY 2007 Payment rates; Final Rule, November 24, 2006 *Federal Register*
- Office of the Inspector General
  - Compliance Program Guidance for Hospitals (February 23, 1998)
  - Supplemental Compliance Program Guidance for Hospitals (January 27, 2005)
  - Compliance Program Guidance for Third-Party Medical Billing Companies (December 18, 1998)

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