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Medicare Disclaimer

This publication provides the student with coding and reimbursement examples and explanations, of which many are taken from the Medicare perspective. The coder, however, should understand that while private payers typically take their lead regarding reimbursement rates from Medicare, it is not the only set of rules to follow.

While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible for students and examinees. All examples and case studies used in our study guides, exams, and workbooks are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Chapter 7

CMS and Inpatient Payment Systems

The Different Types of Payers

There are two types of payers: private or commercial insurance plans and government insurance plans. Individual payers may specify coding requirements in addition—or even contradictory—to those guidelines found in code books, which can increase the administrative burden of medical coding.

Commercial carriers are private payers offering both group and individual plans. The contracts they provide vary, but may include hospitalization, basic, and major medical coverage. Private payers are further classified into for-profit and not-for-profit. For profit payers are more likely than others to decide which medical services to cover based on service profitability, as well as to configure insurance contracts based on profitability. For-profit payers may disperse profits to shareholders, whereas government and nonprofit payers enjoy income and tax exemptions. Not-for-profit payers usually roll profits back into the products and services offered or give them to charitable causes.

For example, BlueCross/BlueShield organizations are private payers and usually operate in the state in which they are based. They can be either for-profit, like Anthem, UnitedHealth Group, or Cigna; or non-for profit, which typically occurs at the state or regional level, like BlueCross/BlueShield of Arkansas or CareFirst BlueCross/BlueShield. BlueCross/Blue Shield offers hospital, medical, and surgical benefits.

The most significant government insurer is Medicare, which is by far the largest payer in the United States, conducting over $700 billion in business in 2017. Medicare is a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) that provides coverage for people over the age of 65, blind or disabled individuals, and people with permanent kidney failure or end-stage renal disease (ESRD). CMS regulations dictate coding requirements for Medicare and most non-Medicare payers. The Medicare program is made up of several parts:

- Medicare Part A helps to cover inpatient hospital care, as well as care provided in skilled nursing facilities, hospice care, and home healthcare. Part A also covers nursing home care, as long as custodial care is not the only care that you need. Unfortunately, in most nursing homes, custodial care is all that is provided. Therefore, most nursing home care does not meet the requirements to be covered for Part A Medicare payment. Part A allows a 90-day per episode of care benefit with a 60-day lifetime reserve. Illness episodes begin when the Medicare beneficiary is admitted and end after the beneficiary has been out of the hospital or Skilled Nursing Facility (SNF) for 60 consecutive days. Inpatient coders and billers deal mostly with Medicare Part A. If a patient has a hospital stay that lasts longer than 90 days, they will need to use any remaining lifetime reserve days to pay for those days over the 90 day stay. Once the lifetime reserve days are used up, there are no more lifetime reserve days.
- Medicare Part B helps to cover medically necessary doctors' services, outpatient care, and other medical services (including some preventive services) not covered under Medicare Part A. Medicare Part B is an optional benefit for which the patient must pay a premium, and which generally requires a yearly deductible and co-insurance. Coders working in outpatient facilities and ambulatory surgical centers (ASCs) deal mainly with Medicare Part B.
- Medicare Part C, also called Medicare Advantage, combines the benefits of Medicare Part A, Part B, and (sometimes) Part D. The plans are managed by private insurers approved by Medicare, and may include Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and others. The plans may charge different co-payments, co-insurance, or deductibles for services. Accurate and thorough diagnosis coding is important for Medicare Advantage claims because reimbursement is affected by the patient's health status. The Centers for Medicare & Medicaid Services-Hierarchical Condition Category (CMS-HCC) risk adjustment model provides adjusted payments based on a patient's diseases and demographic factors. If a coder does not include all pertinent diagnoses and co-morbidities, the provider may lose out on additional reimbursement. Conversely, if the patient's diagnosis is over-coded, the provider may end up paying a penalty for overpayment.
- Medicare Part D is a prescription drug coverage program available to all Medicare beneficiaries. Private companies approved by Medicare provide the coverage.

Medicaid is a health insurance assistance program for some low-income people (especially children and pregnant women) sponsored by federal and state governments. Coverage varies on a state-by-state basis, although each of the state programs adheres to federal guidelines.

Some individuals qualify for both Medicare and Medicaid. These individuals are dual eligible beneficiaries. Medicare is

EXAMPLE

A patient presents with fatigue and shortness of breath. Blood tests reveal the patient has severe anemia. The patient is admitted. The provider determines the signs and symptoms caused by the severe anemia. Further testing identifies severe blood loss anemia. The patient is currently being treated for hypertension and hyperthyroidism.

Step 1: Assign diagnosis codes - The diagnoses for this case include: D62 *Acute posthemorrhagic anemia*; I10 *Essential (primary) hypertension*; E05.90 *Thyrotoxicosis, unspecified, without thyrotoxic crisis or storm.*

Step 2: Determine the principal diagnosis code - The principal diagnosis is D62. The MS-DRG options are provided below

MS-DRG	MS-DRG Description	MDC	MDC Description	Type	Geometric Mean LOS	Arith-metic Mean LOS	Relative Weight	Final Rule Post-Acute DRG	Final Rule Special Pay DRG
811	RED BLOOD CELL DISOR-DERS W MCC	16	Diseases and disorders of blood, blood-forming organs and immunologica	MED	3.7	4.9	1.3560	No	No
812	RED BLOOD CELL DISOR-DERS W/O MCC	16	Diseases and disorders of blood, blood-forming organs and immunologica	MED	2.7	3.5	0.8832	No	No

Source: AAPC Facility Coder

Step 3: Eliminate any MS-DRGs that include diagnoses that are not pertinent to this patient. This patient does not have HIV, eliminate all MS-DRGs except 811 and 812.

Step 4: Narrow the MS-DRGs based on surgery. There is no indication a surgical procedure is performed. So, we still have MS-DRG 811 and 812.

Step 4: Determine the MCCs and CCs. Search in the MCC and CC list to determine if I10 or E05.90 appear on the lists. Access the MCC and CC table at www.cms.gov.

Neither of the diagnosis codes are on the list. The correct MS-DRG for this example is 812, Red Blood Cell Disorder without MCC.

APR-DRGs

Gaps and shortfalls have been noted since the inception of the DRG system in the 1980s. DRGs are used in facilities to determine whether an expansion in the facility is necessary, whether patients would benefit from more services, if staffing is adequate in certain areas of the facility, and in many more applications. It is important to many facilities to be able to compare and study all patient groups, including neonates, mental health patients, or pediatric patients. MS-DRGs focus on diseases and disorders of the elderly and Medicare population, but do not accurately reflect the resources used by all patients. MS-DRGs are also not as useful in capturing severity of illness, evaluating mortality rates, or supporting quality improvement of patient care.

All-Patient Refined Diagnosis-Related Groups (APR-DRGs) were developed by 3M Health Information Systems to meet these needs. APR-DRGs expand the basic structure of the DRG system. There are four subclasses for each DRG that relate to the severity of illness and risk of mortality. Severity of illness is defined as the extent of physiologic decompensation or organ system loss of function. Risk of mortality is defined as the likelihood of dying. A patient may have a condition that has a major severity of illness, but a minor risk of mortality. For example, a patient may have acute appendicitis, which is a major severity of illness, but the risk of mortality for a patient with acute appendicitis is minor. The four subclasses for severity of illness and risk of mortality are numbered from 1 to 4 to represent categories; minor, moderate, major, and extreme. Severity of illness (SOI) and risk of mortality (ROM) are scored separately for each inpatient admission based on the patient's principal diagnosis, MCCs and CCs, other secondary diagnosis, the admission status, the discharge status, and the sex and age of the patient. The secondary diagnoses that affect an APR-DRG are specific to each APR-DRG. A secondary diagnosis that weighs heavily in one APR-DRG may not affect another APR-DRG. APR-DRGs are highly dependent on the patient's underlying problem or principal diagnosis. SOI and ROM are affected by the presence of multiple diseases involving multiple organ systems. For example, a patient with a new CVA, with comorbidities such as autoimmune hepatitis, a decubitus ulcer, and lung cancer, would have a higher SOI and

ROM score than a patient with a new CVA and no comorbidities. For each patient an APR-DRG, a severity of illness subclass and a risk of mortality subclass is assigned.

Many states use APR-DRGs for their Medicaid population, as do university and teaching hospitals throughout the U.S.

- They can be used as part of a quality improvement program for utilization control.
- They can be used for reimbursement in a prospective payment system. They can be used rank hospitals in risk of mortality.
- They can also be used to review mortality cases retrospectively to examine the relationship between the patient's illness and ROM score to look for potential opportunities for improvement in patient care.

Coding for APR-DRGs requires capturing all valid secondary diagnoses and requires that chart documentation be as specific as possible. Many facilities that use the APR-DRG system may choose to expand their physician query program to include queries pertaining to codes that may affect the SOI or ROM. APR-DRGs do not use a specific CC/MCC list; it is important that training is on-going, so that coders are aware of the types of conditions that may affect the APR-DRG.

Long-term Care Hospital MS-DRGs

The Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 established the Prospective Payment System (PPS) for operating and capital related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A. Under this system, a hospital is paid a fixed amount for each patient discharged in a treatment category or Diagnosis Related Group (MS-DRG). This fixed amount is intended to cover the cost of treating a typical patient for a MS-DRG.

CMS is also continuing to implement the changes required by The Pathway for SGR Reform Act of 2013 that establish two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria. CMS projects that LTCH PPS payments will decrease by approximately $195 million in FY 2018 CMS. CMS finalized its regulations regarding the 25 percent threshold policy, which is a payment adjustment made when the number of cases an LTCH admits from a single hospital exceeds a specified threshold (generally 25 percent).

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required quality reporting measures data to CMS is reduced by two percentage points. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the continued specification of quality measures for the LTCH QRP, as well as resource use and other measures. Every year, the LTCH Final Rule will outline which quality measures are required to be included in the LTCH reporting data.

Chapter 7 Questions

1. Medicare is secondary payer to:

   I. Workers Compensation
   II. EGHP
   III. Automobile insurance
   IV. Liability insurance

   A. I, III
   B. I, IV
   C. II, III, IV
   D. I, II, III, IV

2. Medicare statutory denials include:

   I. Services performed by a physician assistant, midwife, psychologist or CRNA when furnished as an inpatient, unless furnished under arrangement with the hospital.
   II. Services performed by a physician who is an immediate relative.
   III. Outpatient occupational and physical therapy services furnished incident-to a physician's service.
   IV. Cosmetic surgery
   V. Admissions for exacerbated chronic conditions
   VI. Surgical services to excise cancerous tumors

   A. I, II, III. IV
   B. I, II
   C. I, III, IV, V, VI
   D. I, II, III, IV, V, VI

3. Medicare Part A helps cover:

   A. Inpatient hospital care, outpatient hospital care, skilled nursing facility care, hospice care.
   B. Inpatient hospital care, skilled nursing facility care, partial hospitalization, and home healthcare.
   C. Inpatient hospital care, skilled nursing facility care, home healthcare, and hospice.
   D. Inpatient hospital care, skilled nursing facility care, home healthcare, and assisted living facilities.

4. A patient presents for preoperative lab tests in the outpatient hospital clinic on 6/2. The patient is admitted on 6/3 for a resection of her colon due to colon cancer. How are the lab tests billed?

   A. The lab tests are billed as an outpatient service because they were performed on a separate date of service.
   B. The lab tests are included with the inpatient claim because it was related to a surgery.
   C. The lab tests are included with the inpatient claim because the services are related to an inpatient service within the three-day window.
   D. The lab tests are billed as an outpatient service because all lab services must be billed separately.