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CODING & BILLING FOR PROSPECTIVE PAYMENT SYSTEMS

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CMS Takes Steps to Crack Down On Inappropriate Hospital Outlier Claims

The Centers for Medicare & Medicaid Services (CMS) today proposed new regulations that will prevent further gaming of the outlier system. A few hundred hospitals in recent years have obtained the lion's share of these payments by manipulating their Medicare billing to maximize Medicare outlier revenues.

Hospitals receive an additional payment - called an outlier payment - if the estimated costs of an individual case exceed the Medicare payment rate by a threshold amount that is set by Medicare regulations. In the final hospital inpatient prospective payment rule for fiscal year 2003, the threshold amount was set at $33,560. The threshold amount would remain the same in the proposed rule, but will be fully reviewed and evaluated during the comment period.

"The new policy will achieve a balance between paying hospitals fairly for high cost cases and limiting outlier payments to the 5 to 6 percent of total inpatient spending that Congress mandated," said CMS Administrator Tom Scully. "We anticipate that the changes we are announcing today will stop, and likely reverse, the recent trend toward a rapid upward spiral in the threshold for eligibility for outlier payments. As a result, we believe more hospitals will appropriately receive higher payments in the future."

Medicare generally pays hospitals a predetermined amount for a patient's stay, based on the average cost of providing care to a patient in a similar condition. The payment is set at an amount that will allow an efficiently operated hospital to earn a reasonable rate of return overall for the average patient. However, Medicare law recognizes that there are some cases that are more complicated and therefore more costly to treat and requires that CMS pay an additional amount to hospitals for these outlier cases. In the 2003 hospital payment update, CMS has set the outlier threshold at a level projected to pay 5.1 percent of total payments for inpatient care for these outliers - about $3.8 billion.

In recent years, the outlier spending targets were $3.5 billion in 2000 and actual spending was $5.3 billion; $3.6 billion in 2001 while spending was $5.5 billion; and $3.7 billion for 2002, while spending was $5.3 billion.

"Obviously this system is badly broken," said Scully. "CMS did not understand why spending was escalating beyond Congress' allotment and kept raising the outlier threshold. Now that CMS understands the gaming that led to this unintended spending, we are acting to end these practices."

Under current rules, in order to estimate the actual costs incurred by a hospital for a given case, Medicare uses the historical relationship between each hospital's costs and its charges. So long as hospital costs and hospital charges change at roughly the same rate, this estimate produces a relatively reliable result. However, if a hospital increases its charges dramatically relative to costs, the use of the historical relationship will yield higher outlier payments than would be appropriate. In addition, the longer the lag between the historical data and the current charges - currently two years - the less accurate the estimate will be.

Each year, when CMS updates the hospital payment rates, it sets a threshold for outlier payments designed to keep them at the target of 5.1 percent of total payments under the DRG. As outlier claims (heretofore inexplicably) increased, the outlier threshold has gone up sharply - from $14,050 in 2000 to $33,560 in 2003 to stay within the 5.1 percent target. As a direct result, more hospitals have had to absorb the costs of complex cases, while a relatively small number of hospitals have been aggressively taking advantage of the current rules, and receiving a growing portion of outlier payments.

"In December, we announced several steps we were taking to identify hospitals that appear to have engaged in schemes to obtain higher outlier payments than they were entitled to in good faith," said Scully. "In this rule, we are looking to the future to ensure that these practices do not continue -- period."

Today's rule proposes three significant changes to prevent hospitals from manipulating the outlier formula:

- It allows Medicare to use more recent data to calculate outlier payments.
- It eliminates the use of a statewide average ratio of costs to charges for hospitals with very low computed cost-to-charge ratios.
- It allows Medicare to recover overpayments if the actual costs of a case as reflected in the settled cost report are less than the provider had claimed.

Overpayment recoveries would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital.

"With the rule we are proposing today we are showing our intention to turn off the faucet to those hospitals that have been overcharging Medicare, while making sure that all hospitals will be paid appropriately for the care they provide to Medicare beneficiaries," said Scully. "This will ultimately provide relief to the many hospitals that have been denied legitimate payment for complex patients due to the inappropriate behavior of a small group of other hospitals."

The rule will be published as a notice of proposed rulemaking in the March 5 Federal Register with a 30-day comment period. Comments will be accepted until April 4, and a final rule will be published as soon as possible.

CMS Public Affairs Office released the above information, February 28, 2003.

2003 Physician Fee Schedule Update

Emergency Changes to the 2003 Medicare Physician Fee Schedule

Medicare Program Memorandum AB-03-035 activates the new CPT-4 and HCPCS codes in the 2003 physician fee schedule as well as payment adjustments. This memorandum does not directly affect the APC payment system.

To view this program memorandum click on the link below.

http://cms.hhs.gov/manuals/pm_trans/AB03035.pdf

Laboratory Billing

Effective on July 1, 2003, Medicare Program Memorandum AB-03-021 instructs fiscal intermediaries and carriers to request medical necessity data from the practitioner that ordered a laboratory test. It is the responsibility of the entity that submits the claim for any laboratory test to accurately identify the ordering practitioner.

Where the practitioner ordering the test cannot be identified, the claim will be developed solely on the information submitted with the claim.

Where the ordering practitioner fails to submit the requested information, the claim will be denied and the entity submitting the claim will be notified that the denial is based on the lack of a response to the request.

To view this program memorandum click on the link below.

http://cms.hhs.gov/manuals/pm_trans/AB03021.pdf

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