Payer's (Still) Going WILD-- Line item/Forensic Audits and Bundles

Presented by:

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Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.
Let me be the Patient Financial Navigator!

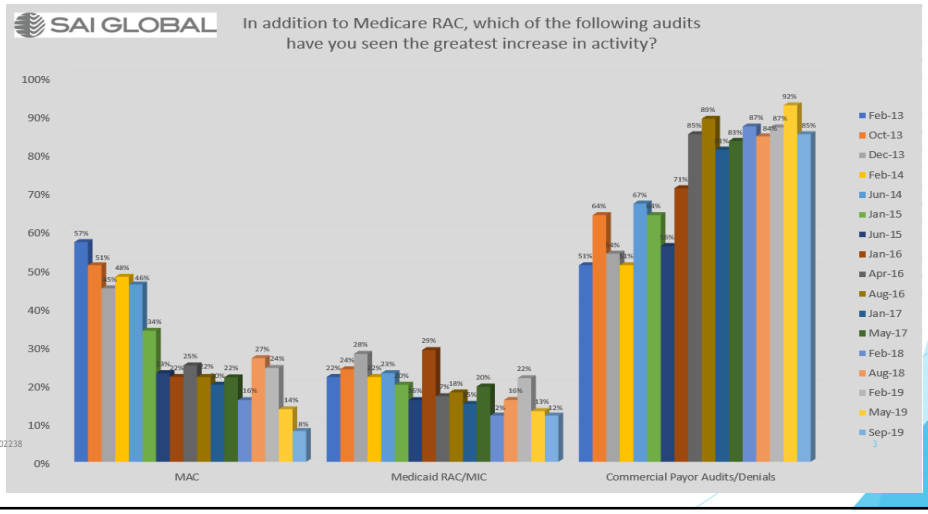
Hospitals at risk – **300+ rural hospitals at immediate risk of closure** –have lost $ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23)

Stats from AHA	2023	
Total hospitals in all US	6129	
# of community hospitals	5157	84%
Of these, # of nongovt not-for-profit com hosp	2978	58%
# of owner investor-owned, for profit	1235	20%*
# of State & local govt community hospital	944	15%
Additional: # of Fed Govt hospitals	206	3%
# of nonfed psych hosp	659	11%
Other hospitals	107	2%

By state - sample	# at risk of total # hosp
Kansas	29 Of 169 *34 private
Mississippi	25 of 128 *36 private
Oklahoma	24 of 165 *61 private
Alabama	19 of 133 *62 private
California	9 Of 570 *148 private
Iowa	7 Of 145 *5 private
Idaho	2 of 55 *13 private
Nevada	2 of 76 *37 private
As we carefully watch multiple small rural hospitals close , many are tied to Private for-profit investor owned.	Communities without a hospital - also means providers too & Jobs

8 year history with Compliance 360/SAI

AHA survey: 78% of hospitals =payer relationships are getting worse. 84% said the cost of complying with payer policies is increasing; 95% saw increase in staff time spent trying to get prior authorization. 11-22 Win/Lose!



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Payers have found a new way to deny services. Dreaded new phrase: **Provider is unbundling separate items that are included in the primary service provided. "Services are paid as part of another service" BUNDLING. Used for Inpt outlier "reviews/disallowed" & outpt procedures.**

Commercial and MA are the largest ones current doing this.

Where does it say in their CONTRACT that this is defined?

How can commercial, WC, & Medicaid contracted payers use Traditional Medicare language when these are not Traditional Medicare patients?

There is no Rule for your Rule - to the payers from the providers…

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Post –discharge, outlier payment, INPT **line item audits.** Commercial, MA, Medicaid Mgt Care. Each payer has their own list, their own justification, internal.

- BIG AT RISK: **If paid by DRG and an outlier payment is expected, here come the line item audits. If paid a % of billed charges, here come the audits.**
- Absolutely a contract issue. Join other providers. Strategize. Charge the payer for sending records, make decision to severe contract, etc. What to expect? Other outpt areas-Huge hit!

Unbundling means—as defined by the payers?

- Inpatient: Disallowing any separate nursing charges. R&B covers all nursing inpt uniquely ordered services. NO venipuncture, in-room pt specific ordered treatments/blood transfusion, ICU/ ventilator daily.
- Observation: No drug adm, OR additional CPTS, Cardio procedure, conscious sedation, assisting provider with procedures/any setting, CPR, suctioning, multiple CPTs, obs hrs, drugs, injections…….

Need to outline: What is covered in a medical R&B rate? ICU rate? What does 1 hr of OBS cover?

Defending the 1) uniqueness of the service, 2) physician ordered and 3) documented. Non-Routine of the service.

ROUTINE VS NON-ROUTINE SUPPLIES & ROUTINE NURSING

The Medicare Reimbursement Manual defines Routine Services in 2202.6 on page 22-7:

"Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

"In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. " (See § 2203.1 for further discussion of routine services in an SNF.)

Outpt Services – WOW!

Denied: Bundled into the primary service. C0 97 (Not all payers)
Denied: Service is not payable separately as another service has been adjudicated/paid.
Denied: Bundled as they are considered components of another procedure. M15 (From comparing UB to RA- line item)

- Wow! It is hard to believe the disallowing of charges that is occurring with Medicare Advantage, Commercial and Medicaid. DO COMPARISON OF TRADITONAL MEDICARE FOR LIKE SERVICES AND SEE THE DIFFERENCE IN ALLOWED. Then the contracted rate is applied – against the ALLOWED amt..no consideration for all the denied line items. OR **Is the site being paid the OPPS Medicare rate +?%**
- Let's look at some deadly recent examples from NC, TN, OR, WA….

- Chemo treatment. Billed 2 labs, Chemo injection code, Chemo drug.
  Total charges: $4042. Disallowed all lab, injection codes, HBC visit. C0 97
  Drug: $3215 billed/$194 allowed and Hospital based clinic G046325 $238 billed/ $110.
  Total billed: $4042 Amt allowed: $304.98 8% of billed charges United (CO 97)
  2nd Ex: Billed charges $30,339 Amt allowed: $7103 M15, CO 45 23% of billed Blue Cross MA

After reviewing the multiple examples of payer's doing line item denials – it is recommended to take a like procedure (EX: ER TO OBS) and do: Comparison with Traditional Medicare/APC and Comparison with all primary payers.

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Surgical procedures	Billed charges	Covred items	MA Covered Items	% of billed chrgs pd
1) Arthroscopy shoulder, debridement of 1 02 structures 29822	$5987	$2633	$2633	
Denied: 11042 Removal of devitalized tissue from the wound	$11,974	0	0	0
Denied: 36573 Insertion of a central venous cath	$3144	0	0	0
Denied all: Obs hrs/65, recovery, anethesia, all drugs, pulmonary function, all lab, all injection codes Blue Medicare Adv	Full charges on claim: $37,630	$2633/ 1 CPT code	$2633 **Was this paid under OPPS + %? Who has done this type of comparison analysis?	**7% of billed charges** ***Contract rate is? Once they identify Covered services. How are the line items being determined as not separately billable?**

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More Line item examples	Billed items	Covered Items Payer identifies the Primary Service/only line paid	% of billed charges
ER to obs **United MA**	$24,858	ER visit 99284 $1527/but payer had a higher allowable of $2236	
All obs hrs/72, 250 & 636 drugs, 73 hrs of IV infusion w/some hydration, 14 labs, 1 xray, 1 CT/351, 3 IM injections/940 U	ALL DENIED - C0 45 All services are included in the single payment for 99284 $23,331	$1527	**9% of billed charges**
OR outpt Carpel Tunnel Aetna MA	$11,377	Single CPT for Surgery 29848 $6197 Pd: $1059	
All J codes, 2nd procedure 20600XU, anesthesia and recovery	ALL DENIED-benefit not separate payable $10,318	$1059	**9% of billed charges**
Rt Cath procedure United Healthcare MA	$22,032	$15,754	
All obs hrs/17, all 250/drug, 636/drugs, lab, US/402, arteriography/323, C code implants, anesthesia, recovery.	ALL DENIED -C097 $52,522	$15,754	**30% of billed charges**
Cath w/Obs - BCBS comm All obs, additional cath procedure, C codes, all drugs, labs, no anesthesia or recovery 93460	$16, 738 Some J codes /636 were paid.	$6685 Used RA codes: 234= This procedure is not paid separately. M15: Separately billable have been bundled/part of another component N20: Not pd with other service	**40% of billed charges** ****What are they basing their 'rules' on as not Medicare?**

Chemo Therapy – Medicare Advantage Examples
Who determines the 'primary service/only line paid?

Payer	BilledChgs	AllowedAmt	Denied	Amt Paid	% of billed chg
Blue Adv HMO	$30,339	$7103 1 IV adm, 1 chemo inj, HBC visit Chemo Drug: C9399JZ $26,473 PD:	All other drugs, lab tests, IV solutions	$7103 C045: M15 $6486	23% including large contractual with Chemo drug
United MA	$4042	$304 HBC visit, J9395/drug	Chemo injection adm, all lab Denied. CO97 included in other payment	$304	9% pd of billed charges

ER to obs & outpt procedure- Medicare Advantage. Examples from mid-sized hospital 11-23 * Allowed PT & OT eval

Aetna	$9087 Inc 18 hrs of obs	$2225 ER 99285	All obs hrs, solutions, all lab, IV therapy, all injections	$2225	24% of billed charges
Blue Medicare	$34,050 Inc 47 hrs of obs	$2369 ER 99285, 1 PT, 1 OT **Why does this payer allow for 1 OT & PT evval?	All obs hrs, all solutions, IV therapy, EKG, Echo, MRI/brain and spinal cord, CT headscan, all lab 2 drugs- units exceeded our accepted max N362	$2369	C027, M15 6% of billed charges
United MA	$42,570 Inc 31 hrs of obs Tx room/33285/761 Insert Loop recorder	$7663 Covered single CPT, 1 PT, 1 OT **Why does this payer allow for 1 OT & PT evval?	All Labs, injection adm, drugs, solution, 2nd CPT C1764/loop recorder lingual system $15,700, all obs hrs, pulmonary tests, xray, CT head, and ER VISIT, all labs, non-routine supplies, EKG	$7663	18% of billed charges

Medicare Advantage Outlier Line Item Audit

Each line on the RA has a code –C097 or CO 45

Both result in $0 payment /disallowed. Thus, charges not included in the outlier total.

Payer	Billed Charges & Paid %	Disallowed Items - no other allowed items
Humana Medicare Adv	$370,141 26 day stay	ALL items on the RA had a code of CO 45 with a Zero payment
	Covered: 120 RC $4257. 3 days RA states: Pd $13,056 Negotiated rate. ONLY LINE PD DRGs do not usually have a Line item disallowed code C045 or 198 DRGs are paid according to the grouper payment, regardless of charges. Outliers meet a higher threshold. Do by disallowing all line items on the UB except the single line, the total charges eligible for outlier is only $13,056; not $370,141. Payment represents 4% paid of billed charges	CO 45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amt and must not duplicate provider adjustment amounts (payments & contractual adjustments that have resulted from prior payment adjudication. **How does this equal a $0 payment for many lines?
202238		Adj Reason Code: 198 Precertification/notification/authorization/pre-treatment exceeded. Assigned to RC 206/ 15 days R&B $46,230. All R&B

Medicare Advantage Outlier Line Item Audit

Each line on the RA has a code –C097 or CO 45

Both result in $0 payment /disallowed. Thus, charges not included in the outlier total.

Payer	Billed Charges & Paid %	Disallowed Items - no other allowed items
Humana Gold	$327,820 15 days	Allowed R&B $32,580of billed $55905 Rev Code 200
	Only R&B was considered for payment **Payment Represents 9% of billed charges**	Disallowed surgery codes, DOS 8-6 with CO 45. But 45 had a $0. Additional codes 216/N702= based on review findings, not pd. (No records requested) No payment for RT, pulmonary function, lab, inhalation therapy, tx room.
Does the Contract allow for line item review for inpts paid under DRG? By disallowing the charges, the account amt considered for payment is under the outlier threshold.		

What are some examples and challenges- NW

- **Critical Access Hospital or % of billed charges payment**
  - Did not request records
  - Identified by Revenue Code and as an outpt, CPT code/UB-04 only.
  - Auto denied as 'unbundled.'
  - EX) Surgery charged for unique supplies and implantable. Had to have an xay due to the provider's need to ensure it was placed correctly.
  - Payer auto denied all supplies and the xray as considered 'bundled' –included in the charge for the procedure or the pre min charge.
  - Traditional Medicare pays CAHs a % of charges/allowables for outpt. Many commercial & MA plans also do%. High risk for audits.
- **DRG hospital:**
  - Did not request records
  - Identified by Revenue code only as inpt ICU claim. No CPTs.
  - Requested itemized statement
  - (EX) Used Rev Code/RT and itemized statement to disallow all ventilator management charges. Only left the ICU R&B rate.
  - (EX) Bedside procedures that are unique to the pt are routinely disallowed as 'bundled.'
  - Focus – Charge outliers, high charge pts
  - Focus- Any outlier in the contract (Neonate, high costs/transplants, cancer treatment.) High risk for audits.

Super Big Challenge –Charges for unique care

- Bundling 'assumes' that all services are similar for all patients.
- Hospitals assign unique charges to align COST TO CHARGE.
- Separately billable services require an order, documentation to support separate unique to the pt item/service and charges to cover costs.
- IF the hospital simply states: we will no longer bill ___ separately, then ALL patients receive the SAME amount for the denied Surgery or the Ventilator for the ICU patient or any other 'identified bundling' that the payer is using…based on their own definition. (Think ER too)
- EX) ICU R&B rate. Historically $1500 per day with add on for unique services the pt needs. Now R&B rate is $2000 per day regardless of what unique services the individual pt needs. VERY WRONG! No cost to charge alignment.
- IT IS ALL ABOUT THE CONTRACT!! PREVENT thru OPERATIONAL ADDENDUMS- NOT AT THE BACKEND…

What to do with line item audits? Get prepared!

- Some payers are strictly using the itemized statement to disallow. *They have to request them as they are not submitted with 837/claims.
- **How pt friendly are the descriptors**?
- OR levels – have you developed an outline of what is covered in each level? Procedure level vs time – what is included, reducing price of multiple procedures. (Set up, clean up, routine supplies, all staff in attendance, sterilization, preference card items, 02)
- Nursing services – have you developed what is covered in R&B rate? ICU will be different than medical/surgical. (Medical: 8 hrs direct pt care, CN A, usage/equipment in the room, IV items, cleaning, adm meds.)
- NON ROUTINE: Separately ordered for the pt, specific to the patient, usually CPT, documented.
- Assume the payer 's team does not know what is included in ANY CPT code or how it is used.
- What is the payer's definition of routine, unbundling, etc? Need their policy ahead of time to review
- If requesting a full medical record,validate prior to sending. If records are sent, charge fee and get payment prior to sending. $150 ea
- OR OR OR – require all line- item audits be done onsite. Have a trained nurse /revenue cycle internal staff sit with the payer. Every line item is discussed, with the internal staff noting all variances.
- This internal control will ensure a) variances are known immediately, b) challenges are ready to be sent and c) anything need clarified?
- The departments need a way to relieve items, count for productivity = all done thru charging. Some routine items roll, but others are chargeable.
- **Be ready to discontinue contract. Where does it say this is allowed? Join with others.**

Challenging the payer's arbitrary decision to disallow a separate charge as unbundling from the primary charge.

- Key – Must challenge the 'routine/not separately billable ' item. The payers are stating that the item is part of the service/a routine part and not separately billable. It is not a medically necessary denial; it is an unbundling denial. How is that defined, payer specific? Commercials using Medicare guidelines??
- **Possible confusion with the "N" packaged indicator on CMS's Addendum B:**

  This is a billable service; just not separately payable by Medicare. Does not apply to Critical Access hospitals who are not paid by APC groupers.
- HOW CAN WE APPEAL:
  - Does sending records help? Are the below items present in the record? 1-3
  - **Golden rule: The item is separately billable as it was NON-ROUTINE. 3 step**
    - If there a unique service/item that was ordered for this unique patient? (1)
    - If there an order from the physician for the service? (2)
    - If there documentation that it was done? (3)
    - Who did the service? NOTE: RT doing ventilator care was disallowed.
    - What if nursing does the service plus an OBS hr, an inpt day, an ER level visit, and OR procedure charge? Must clearly outline what its ROUTINE that is included with the above items and why is unique to the pt-meeting the 3 elements above!

Payer Challenges: It's All About the Money!

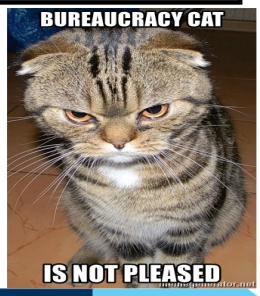
Health Insurance Companies are reporting record profits at the expense of providers.

Insurance	2017 revenue	2018 revenue	2019 revenue	2020 revenue	Revenue increase from 2017 to 2020	% Revenue Increase (2017 to 2020)	2017 net income	2018 net income	2019 net income	2020 net income	Net Income increase from 2017 to 2020	% Net Income Increase (2017 to 2020)
United Healthcare	$201.16 billion	$226.25 billion	$242.16 billion	$257.14 billion	$55.98 billion	27.83%	$10.56 billion	$11.99 billion	$13.84 billion	$15.40 billion	$4.84 billion	45.83%
Cigna	$41.81 billion	$48.65 billion	$153.57 billion	$160.40 billion	$118.59 billion	283.64%	$2.27 billion	$2.64 billion	$5.10 billion	$8.46 billion	$6.19 billion	272.69%
Anthem	$90.04 billion	$92.10 billion	$104.21 billion	$121.87 billion	$31.83 billion	35.35%	$3.84 billion	$3.75 billion	$4.81 billion	$4.57 billion	$0.73 billion	19.01%
Humana	$53.77 billion	$56.91 billion	$64.89 billion	$77.16 billion	$23.39 billion	43.50%	$2.45 billion	$1.68 billion	$2.71 billion	$3.37 billion	$920 million	37.55%
Centene	$48.38 billion	$60.12 billion	$74.64 billion	$111.12 billion	$62.74 billion	129.68%	$828 million	$900 million	$1.32 billion	$1.81 billion	$982 million	118.60%
Molina	$19.88 billion	$18.89 billion	$16.83 billion	$19.42 billion	$-0.46 billion	-2.31%	$-512 million (loss)	$707 million	$737 million	$673 million	$1.19 billion	231.45%

Average Claim Denial Rate for Large Hospitals

Geographic Region	Denial Rate
Northern Plains	10.58%
South Central	8.88%
Midwest	7.89%
Southern Plains	7.72%
Pacific	7.58%
Northeast	7.21%
Mountain	7.18%
Southeast	7.14%

Thanks, Chris Loftin, MS HFMA



BAPTIST

Get Better.

Payers continue to do what providers let them do. Dr Ron Hirsch, RAC Relief 7-23

WHAT CAN A PROVIDER DO WITH THIS BROAD RANGING DENIAL RULING – UNBUNDLING?

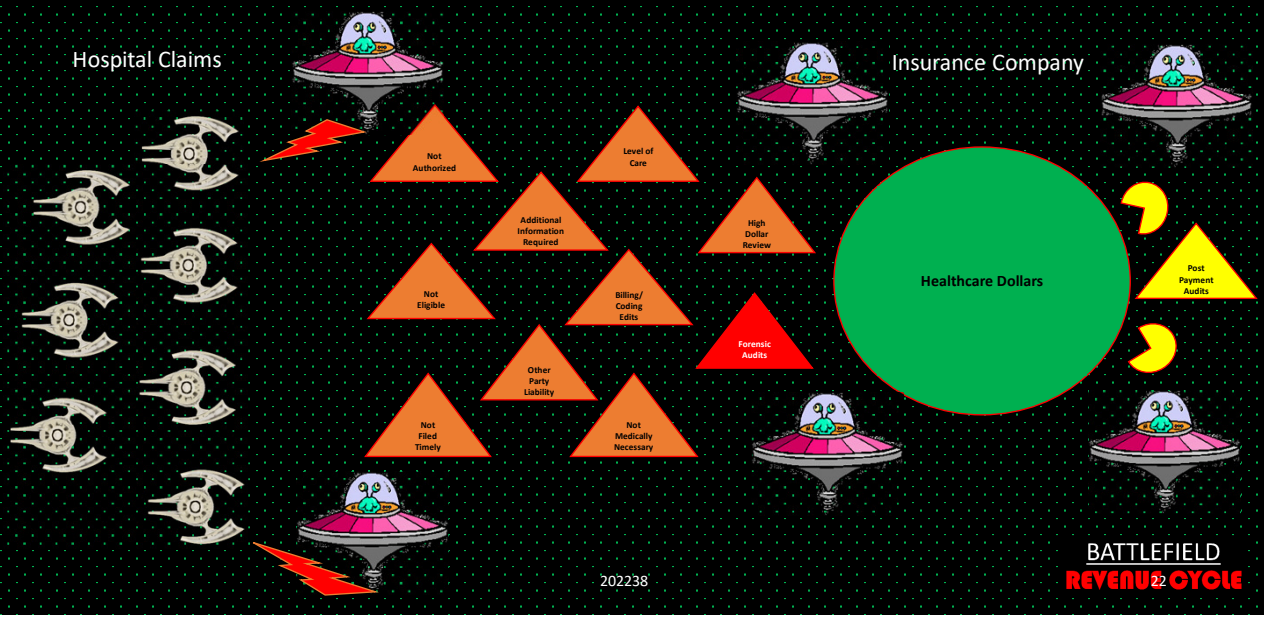
APPEAL FOCUS: Is there an order for this unique service, is it patient specific, is it documented as done and is there an accompanying charge to cover the unique cost… We are not appealing the 'medical necessity of the denial." Different type of denial that is all about the 'UNIQUENESS" of the charge that meet the 3 Step Test.

BATTLEFIELD
REVENUE CYCLE

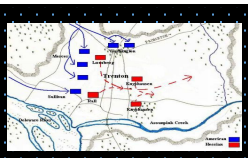
Strategies and Tactics to combat Forensic Audits

From a 16 hospital health system who has been living
With the forensic/line item audits for approx. 5 years.
In South East

The Revenue Cycle Battlefield



BATTLEFIELD
REVENUE CYCLE



Battlefield Analysis

Forensic Audits

Background

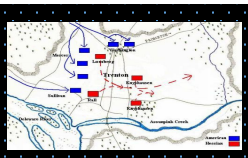
Insurance companies are using cost containment vendors to perform forensic audits (aka itemized bill reviews or line-item audits) prior to fully adjudicating claims for the sole purpose of reducing the hospital's outlier payment. In some cases the insurance company pays nothing up front while in other cases they pay the inlier payment but hold up on considering the outlier payment until the audit is finalized. We first encountered forensic audits over 5 years ago and they only involved Medicare Advantage Plans. Since that time we have seen most of the large commercial insurance companies, Medicare Advantage Plans, and Medicaid Managed Care plans adopting this cost containment tactic.

Charge-Based Cost Outlier Contracts versus Day Outlier Contracts

If your hospital or health system has charge-based cost outlier contracts, these type of audits should already be impacting your organization. If your hospital or health system has day outlier contracts, your organization should not see these type of audits.

Common Cost Containment Vendors

- CERiS
- Equian (owned by Optum/UHC)
- MedReview
- Humana has an internal team and does not outsource these audits
- Zelis



Battlefield Strategy

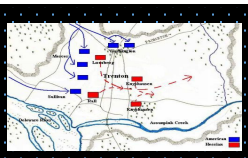
RAC Monitor Article

Fighting Spurious Forensic Audits

By: Amanda Gilliland, RN, BSN | March 7, 2019

https://racmonitor.medlearn.com/fighting-spurious-forensic-audits/

- Here is the scenario: an itemized bill is requested, but not medical records. They run the charges through their software, and voila! They identify many charges they find to be not reimbursable. They state that the charges are routine, not billable on an input claim, and unbundled, i.e. they should be included in the R&B charge or in an OR or procedure charge.
- The amount of time that an appeal can take is significant, especially since Equian demands to see documentation that the services in question were provided, although that is not the basis of their original denial.
- They try to justify these denials by quoting the Medicare Provider Reimbursement Manual, Sec. 2202.6, which very loosely defines inpatient routine services as "those services included by the provider in a daily service charge, sometimes referred to as the room and board charge…included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services ,(etc.) for which a separate charge is not customarily made."
- In appealing these denials, I have quite recently provided them with 2004 correspondence from Herb Kuhn, who was Director of the Center for Medicare Management, and a 2018 email from Rhonda Jones in the Dallas CMS office, both of which make it clear that Equian is misinterpreting the intent of 2202.6. I have not fully resolved any cases as yet. Also, I understand that the "clinical experts" Equian refers escalated issues to are not clinical at all.
  - Herb Kuhn: "PRM section 2202.4 provides that a provider's charges should be related consistently to the cost of the services and uniformly applied to all patients, inpatients or outpatients, and that these uniform charges are used in determining Medicare's payment on the Medicare cost report. PRM Section 2203 emphasizes that while Medicare does not dictate a provider's charge structure, it determines if the charges are appropriate for the cost report…Medicare does not dictate a provider's charge structure or how it itemizes charges but does determine whether charges are acceptable for Medicare purposes….we do not see an issue of a hospital's having a basic ancillary department charge for the room with additional charges for other items and services furnished to patients depending on the procedure, as long as the various charges are reasonably and consistently related to the cost of the services to which they apply and are uniformly applied (Sections 2202.4 and 2203). This applies to any ancillary department.
  - Rhonda Jones: "Providers are responsible for establishing their own charge structures and should bill third-party payers accordingly. CMS does not dictate what is included on a hospital's itemized statement. However, hospitals are required to follow appropriate uniform billing guidelines…hospitals can list services such as surgical instruments, surgery packs, and supplies separately on the itemized statement, but these items should be rolled up and reported under the appropriate revenue codes, according to billing guidelines."



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification

Unbundling

The Forensic Review evaluated this claim to determine whether it contained charges for supplies or services that appear to be either "routine," and/or are integral and necessary components of underlying daily service or procedure charges.

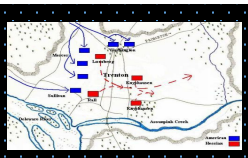
Section 2202.6 of the CMS Provider Reimbursement Manual ("PRM") directs facilities to include routine supplies and services within underlying daily room or procedure charges and specifies that such routine charges include "the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

PRM Section 2202.8 limits a facility's ability to separately charge for ancillary services and defines separately billable ancillary services as including "laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational)."

PRM Section 2203 requires that each facility create and maintain "an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services." Accordingly, this provision instructs that all facility bills shall comply with the above PRM provisions and that a facility's charges need to "reasonably and consistently" relate to the facility's underlying cost.

Resolution of Unbundling Questions – If you disagree with any of the Forensic Review Report's unbundling findings, please submit the explanations and/or documentation necessary to show that these charges are separately payable.

BATTLEFIELD REVENUE CYCLE



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification

The cost containment vendors attempt to use the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) language to justify their tactics.

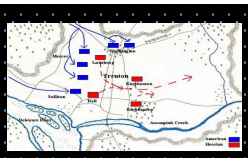
- ✓ The cost containment vendors claim that this section directs hospitals to include routine supplies and services within the underlying daily room or procedure charge. The language in this section simply states that a room and board or procedure charge is intended to encompass a variety of services but does not mandate anything.

2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

- ✓ The cost containment vendors claim that this section limits a hospital's ability to separately charge. The language in this section simply defines Ancillary Services and limits nothing. The part that the cost containment vendor chooses to exclude reads, "Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge."

2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)

BATTLEFIELD REVENUE CYCLE



Battlefield Analysis

Forensic Audits

Example of Cost Containment Vendor Justification

2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges described in §2314.B.

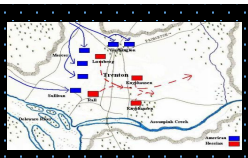
In determining reimbursement for the costs of routine services, providers do not use charges but use patient days for apportionment purposes in a skilled nursing facility (to the extent certified) or in a hospital (with separate computation for each separate care unit). Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.

The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in §2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement. A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge. Where there is no

common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program. Ancillary charges for items or services furnished Medicare beneficiaries, including those enumerated in §2202.8, are not recognized by the program if separate charges are not also recorded by the provider for all non-Medicare patients receiving these same items or services directly from the provider.

- ✓ First, your charge to cost ratio is not changing. Services were rendered and your cost has not changed. If you remove charges, the charge to cost ratio is going to go up and the payer will end up paying you more anyway.
- ✓ Second, Section 2203 simply states that providers need to have a charge structure that accurately allows for the determination of cost to the program and that Medicare is entitled to contest certain charges if they determine that they inflate costs to the program.
- ✓ Third, Section 2203 gives providers the latitude on creating and maintaining a charge structure as long as that charge structure is charged consistently to all patients. Bottom line, section 2203 does not give the Insurance Company or their cost containment vendor the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- ✓ Finally, Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The regulations governing for operating costs under the Inpatient Prospective Payment System (IPPS) are located at 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86. CMS publishes the outlier threshold in the annual IPPS Final Rule.

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits – Strategy 1

Consider working with the Insurance Company to modify your contract.

Some Insurance Companies are willing to work with you because they are good business partners and prefer not to lose valuable in-network hospitals or health systems. If this scenario applies, you may want to consider doing the following:

Tactic 1

Require the Insurance Company to add language to the contract that eliminates internal and external forensic audits

or

Tactic 2

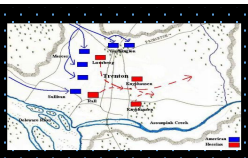
Require the Insurance Company to add language to the contract that limits the number of forensic audits

or

Tactic 3

Require the Insurance Company to reimburse your hospital/health system up-front to offset the potential financial impact of forensic audits

BATTLEFIELD REVENUE CYCLE



Battlefield Strategy

Forensic Audits – Strategy 2
"The Nuclear Option"

Consider terminating your contract with the Insurance Company.

Terminating your contract "The Nuclear Option" is a strategy to consider if forensic audits in conjunction with other audits is a significant financial issue for your hospital/health system. Some Insurance Companies may be willing to work with your hospital or health system if you even mention this option.

Special Note

If the Insurance Company is a Medicare Advantage plan, you may want to consider this option because out-of-network plans are required to reimburse your hospital/health system for Part A and Part B services provided to Medicare beneficiaries with an amount that is no less than the amount that would be paid under original Medicare. Non-contract providers are required to accept as payment, in full, the amount that the provider could collect if the beneficiary were enrolled in original Medicare.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf
https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/providerpaymentdisputeresolution
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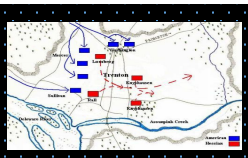


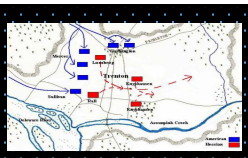
Battlefield Strategy

Forensic Audits – Strategy 3

Consider implementing proactive processes to prevent the audits.

Implementing proactive processes will require utilizing internal resources with expertise in determining how best to combine the applicable charges. For example: You may be currently billing saline under revenue code 258 and the auditor is indicating that you can not bill it separately. You may want to consider working with the Pharmacy in your facility to include the saline cost as part of the drug cost when the charge is routed to your financial management system.

- ✓ Identify the Insurance Companies conducting forensic audits;
- ✓ Pinpoint the charges they are routinely including in their audit findings; and
- ✓ Develop internal processes to combine the auditable charges.



Battlefield Strategy

Forensic Audits – Strategy 4

Consider developing letter templates and tactics to dispute the forensic audits

Although it is admirable to consider fighting forensic audits, you will most likely end up losing your disputes. After all, your fighting judgements already made by the same company. If you decide to fight, listed below are things to consider.

- ✓ Use language from your hospital's Provider Participation Agreement
- ✓ Use language from Medicare Law
  - Section 1886(d)(5)(A) of the Social Security Act provides for Medicare payment to Medicare participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs.
  - The Centers for Medicaid and Medicaid Services (CMS) Provider Reimbursement Manual (PRM) gives providers the latitude on creating and maintaining a charge structure as long as the charge structure is charged consistently to all patients. The PRM does not mandate or give the MA Plan the authority to dictate how a provider's Charge Description Master (CDM) should be maintained.
- ✓ Use language from the Medicare Managed Care Manual (if a Part C plan)
  - MA organizations are required to pay "Clean Claims" within 30 days of receipt;
  - Otherwise, the MA organization must pay interest on claims that are not paid in a timely manner.