J11 Part A
Provider Audit and Reimbursement Update
March 19, 2013
Scott Neely
Michelle Anderson
Agenda

• Operational Update
• Sequestration
• SSI Update
• Reimbursement Issues
• Miscellaneous Issues
• PSR Update
• OPS/E-Check
• Contacts
Operational Update
Operational Update

• Celerian Group
  Five companies serving the federal government

• Palmetto GBA
• InStil Health
• CGS Administrators
• PGBA
• TrailBlazer Health Enterprises
Operational Update

• Palmetto GBA
Operational Update - Audit and Reimbursement

- Sharon Roberts retired as Senior Director for Audit effective 2/1/13
- Mitch Williams retired as Senior Director for Reimbursement and Provider Enrollment effective 3/1/13
- Audit and Reimbursement now combined under single department
- Audit and Reimbursement Director – Scott Neely
- Provider Enrollment Director – Teresa Newton
Audit
• Columbia, SC
  – SC, NC, HHH
• Richmond, VA (NGS)
  – VA, WV, NC
• Springfield, IL
  – No longer J11
• Appeals
  – Columbia, SC

Reimbursement
• Columbia, SC (All states)
Sequestration Impacts
• Sequestration order signed into law 3/1/13
  – Medicare FFS claims with dates of service or dates of discharge on or after 4/1/13 will incur a 2% reduction in Medicare payment
  – Claims payment adjustment will be applied to all claims after determining coinsurance, deductibles and MSP adjustments
Sequestration

• No known Contractor impacts at this time
• No communication regarding any cost report implications
  – Likely Impacts: New PSR Sequestration Fields
    • Value code will be used to track amounts
    • Other adjustment field will be used on cost report
• No communication regarding impacts to rate setting, tentative settlement activities
SSI/DSH Update
SSI Update

- Settlements
  - Staggered settlements
    - Pre-2006 remain on hold
    - 2008
    - 2009
    - 2010 (most are in current year workplan) – No official CMS guidance
    - 2011+ will continue to be on hold
    - No new documentation
Settlements

- **2007 (2006) – South Carolina**
  - 31 Planned settlements
  - 30 Completed

- **2008 – South Carolina**
  - 39 Planned settlements
  - Complete by early June 2013

- **2009 – South Carolina**
  - 39 Planned settlements
  - Complete by early September 2013
SSI Update

• Reopenings
  • 29 FFY 2006 SC Reopenings completed
  • 10 FFY 2007 SC Reopenings completed
  • 1 FFY 2008 SC Reopening completed
    – Retractions required – 1 Unit

• Reimbursement
  – Latest published SSI percentages used in rate reviews, tentative settlement
    • CMS Published SSI percentages thru FFY 2010
DSH/Court Decisions

• Allina Health Services
  – Impact??

• Alegent Health – Immanuel Medical Center
  – Impact??

• No direct impact to SC providers
  – Reopening letters to be issued for settlements issued on or after 11/15/12
Future of DSH:

• Medicare DSH is to be reduced by 75% beginning in FFY 2014
• Each IPPS hospital receive a distribution from a pool based on its share of national “uncompensated care”
  – The “pool” is based on 75% of current spending less other reductions
  – S-10 likely source of “uncompensated care” data
DSH Payments and the ACA

• Accumulation of Medicare DSH listings will likely continue to be a requirement
  – Listings will remain subject to audit
• CMS has yet to provide Audit guidance related to the DSH calculation under the ACA
Reimbursement Update
Michelle Anderson
Hospital Readmissions Reduction Adjustment

- Effective for claims with dates of discharge on or after October 1, 2012.
- Table 15 for the FYE 2013 IPPS/LTCH PPS Final Rule
- Adjustments are made on a claim by claim basis.
- Sections of claim not affected are IME, DSH, Outlier, and Low-Volume Adjustments
Technical errors were noted in the calculations of the adjustment factors published for the FY 2013 IPPS/LTCH PPS final rule.

Table 15 was corrected and reposted March 8, 2013.

IPPS claims with a discharge date on or after October 1, 2012 received through March 18, 2013 for affected hospitals, will be reprocessed by May 31, 2013.
Value Based Purchasing Adjustment

- Effective for claims with dates of discharge on or after October 1, 2012.
- Adjustments are made on a claim by claim basis.
- Sections of claim not affected are IME, DSH, Outlier, and Low-Volume Adjustments
- Implemented January 1, 2013.
Value Based Purchasing Adjustment

- IPPS claims with discharge date October 1, 2012 and after that processed prior to implementation of the Value Based Purchasing adjustment will be reprocessed by May 31, 2013.
Medicare Inpatient Hospital Payment Adjustment for Low-Volume

- Extended with Section 605 of the American Taxpayer Relief Act of 2012.
- The amended criteria (less than 1,600 Medicare discharges and 15 miles or greater from the nearest IPPS Hospital) is now extended through September 30, 2013.
- To receive the low-volume hospital payment adjustment for FY 2013, a hospital must meet both the discharge and mileage criteria.
The hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other “subsection (d)” hospital.

– If received on or before March 22, 2013, this adjustment will be applied retroactively to claims with a discharge date on or after October 1, 2012. These claims will be adjusted by June 30, 2013.
Medicare Inpatient Hospital Payment Adjustment for Low-Volume

• Adjustments are made on a claim by claim basis.
• The adjustment is applied to the full DRG calculation including DSH, IME, Outlier, Hospital Readmissions Reduction, and Value-Based Purchasing adjustments.
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<tr>
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<th>SERVICES FOR PERIOD</th>
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<td>No Data Requested</td>
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<td>TOTAL COVERED CHARGES</td>
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<td>$210,379,191.00</td>
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**REIMBURSEMENT SECTION**

**OPERATING**

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<td>OUTLIER</td>
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<td>DSH/LIP</td>
<td>$6,284,453.62</td>
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<td>IME/TEACHING ADJ.</td>
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<td>TOTAL OPERATING PAYMENTS</td>
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<td>HOSPITAL READMISSION ADJ.</td>
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<td>VALUE BASED PURCHASING ADJ.</td>
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**CAPITAL**

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<td>INDIRECT MEDICAL EDUCATION</td>
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<td>EXCEPTIONS</td>
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<td>TOTAL CAPITAL PAYMENTS</td>
<td>$2,918,294.98</td>
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Rate Review

• Rate Reviews were completed twice a year, at eight months and twelve months.

• Rate Reviews will now be completed twice a year at approximately four and eight months.

• The Rate Review letter will include updates for the DSH Review.

• The yearend review will include a complete passthrough schedule.

Tentative Settlement

- Tentative Settlements are to continue to be completed within 60 days of the cost report being accepted.

- The Tentative Settlement letter will include updates for the Review of Cost to Charge Ratios.
Review Notification

• We will no longer be mailing underpayment and no money letters and their enclosures. These will be emailed to the contact on file.

• Overpayment letters will continue to be mailed certified; however we will also email these to the contact on file. This will allow the full 15 days notice of the overpayment.
• If you believe the contact email we have is incorrect or if multiple people should be contacted; send an email to Michelle.Anderson@PalmettoGBA.com with the contact information.

• Contact information for the Reimbursement Consultant assigned to your facility is available.
Miscellaneous

Wage Index status
EHR Audit status
Bad debts
L & D for DSH
GME - IME
Wage Index 2014

- Current status of wage index
  - Rebuttal period ended March 4, 2013
  - Rebuttal reviews currently in process
  - Rebuttal findings submitted to CMS by 4/10/13
  - Appeal period ends April 17 (rec’d by 4/17)
  - February 21 – CMS issued revised PUF
    - Will be further refined by CMS pending outcome of rebuttal process and Appeal process
  - Early May – CMS will re-release PUF
    - 6/3 deadline to submit final correction requests
EHR/EHR Audits

• CMS continues to work on their global scoping plan for HITECH reviews
• No audit plans released to date
• Loading of initial data will continue
• Payments
  – No tentative settlement
  – HITECH monies will not be offset with any non-HITECH related overpayments
  – Two sources of funding from CMS
Bad Debts

- No new information or updates from CMS regarding the topic of bad debts
- MAC contractors developed a bad debt “position paper” to CMS for consideration in refining/clarifying bad debt policy and resulting audit steps
  - No response from CMS at this time
L&D for DSH

Effective for Cost Reporting Periods beg. on or after Oct. 1, 2009

- Labor and delivery room days methodology for Medicare DSH calculation not used in apportionment
- Days included in DPP as inpatient days once the patient has been admitted
- If patient did not occupy a bed prior to routine census, day not included in determination of available beds

Effective for Cost Reporting Periods beg. On or after Oct. 1, 2012

- Labor and delivery room days methodology for Medicare DSH calculation not used in apportionment
- Days included in DPP as inpatient days once patient has been admitted
- Labor and delivery room days included in determination of available beds
Regulations at 42 CFR 412.105(b)(4) revised to removed Labor and Delivery Room days from excluded beds

- Labor and delivery room days included in count of available beds
- If patient not admitted, related day(s) not included in DSH or available beds
- If beds furnish service payable under IPPS, beds included in bed count. Includes:
  - Maternity suite
  - Ancillary labor and delivery room beds
- Medicare cost report will require a carve-out of outpatient labor and delivery room days
New Programs

• For hospitals training residents in new programs for the first time on or after Oct. 1, 2012, the FTE cap is based new Program growth after five years

• Prior FTE cap based on three years
In order to determine a hospital’s cap adjustment for a new program, the sum of products of three factors will be taken into account (limited to the number of accredited slots for each program)

1) The highest total number of FTE residents trained in any program year, during the fifth year of the first new program’s existence at all of the hospitals to which the residents in that program rotate;

2) The number of years residents are expected to complete the program, based on the minimum accredited length for each type of program;

3) The ratio of the number of FTE residents in the new program that trained at the hospital over the entire five-year period to the total number of FTE residents that trained at all hospitals over the entire five-year period
• The FTE resident cap will be applied beginning with the sixth academic year of the new program
  – This policy applies to both GME and IME FTE resident caps
• New program FTE residents will continue to be exempt from the rolling average and the cap on the interns and residents to beds ratio for the minimum accredited length for the specific type of residency training program
• The methodology used to calculate a new teaching hospital’s FTE cap adjustment for a new training program will take into account any residents rotating to more than one hospital during the five-year window
PSR Update
• PSR Negative Charge Issue
  – Issue started when FISS implemented CR 6712 around April 2010
  – CR 6712 implemented Medically Unlikely Edits (MUEs)
  – 51 MUE is an edit applied to claim lines that exceed a certain number of units
- FISS programming initially labeled the claim line charges as denied.
- The 51 MUE programming identified the claim line as non-covered and the charges were subtracted a second time from the claim line.

**Example:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Covered Charges</td>
<td>$500</td>
</tr>
<tr>
<td>Denied Charges</td>
<td>($500)</td>
</tr>
<tr>
<td>51MUE Non covered</td>
<td>($500)</td>
</tr>
<tr>
<td>Total Covered</td>
<td>($500) in some cases may be zero</td>
</tr>
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</table>
PSR Update

• FISS initially reported that 51 MUE affected only outpatient hospital claims with the following bill types:
  • 13X - outpatient hospital
  • 14X - outpatient hospital non-patient
  • 85X – outpatient CAH
• FISS fixed the problem on June 6, 2011 on a prospective basis
• TDL11363 required mass adjustments in July 2011 to fix claims on a retro basis for 13X, 14X and 85X
• The FISS mass adjustment utility didn’t work: it couldn’t adjust negative charges
PSR Update

• CMS issued instruction in early 2012 that addresses settlement of affected cost reports
  • Contractors should review any significant overpayments that may be due to the negative-charge issue and hold settlement
  • PS&R Negative charges should be changed to zero on as-filed cost reports to avoid a fatal error
  • BCBSA distributed PS&R reports showing negative charges for each provider in March 2012 to help determine materiality
• Hold impacted cost reports open until issue has been resolved
PSR Update

- FISS fixed all claims for TOBs 13X, 14X and 85X in January 2013
- FISS did **not** fix 12X (inpatient B) claims
- CMS may instruct MACs to mass adjust the 12X claims
- CMS Instruction has been drafted that will require settlement of all affected cost reports within 6 months. Instruction will be released very soon if MACs can successfully mass adjust 12X claims
Online Provider Services
Online Provider Services (OPS)

- A secure web-based self service tool for providers
  - Inquiry – claims status, eligibility, payments (history, pending)
  - Remittance Advice view/retrieval
- “Secure messaging”
  - Submission of inquiries via interactive form format
  - Submission/retrieval of documents and forms with PHI/PII
  - Real-time confirmation of inquiry receipt, tracking information and ongoing related statuses
  - Two-way communication for MR notices of review, record requests, review outcomes
Online Provider Services (OPS)

- Provider Audit and Reimbursement not currently one of the services offered through OPS
  - We are pursuing this option
NEW!!

• OPS eCheck
  – Automates multiple manual steps of check processing
    • Receipt/Deposit/Receivable processing
  – Reduces manual refunds for checks received close to the designated offset date for solicited overpayments
  – Provides immediate provider notification of payment
  – Reduces calls to the PCC and F&A
  – Payments can be made 24/7
  – Offers security against lost or stolen checks
  – Process time reductions – manual 17 days, eCheck 6 days
Make Your Payment ELECTRONICALLY!

You can now submit your payment or request an immediate offset electronically via Online Provider Services (OPS).

The E-check and E-Offset features are easily accessible from the Financial Tools Tab or the Message Inbox drop down menu.

Benefits of using E-Check and E-Offset electronically:

** Save $$ on postage expense and no more lengthy mail time

** Immediate confirmation of receipt by Palmetto GBA

** Assigned a document control number allowing you to check status of payment via OPS

** Electronically attach PDF file for related documentation

If you have not already registered for OPS and would like to take advantage of the benefits of these new features, just click on the Provider Services link at www.palmettoGBA.com/medicare. If you need additional assistance, call the Technology Support Center at 866-749-4301.
Contact Information
Contact Information

• Key Contact Information
  – Payment/remit/claims issues
    • Provider Contact Center (PCC)
    • PCC Number
      – (866) 830-3455
    • IVR Number
      – (877) 567-9249
Key Contact Information

- For filing of Cost Reports

  Courier Service
  Palmetto GBA
  Attn: Cost Report Acceptance (AG-330)
  2300 Springdale Drive, Building One
  Camden, SC 29020-1728

  U.S. Postal Service
  Palmetto GBA
  Attn: Cost Report Acceptance (AG-330)
  Post Office Box 100144
  Columbia, SC 29202-3144
Contact Information

• Key Contact Information
  – HITECH Payment Issues/Hospice Caps
    • Jim Peebles at jim.peebles@palmettogba.com or (803) 382-6118

  Courier Service
  Palmetto GBA
  Attn: Jim Peebles, Manager (AG-330)
  2300 Springdale Drive, Building One
  Camden, SC  29020-1728

  U.S. Postal Service
  Palmetto GBA
  Attn: Jim Peebles, Manager (AG-330)
  Post Office Box 100144
  Columbia, SC  29202-3144
• **Key Contact Information**
  – **Reimbursement Issues**
    • Michelle Anderson at michelle.anderson@palmettogba.com or (803) 382-6171
      
      **Courier Service**
      Palmetto GBA
      Attn: Michelle Anderson, Supervisor (AG-330)
      2300 Springdale Drive, Building One
      Camden, SC  29020-1728
      
      **U.S. Postal Service**
      Palmetto GBA
      Attn: Michelle Anderson, Supervisor (AG-330)
      Post Office Box 100144
      Columbia, SC  29202-3144
      
    • Alternate Contact: Jim Peebles, Manager
• Key Contact Information
  – Provider Audit
    • Issues relating to the cost report, desk reviews, audits, and settlements
      Palmetto GBA
      Provider Audit, AG-320
      Post Office Box 100144
      Columbia SC  29202-3144

      Contact:
      Scott Neely (or assigned manager)
      Manager, Provider Audit
      (803) 763-5526  (direct line)
      (803) 935-0248  (fax)
      Scott.Neely@palmettogba.com

  – Wage Index: Costreport.Wageindex@palmettogba.com
• **Key Contact Information**
  – Provider Audit
    • **Filing of Cost Report Appeals and Reopenings**
      Palmetto GBA
      Cost Report Appeals and Reopenings, AG-380
      Post Office Box 100144
      Columbia SC 29202-3144

      Contact:
      Cecile Huggins
      Supervisor, Provider Appeals and Reopenings
      (803) 382-6242 (direct line)
      (803) 935-0248 (fax)
      Cecile.Huggins@palmettogba.com
Contact Information for Cost Report Appeal and Reopening Requests

- Two email addresses have been created for the electronic submission of cost report appeals and cost report reopening requests:

  - Filing of Cost Report Appeals
    - CostReport.Appeals@palmettogba.com

  - Filing of Cost Report Reopenings
    - CostReport.Reopening@palmettogba.com
Contact Information

• PRRB appeals correspondence that providers send to the Blue Cross and Blue Shield Association should now be sent via e-mail to ImageNow_SGI@BCBSA.com
  – In the Subject line, reference the case number first, followed by the case name, followed by the nature of the correspondence
    • For example:
      Subject: PRRB Case No. 10-9999; ABC Hospital; Provider Preliminary Position Paper

• There is no need to send a paper copy