



US Payer News

**SPECIAL
POINTS OF
INTEREST:**

- Private payers are considering MS-DRGs.
- NPI numbers are mandatory since May 23rd for FFS Medicare providers.
- There is opportunity to comment on the Proposed 2009 Medicare updates to MPFS and OPFS.

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Medicare Severity DRG (MS-DRG) News

The original hospital inpatient Diagnostic - Related Group (DRG) system adopted in 1983, known as CMS-DRG, was never fully prospective because cases where patients developed complications after admission were assigned to a higher paying DRG. The Centers for Medicare and Medicaid Services (CMS) also made "outlier payments" for costly complications.

The original CMS-DRG system in-effect has penalized hospitals that have adopted successful patient-safety practices that reduce hospital-based infection rates; at the same time, Medicare has paid more to hospitals that incur higher costs due to infections and complications.

Beginning for discharges on or

after October 1, 2008, CMS will adopt the MS-DRGs in an effort to improve patient care and reduce unnecessary health care costs. The MS-DRGs will be tied to the severity of illness and complications documented upon admission. Medicare will no longer recognize additional costs incurred by hospitals due to certain hospital-acquired infec-

GIRS analyzes far reaching changes for clients.

tions or medical errors. Specifically, CMS will not pay more for the following complications: foreign objects retained after surgery, air embolism, blood incompatibility, stage III & IV pressure ulcers, falls and trauma, catheter-associated urinary tract

infection (UTI), vascular catheter-associated infection, surgical site infection or Mediastinitis after coronary artery bypass graft (CABG). CMS also proposed to exclude other conditions such as surgical-site infections following elective procedures including total knee replacement.

Medicare will require hospitals to report 27 quality-related measures to CMS in order to receive the full annual Medicare payment rate update. This may encourage private payers to do the same. The Blue Cross Blue Shield Association, CIGNA, Aetna, and UnitedHealth Group are all looking to adopt the MS—DRG system.

Source: www.cms.hhs.gov

National Provider Identifier (NPI) News for Medicare Fee-for-Service (FFS) Providers

The NPI is mandatory for all Health Insurance Portability and Accountability Act (HIPAA) standard transactions! Claims submitted with legacy numbers on or after May 23, 2008, are being rejected. On May 23, there were a number of rejections for claims with legacy numbers in the

secondary provider identifier field. If there is a secondary provider who does not furnish an NPI, the billing provider must attempt to obtain that NPI to enter it on the claim in the secondary provider field.

Providers can apply for an NPI online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

or call the NPI enumerator to request a paper application at (800) 465-3203. Getting an NPI is free - not having one can be expensive.

Source: Medicare contractors

CMS Instructs Carriers to Hold Claims Until July 15

Under existing law, Medicare must cut physician payments by 10.6 percent for services provided on or after July 1, 2008. This cut is very controversial and there has been tremendous pressure for Congress to legislate a change to this policy. Therefore, CMS instructed its Part B contractors to hold claims with dates of service of July 1 or later for at least 10 days. The main reason for this directive is to avoid having to process claims twice if the policy is reversed successfully after July 1, not to mention the burden

GIRS monitors payer trends to keep clients updated.

for providers to reconcile initial and final payment and patient coinsurance amounts.

CMS expects this delay will not impact providers because claims for services before July 1 still are being processed and because Medicare carriers cannot pay claims sooner than 14 days anyway.

When Congress adjourned for the July 4 recess, only the House had

passed a measure to address this payment cut. Please stay tuned to hear what will happen in the Senate after the recess. Also, President Bush may veto the bill if it contains a provision that this fix be paid for by taking money from Medicare Advantage Plans.

Source: Medicare contractors and cms.hhs.gov.

GIRS is aware that your customers are concerned about pending rate cuts and payment delays. GIRS helps you and your customers to stay current on these changes.

CMS Proposes 2009 MPFS Annual Update

CMS has published its proposed annual update to the Medicare Physician Fee schedule (MPFS). The proposed rule appears in the July 7, 2008, *Federal Register*. CMS will accept comments on the MPFS until August 29 and intends to publish its interim- final update on November 1, 2008 to be effective on January 1, 2009.

In addition to changes in relative weights for procedures performed by physicians and non-physician practitioners (NPPs), the MPFS

update includes changes in quality measures and reporting under the physician quality reporting initiative (PQRI); refinements to the Competitive Acquisition Program (CAP) for drugs; discussion of the ESRD-facility drug add-on payment; as well as various physician and NPP enrollment requirements.

The 2009 update announces an additional 5.4 percent across-the-board reduction to payments as required by the sustained growth rate (SGR) statute. This is in addition

to the 10.6 percent decrease that everyone hopes congress will reverse this week.

Source: *Federal Register* July 7, 2008. CMS-I403-P

GIRS can analyze the proposed rules to determine how your customers will be impacted by changes in payment rates and policy initiatives. GIRS can help you to submit comments to CMS if appropriate.

CMS Proposes 2009 Outpatient PPS Update

On July 3, CMS released via “public display” its proposed 2009 annual update to the outpatient PPS including all the addenda. CMS plans for the actual notice to appear in the FR on July 18, and CMS will accept comments until September 2, 2008,

This proposed rule updates the APC relative weights used for determining payment rates in the outpatient hos-

pital and Ambulatory Surgical Center (ASC) settings. This is the second year of a phased-4-year transition to using APC weights to determine ASC payment rates.

The update specifically addresses issues relating to calculation of payment for drugs and devices both bundled and separately paid under OPFS. There is an overall 3

percent increase in payment for inflation. As part of its quality improvement initiatives, CMS seeks comments on reporting requirements and considerations for conditions that could be preventable if physicians follow guidelines.

Source— CMS. CMS-I404-P at <https://www.cms.hhs.gov/center/hospital.asp>

GIRS also can help educate customers about pending changes.

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- Help providers appeal denials of coverage for your products

Dynamic Strategies for the Future

Important Notice: Do not print, distribute, edit, or duplicate. This newsletter is for the purpose of providing educational payer trends information for GIRS current and potential clients. It is not intended to increase reimbursement or provide a guarantee to anyone. Coverage and reimbursement are dynamic and change frequently. Every effort will be made to provide the most updated information. This information is current as of July 8, 2008.

Recovery Audit Contractor (RAC) Findings

CMS is using recovery audit contractors (RACs) to assure accurate payments. RACs get paid a contingency fee that is negotiated between CMS and the RAC. The pilot program which launched in five states in 2005, ended in March 2008. CMS has just started to implement the permanent, national RAC program, in stages. The first part of the rollout began in May 2008 and the RACs will be operational in all states by early 2009. The RACs have used their prior experience and the findings of OIG and GAO reports to help target their review efforts. The CMS 2007 RAC Status Document shows that RACs corrected \$371 million dollars of Medicare improper payments during FY 2007.

A large number of the improper pay-

ments identified were overpayments. Almost half of the overpayments were due to incorrect coding. Examples by provider type of top RAC identified services that were subjected to overpayment collections include the following:

Inpatient hospital: excisional debridement, inpatient rehabilitation facility (IRF) services after joint replacement surgery, heart failure and shock, surgical procedures in the wrong setting, respiratory system diagnosis with ventilator support, extensive operating room (OR) procedures unrelated to principal diagnosis, and DME items.

GIRS' multitalented team can help your customers document medical necessity and appeal denials of coverage.

Outpatient hospital: colonoscopy, speech language pathology services and infusion services.

Physician: pharmaceutical injectables, duplicate claims and vestibular function tests.

The pilot experiences with RACs also show that hospitals may be able to overturn RAC claims denials based on deemed lack of medical necessity.

An effective strategy to reduce RAC denials entails detailed documentation of the medical necessity of inpatient admissions, including services and the documentation of patient comorbidities and complications as described in the Medicare Policy Manuals.

Source: CMS RAC Status Document, FY 2007