

CMS Reimbursement Methodologies & Medicare

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MHA631
Health Insurance

Lecture 7



Objectives

- Understand CMS Payment Systems.
- Explore Non-physician Practitioners.
- Examine Medicare Program.

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Overview of CMS Reimbursement Systems

- Reimbursement was according to a **retrospective reasonable cost system**, which meant that hospitals reported actual charges for inpatient care to payers after discharge of the patient from the hospital.
- Payers then reimbursed hospitals 80 percent of allowed charges.
- Shortly after the passage of Medicare and Medicaid, Congress began investigating **prospective payment systems (PPS)**, which established predetermined rates based on patient category or the type of facility (with annual increases based on an inflation index and a geographic wage index).

CMS Payment Systems



Hospital Inpatient Prospective Payment System

- Before 1983, Medicare payments for hospital inpatient care were based on a **retrospective reasonable cost system**, which meant hospitals received 80 percent of reasonable charges.
- Since 1983, when the **inpatient prospective payment system (IPPS)** was implemented, Medicare has reimbursed hospitals for inpatient hospital services according to a predetermined rate for each discharge.

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Hospital Outpatient Prospective Payment System

- CMS implement an **outpatient prospective payment system (OPPS)** for hospital outpatient services provided to Medicare patients.
- All services are paid according to **ambulatory payment classifications (APCs)**, which group services according to similar clinical characteristics and in terms of resources required.
- A payment rate is established for each APC and, depending on services provided, hospitals may be paid for more than one APC for a patient encounter.

Hospital Outpatient Prospective Payment System

- An **outpatient encounter** (or **outpatient visit**) includes all outpatient procedures and services (e.g., same-day surgery, x-rays, laboratory tests, and so on) provided during one day to the same patient.
- Thus, a patient who undergoes multiple outpatient procedures and receives multiple services on the same day will be assigned to one or more outpatient groups (called APCs).

Medicare Physician Fee Schedule

- **Medicare physician fee schedule (MPFS)**, reimburses providers according to predetermined rates assigned to services and is revised by CMS each year.
- All services are standardized to measure the value of a service as compared with other services provided. These standards, called **relative value units (RVUs)**.

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Medicare Physician Fee Schedule

- **Relative value units (RVUs)**, are payment components consisting of:
 - Physician work, which reflects the physician's time and intensity in providing the service (e.g., judgment, technical skill, and physical effort).
 - Practice expense, which reflects overhead costs involved in providing a service (e.g., rent, utilities, equipment, and staff salaries).
 - Malpractice expense, which reflects malpractice expenses (e.g., costs of liability insurance).

Nonphysician Practitioners

Nonphysician Practitioners

- Medicare reimburses professional services provided by nonphysician practitioners, including:
 1. Nurse practitioners
 2. Clinical nurse specialists
 3. Physician assistants

Nonphysician Practitioners

- The types of services nonphysician practitioners provide include those traditionally reserved to physicians, such as physical examination, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve independent evaluation or treatment of the patient's condition.

Nonphysician Practitioners

- Also, if authorized under the scope of their state licenses, nonphysician practitioners may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

Nurse Practitioner

- A **nurse practitioner (NP)** is a registered nurse licensed to practice as an NP in the state in which services are furnished, is certified by a national association (e.g., American Academy of Nurse Practitioners), and has a master's degree in nursing.
- NPs often work as primary care providers along with physicians.

Clinical Nurse Specialist (CNS)

- A **clinical nurse specialist (CNS)** is a registered nurse licensed by the state in which services are provided, has a master's degree in a defined clinical area of nursing from an accredited educational institution, and is certified as a CNS by the American Nurses Credentialing Center.

Physician Assistant

- A **physician assistant (PA)** must be legally authorized and licensed by the state to furnish services, have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

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Chargemaster

- The **chargemaster** (or **charge description master, CDM**) is a document that contains a computer-generated list of procedures, services, and supplies with charges for each. The chargemaster allows the facility to accurately and efficiently bill the payer for services rendered.



Chargemaster

- When submitted directly to the payer, the claim is processed to authorize reimbursement to the facility.
- When submitted to a clearinghouse, electronic claims are edited and validated to ensure that they are error-free, reformatted to the specifications of the payer, and submitted electronically to the appropriate payer for further processing to generate reimbursement to the facility.

Medicare

Medicare

- **Medicare**, the largest single medical benefits program in the United States, is a federal program authorized by Congress and administered by the Centers for Medicare and Medicaid Services (CMS).
- **CMS** is responsible for the operation of the Medicare program and for selecting Medicare administrative contractors (MACs) to process Medicare fee-for-service.

Medicare

- Medicare is a two-part program:
- ● Medicare Part A reimburses institutional providers for inpatient, hospice, and some home health services.
- ● Medicare Part B reimburses institutional providers for outpatient services and physicians for inpatient and office services.

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Medicare Eligibility

- **General Medicare eligibility requires:**

1. Individuals or their spouses to have worked at least 10 years in Medicare-covered employment.
 2. Individuals to be the minimum of 65 years old.
 3. Individuals to be citizens or permanent residents of the United States.
- Individuals can also qualify for coverage if they are younger than 65 and have a disability or End-Stage Renal Disease.

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Employer and Union Health Plans

- Some employer and union health insurance policies provide coverage for individuals who reach age 65 and who retire.
- Medicare has special rules that apply to beneficiaries who have group health plan coverage through their own or their spouse's current employment.
- Group health plans of employers with 20 or more employees must offer the same health insurance benefits under the same conditions that younger workers and spouses receive.

Participating Providers

- Medicare has established a **participating provider (PAR)** agreement in which the provider contracts to accept assignment on all claims submitted to Medicare.
- By 2000, more than 85 percent of all physicians, practitioners, and suppliers in the United States were PARs.

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Nonparticipating Providers

- Medicare **nonparticipating providers (nonPARs)** may elect to accept assignment on a claim-by-claim basis.
- Nonparticipating physicians who do not accept assignment on Medicare claims are subject to a limit (established by federal law) on what can be charged to beneficiaries for covered services.
- The **limiting charge** is the maximum fee a nonPAR may charge for a covered service. It applies regardless of who is responsible for payment and whether Medicare is primary or secondary.

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Surgical Disclosure Notice

- Providers must notify beneficiaries in writing of projected out-of-pocket expenses for elective surgery and noncovered procedures.
- For Medicare purposes, **elective surgery** is defined as a surgery that:
 - Can be scheduled in advance;
 - Is not an emergency; and
 - If delayed, would not result in death or permanent impairment of health.

Surgical Disclosure Notice

- If the nonPAR fails to properly notify the beneficiary prior to performing surgery, any money collected from the beneficiary that exceeds the Medicare-approved amount must be *refunded*.
- Failure to make the appropriate refund could result in civil monetary penalties and/or exclusion from the Medicare program.

Advance Beneficiary Notice

- An **advance beneficiary notice (ABN)** is a written document provided to a Medicare beneficiary by a supplier, physician, or provider prior to service being rendered.
- The ABN indicates that the service is unlikely to be reimbursed by Medicare, specifies why Medicare denial is anticipated, and requests the beneficiary to sign an agreement that guarantees personal payment for services.

Advance Beneficiary Notice

- A beneficiary who signs an ABN agreement will be held responsible for payment of the bill if Medicare denies payment.
- ABNs should be generated whenever the supplier or provider believes that a claim for the services is likely to receive a Medicare **medical necessity denial** (a denial of otherwise covered services that were found to be not “reasonable and necessary”).

Advance Beneficiary Notice

BILLING TIP:

The purpose of obtaining the ABN is to ensure payment for a procedure or service that might not be reimbursed under Medicare.

- **Do not** have a patient sign an ABN when a service is never covered by Medicare. Instead, have those patients sign a different form, called the **Notice of Exclusion of Medicare Benefits (NEMB)**.
- The ABN is used when the service is sometimes covered by Medicare, but the provider does not think it will be covered for that patient. It communicates that the patient will be responsible for provider charges if Medicare denies the service.

Notice of Exclusion of Medicare Benefits

- The **NEMB** clearly states that the service is never covered by Medicare, and that the patient is responsible for paying provider charges.
- Unlike the ABN, providers are not required to have patients sign an NEMB for a never-covered Medicare service in order to bill the patient; however, use of the form makes it clear to the patient before a service is provided that the patient will have to pay for it.

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ABN & NEMB

Feature	Advance Beneficiary Notice (ABN)	Notice of Exclusion of Medicare Benefits (NEMB)
Purpose	For services that may sometimes be covered but are likely to be denied for this specific patient	For services that are never covered by Medicare under any circumstances
Patient Responsibility	Pays only if Medicare denies the claim	Always pays 100% of charges
Signature Requirement	Mandatory- Patient must sign to be billed	Optional - Recommended but not legally required
When Used	When provider anticipates denial	When service is completely excluded
Medicare Role	Medicare may pay for similar services for other patients	Medicare never pays for this service category

Key Takeaways

1. CMS Payment Systems:

- Inpatient Prospective Payment System (IPPS)
- Outpatient Prospective Payment System (OPPS)
- Medicare Physician Fee Schedule (MPFS)

Key Takeaways

2. Nonphysician Practitioners, including:

- Nurse practitioners
- Clinical nurse specialists
- Physician assistants

3. Medicare, the largest single medical benefits program in the United States, authorized by Congress and administered by the Centers for Medicare and Medicaid Services (CMS).

Key Takeaways

4. General Medicare eligibility criteria.
5. Employer and Union Health Plans, Participating Providers, Nonparticipating Providers, Surgical Disclosure Notice, Advance Beneficiary Notice (ABN), Notice of Exclusion of Medicare Benefits (NEMB).



Thank You