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Update on Medicare and Medicaid Payment Issues

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July 1, 2010

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Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

The DRG Window Becomes a DRG Wall

By: Paul W. Kim

The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 was enacted on June 25, 2010. One of the key provisions of this new law revised the three-day payment policy or the so-called "DRG window." Prior to June 25, 2010, a hospital (or an entity wholly owned or operated by the hospital) had to bundle into the DRG payment all outpatient therapeutic services rendered during the three days prior to and on the day of an inpatient admission if all five digits of a beneficiary's diagnosis codes entered by the outpatient department and the inpatient hospital matched. Effective June 25, 2010, all outpatient therapeutic services provided during the DRG window are presumed to be related to the inpatient admission and charges for the therapeutic services must be bundled into the DRG payment even if all five digits of the diagnosis codes do not match, unless the hospital can demonstrate that such services were not related pursuant to a process to be determined by CMS. Furthermore, the new law prohibits the re-opening of inpatient claims with dates of services prior to June 25, 2010, in order to separately bill for outpatient therapeutic services under the previous DRG window policy. The new law does not affect outpatient diagnostic services furnished during the DRG window, which remain required to be bundled into the DRG payment regardless of the coding match.

Ober|Kaler's Comments

Interestingly, one of the reasons for this change asserted by Congress and CMS is that hospitals for years have been bundling all outpatient therapeutic services into the DRG payment, regardless of the coding match, perhaps conservatively and unnecessarily.

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CMS Posts Proposed Physician Fee Schedule Rule

CMS issued its proposed rule [PDF] for Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, on June 25, 2010.

The proposed rule:

- addresses changes to the physician fee schedule and other Medicare Part B payment policies,
- implements and discusses certain provisions of both the Affordable Care Act and the Medicare Improvements for Patients and Providers Act of 2008,
- discusses payments under the ambulance fee schedule and clinical laboratory fee schedule, payments to ESRD facilities and payment for Part B drugs, and
- discusses the Chiropractic Services Demonstration Project, the Competitive Bidding Program for Durable Medical Equipment, and provider and supplier enrolment issues associated with air ambulances.

Comments are due August 24, 2010. Future publications of Payment Matters will discuss certain selected provisions of the proposed rule.

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CMS Updates Its RAC Data

By: Leslie Demaree Goldsmith

CMS recently published an update [PDF] to its evaluation of the three-year Recover Audit Contractor (RAC) Demonstration Project, which ended in March of 2008. The project was established by Congress in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The jurisdictions chosen for the project initially were California, Florida and New York, because these states had the largest Medicare utilization. The project was expanded to include Arizona, South Carolina and Massachusetts. CMS awarded the RAC contracts to PRG-Schultz, HealthDataInsights and Connolly Consulting.

CMS's recently released report provides updated and corrected data for the demonstration project. The data reflects that providers appealed 12.7% of the RACs' 598,238 overpayment determinations. Significantly, 64.4% of all appealed claims were won by providers.

Ober|Kaler's Comments

With such a high success rate for appeals, providers with RAC overpayment determinations in the future should seriously consider pursuing appeals. Although not part of the report, many providers have reported that they have found their highest success rates at the Administrative Law Judge stage, so providers that appeal should not expect quick reversals of disallowances at the earlier redetermination or reconsideration stages.