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Trends in Medicare Reimbursement

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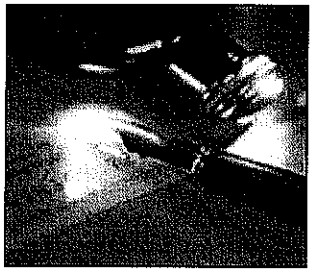
by Daniel B. Brown

Establishing a working relationship with your CMS carrier is key to Medicare billing satisfaction.



Medicare reimbursement continues to be a key financial part of any sleep laboratory's operation. According to the Cahaba Government Benefit Administrators (the Medicare Part B Carrier for the state of Georgia), sleep tests billed under CPT Code 95811 in the state, increased over the past 4 years 133% from 2,341 to 5,465 claims In dollars, that translates to approximately $12,107,200 spent by Medicare on CPT Code 95811 sleep tests in Georgia alone during the period between 2000 and 2003 (based on the flat national factor without geographic variance). Given the aging population and increasing awareness of sleep apnea, there is no reason to believe that the number of Medicare tests will decrease in the short term.

Benefits—Reimbursement is Up

The good news following passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) last December is that reimbursement for sleep testing is up. According to an analysis performed this year by the American Academy of Neurology (AAN), Medicare's global reimbursement for CPT Code 95811 increased 5 5% between this year and last. This follows a 69.7% rise in sleep test reimbursement in the 5 years from 1998 to 2003. Based on the flat national factor, and without regard to geography and local costs, the study shows that global reimbursement for the sleep test reached an all-time high of $852.41 this year. In early August of this year, CMS published the proposed reimbursement rate for 2005. Global reimbursement for the CPT 95811 test is to rise 6.3% to $906.95 (based again on the flat national factor).

Reimbursement for the technical component drove this robust gain. Since 1998, reimbursement for the technical component jumped almost $400 per test from $261.23 to $657.51; however, the AAN study shows a long-term decline in reimbursement for the professional component. During the same 6-year period, general Medicare reimbursement for the professional component slid from $229.48 to $194.90 per test.

Geography does make a difference. For example, global reimbursement for the test in Atlanta brings about $892.83. In Nebraska, the same test brings only about $755.35 on a global basis.

Billing, Fraud, and abuse Compliance

The flip side of reimbursement is the strict compliance required to obtain it. In its role as payor, our government will ensure that all tests are medically necessary and properly documented Potential criminal and civil liability exists for making false Medicare claims or for illegally referring patients for services reimbursed by government health care programs.

The Billing Burden

Criminal and civil fines aside, the most frequent penalty—and the biggest headache—with government payors is just not getting paid Billing the test correctly is the key to continued payments. Sleep centers should be on good terms with the Part B Medicare Carrier in the region. It can assist you in tricky classification matters, such as whether you should bill as part of a physician's practice or as an

independent diagnostic testing facility.

All of the billing rules are published in the CMS Carrier Manuals, available on the Internet at www.cms.gov. CMS recently adopted a few new billing requirements affecting sleep tests. The first applies if a laboratory purchases the test or purchases the interpretation from an unaffiliated physician. The second item offers sleep laboratories a more expansive way to work with sleep physicians in the community. The third deals with payment on electronic claims under HIPAA's Transaction Code Set regulation.

Global Bills

Payments requested on a global bill will be denied if any services are purchased. Effective April 1, 2004, Medicare carriers will deny payment submitted on global bills if one component of the test (either technical or professional) is purchased. The rationale is to retain proper pricing of the service in the carrier jurisdiction where the service is performed. In other words, the cost of a service under the Physician Fee Schedule is different depending on where the service is provided. The carriers want to know where the actual service was provided so the proper carrier can determine and pay the correct price.

Under the new rule, set forth in the CMS Claims Processing Manual (CMS Online Manual System, Pub 100-04), Chapter 1.1.1.2, global billing will not be accepted for purchased services on either electronic or paper forms. These claims will be treated as "unprocessable" under Section 80.3.2 of the manual.

However, the laboratory may still bill for both technical and professional, as long as the technical and professional components of the service are submitted on separate lines of the claim or on separate claims altogether. To show a purchased service, Item 20 on the CMS 1500 form must be marked "yes" and one, but only one, address must appear in Item 32, "Address of Service Provider." The laboratory must bill the technical component to the carrier with jurisdiction over the location of the laboratory, which must bill the professional component to the carrier with jurisdiction over the reading professional.

It used to be that if a sleep laboratory performed the technical component of the test in one place (for example, South Carolina—Palmetto Carrier), but purchased the interpretation from a physician in Georgia, which is a separate carrier jurisdiction (Cahaba Carrier), then the laboratory had to split the bill—the laboratory to Palmetto for the technical component, and the physician to Cahaba for the professional component. Under the new rule, the laboratory may bill for both, but under different carriers depending on the geography involved. In this example, the laboratory will bill Palmetto for the technical component and bill the professional component with Cahaba, which is the carrier the Georgia physician would bill if he or she billed the interpretation separately. This means that the South Carolina laboratory would have to enroll separately with the Georgia (Cahaba) Medicare carrier just to bill the professional component. This change only affects laboratories that purchase the professional or the technical component of the test.

Medicare Reassignment

On February 27, 2004, CMS issued Transmittal 111 amending Section 30.2 of the Medicare Claims Processing Manual relating to the Reassignment Rule (formerly Section 3060 of the Medicare Carriers Manual) (http://www.cms.hhs.gov/manuals/pm_trans/R111CP.pdf).

Before the amendment, Medicare's complex reassignment rules prohibited a sleep laboratory from

paying Medicare funds to an independent contractor physician to read the laboratory's sleep tests unless the physician reads the test on the premises of the laboratory. The rule applied only to independent contractors. Employed physicians could read on the premises, and laboratories could always purchase the interpretation from a qualified physician; however, employed physicians are expensive, and the purchased interpretation rules restrict the laboratory's acquisition of the interpretation if the physician referred the patient to the laboratory for the sleep test.

Congress recognized that the "premises" rule served no beneficial purpose, so it deleted the "on-the-premises" requirement as part of the MMA last December. So, for services performed after December 8, 2003, independently contracting physicians may reassign their Medicare payments directly to the sleep laboratory. Sleep laboratories may bill the test globally and pay the physician for his or her professional services, even if the doctor interprets the test off the site of the sleep laboratory.

Payment on Electronic Bills under HIPAA

Last year, the health care industry braced for a complete transition to the electronic age. Originally, CMS required that all health care providers and suppliers who submit claims to Medicare would have to do so electronically by October 16, 2003, and then only in standard transaction code sets identified by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The task proved too big to complete by the October 16 deadline. On September 23, 2003, CMS announced that it would implement a contingency plan for interim acceptance of noncompliant claims. Then, on February 27, 2004, CMS issued its Change Request Transmittal #114 to modify the contingency plan.

The good news is that CMS will still accept electronic payment claims after July 1, 2004, even if they are submitted in nonstandard formats. The bad news is that Medicare will pay noncompliant electronic claims at the same speed it pays paper claims. In other words, Medicare will pay electronic claims that are not HIPAA-compliant about 13 days later than it would pay if the claim were compliant.

It is expected that commercial insurance companies will adopt these HIPAA requirements for electronic submission in standard code sets. For this reason, all sleep doctors and sleep laboratories should adopt electronic submission of bills in CPT/ICD-9 formats and other applicable HIPAA-compliant electronic formats. If you need assistance on how you can submit HIPAA-compliant claims, you can contact CMS' Electronic Data Interchange (EDI) department toll-free at (866) 582-3253, or log onto the CMS Web site at http://www. cms hhs gov/hipaa/hipaa2/ default.asp

Accreditation as a Condition to Payment

Regional Medicare carriers have the opportunity to "localize" coverage of Medicare benefits such as sleep studies. Carriers publish these coverage rules in Local Coverage Determinations (formerly Local Medical Review Policies [LMRPs]) available on the carriers' Web sites.

As discussed in the March/April issue of Sleep Review, a recent LMRP issued by Arkansas Medicare Services of Arkansas Blue Cross and Blue Shield (AMS), Little Rock, is the first to require, as a condition of Medicare coverage, that a sleep laboratory (i) be accredited by the AASM, and (ii) have on staff a Diplomate of the American Board of Sleep Medicine (ABSM), or an individual who is currently accepted by the ABSM to sit for its certification examination.

This LMRP, applicable to sleep studies in Arkansas, Oklahoma, New Mexico, eastern Missouri, and Louisiana, caused an immediate stir during the applicable comment period. As a consequence, AMS has agreed to postpone implementation of the certification/accreditation requirements until it can

establish an appropriate compliance time frame.

The Future

The MMA enacted last December promises significant changes in the way CMS contracts with carriers to administer. For example, under current law, only insurance companies can act as administrative carriers for Medicare Part B, under which sleep laboratories are reimbursed. Beginning October 2005, the Secretary will be authorized to select any entity to provide carrier services on a competitive basis according to Federal Acquisition Regulations.

These new carriers, to be called "Medicare Administrative Contractors," will be charged not only with making payments and determining payment amounts, but also with providing education to providers. Most refreshing for providers, the law allows for financial incentives for contractors to improve their performance, and requires contractors to meet performance standards, including physician satisfaction measures.

In the meantime, get to know your carrier. Establishing a working relationship is the key to Medicare billing satisfaction.

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