Hospital Billing
From A to Z
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Hospital billing departments are known by various names, but their staff all experience the same problems understanding and complying with Medicare’s many billing requirements.

Hospital Billing From A to Z is a comprehensive, user-friendly guide to hospital billing requirements, with particular emphasis on Medicare. This valuable resource will help hospital billers understand how compliance, external audits, and cost-cutting initiatives affect the billing process.

Beginning with Advance Beneficiary Notice and ending with Zone Program Integrity Contractors, this book addresses nearly 90 topics, including the following:

- 2-Midnight Rule and Inpatient Admission Criteria
- Correct Coding Initiative
- CPT®, HCPCS, Condition Codes, Occurrence Codes, Occurrence Span Codes, Revenue Codes, and Value Codes
- Critical Access Hospitals
- Deductibles, Copayments, and Coinsurance
- Denials, Appeals, and Reconsideration Requirements
- Dialysis and DME Billing in Hospitals
- Hospital-Issued Notice of Noncoverage
- Laboratorv Billing and Fee Schedule
- Local and National Coverage Determinations
- Medically Unlikely Edits and Outpatient Code Editor
- Medicare Advantage Plans
- Medicare Beneficiary Numbers and National Provider Identifier
- Medicare Part A and Part B
- No-Pay Claims
- Observation Services
- Outlier Payments
- Present on Admission
- Rejected and Returned Claims
- UB-04 Form Definitions

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Charlotte L. Kohler, lead author, is the president of Kohler HealthCare Consulting, Inc. She has more than 30 years of healthcare experience.

Kohler’s major clients include large academic centers, multisystem hospitals, insurance companies, medical practices, radiology providers, infusion/chemotherapy providers, psychiatric providers and hospitals, durable medical equipment suppliers, wound care providers, lithotripsy providers, oncology and radiation therapy supporting coding services, and compliance and litigation organizations. In the areas of consulting and litigation support, she specializes in compliance and regulatory issues, valuations, and outpatient and professional services reimbursement.

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Catherine Clark, a vice president of Kohler HealthCare Consulting, has worked in the healthcare industry since 1994. She has worked in all facets of the revenue cycle, with specific emphasis in charge description master process improvements, patient accounting, and rates and reimbursement. She has served as chairman of the board of directors and is a past president of the Maryland chapter of the American Association of Healthcare Administrative Management. Her recent healthcare work has focused on project management of electronic health record installations and integration and ICD-10 project management.

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Introduction

The chief responsibilities of hospital billers include managing and ensuring the accuracy of hospital bills being submitted to Medicare. Numerous regulations, standards, and guidelines govern this function, and hospital billers are expected to maintain up-to-date knowledge of these requirements. Much of this knowledge is acquired by on-the-job training, working through issues, and looking for resources to support the tasks.

This book is a high-level reference guide designed to help hospital billing professionals meet these Medicare billing requirements. Its approach is topical to help readers find the answers to their questions quickly. The 88 chapters are brief, address only one topic each, and are arranged alphabetically. References at the end of chapters provide URLs to Medicare rules and regulations; citations are included to assist in quickly locating the source of the rule, regulation, or guidance.

Submitting inaccurate bills to Medicare carries many potential consequences. These consequences can be long-term or short-term, and can affect patients, hospitals, and hospital employees responsible for Medicare billing. The federal government is systematically reviewing claims submitted to its payers to verify that any payments made are only for services that are necessary and appropriate, and that they are accurately billed.

For example, the U.S. Department of Health and Human Services Office of Inspector General has been performing compliance audits in which a team of auditors evaluates the accuracy of billing and the supporting documentation. Audited hospitals receive feedback on each claim reviewed, and a demand is made for any amount overbilled. These reviews are broad-reaching and include both technical billing compliance reviews and the appropriateness of the care and the setting in which that care was provided. Thus, it is critical that hospital billing staff have a solid understanding of the range of issues affecting claims accuracy.

This book will help hospital billing staff understand the variety of requirements that can affect the accuracy of hospital bills to Medicare. It also provides information that can help mitigate government audits and repayments.
2-Midnight Rule: Inpatient Admission Criteria

On August 19, 2013, the Centers for Medicare & Medicaid Services (CMS) issued final regulations on inpatient admissions criteria as part of the Inpatient Prospective Payment System (IPPS) 2014 regulations. The 2-midnight rule was part of these regulations and took effect October 1, 2013.

The 2-midnight rule is a condition of payment, not a condition of participation, and it includes specific requirements relating to observation services and inpatient admissions. The rule's basic premise is that when hospital stays are two midnights or longer, the inpatient portion may be deemed a qualified admission, even if the first day (midnight) was spent in observation status. Hospital stays of shorter duration should be deemed outpatient or observation.

For inpatient admissions, the order for admission needs to state clearly the intent to admit to inpatient status, such as “admit to inpatient,” rather than “admit to Tower 5” or admit to ICU.” There must also be an expectation, written or inferred, of at least a two-midnight stay.

The certification provision includes the order, but it must also:

1. Include physician certification that services are provided in accordance with 42 CFR 412.3
2. Include the reasons for either the hospitalization for inpatient medical treatment or medically required inpatient diagnostic study
3. Describe special or unusual services for cost outlier cases

Although no special certification document is required, the above documentation needs to be present in the patient’s medical record prior to discharge. Recertification needs to be completed as of the 12th day of inpatient services and no less frequently than every 30 days thereafter.

Under these regulations, there are two medical review policies pertaining to the 2-midnight standard:

1. The first is a presumption by CMS that inpatient stays of two midnights or greater, after formal admission, are generally appropriate for payment under Medicare Part A and will typically not be the focus of CMS medical review efforts, by either the Medicare Administrative Contractor or Recovery Auditors.
2. The second is a benchmark for Medicare contractor reviews of inpatient stays of less than two midnights after the order is written, which are not presumed to be reasonable. CMS contractors will review those cases to evaluate the physician order, as well as the other elements of the physician’s certification and supporting documentation, to determine whether the decision to keep the patient in the hospital was reasonable. If the order, certification, and supporting documentation indicate that the physician reasonably expected that the patient’s care would span two midnights and that it was reasonable for the patient to remain at the hospital, then the payment under Part A would be considered appropriate, even if some unforeseen event caused a shorter length of stay.

The documentation required under this rule includes the actual order for inpatient admission, the certification elements, and the supporting documentation, such as physician’s progress notes. Compliance with the 2-midnight rule will be audited by CMS and its various contractors.
3-Day Rule: What Should Be Combined?

Effective June 25, 2010, the Centers for Medicare & Medicaid Services (CMS) clarified the regulations regarding which services under the broad ownership/control of a hospital must be included in the inpatient invoice.

Prior to the clarification, if preadmission testing, such as an EKG, was performed up to three days before the admission at a freestanding medical practice owned by the hospital but under a separate provider number (and was not provider-based), this testing would not have been combined with the inpatient invoice. The EKG would be billed on a professional fee claim (CMS Form 1500) from that freestanding physician practice. Conversely, if the EKG had been performed in an outpatient department of the hospital, it would have been combined on the inpatient invoice. After June 25, 2010, however, the services are handled the same way. That is, both EKGs would be bundled with the inpatient services on the UB-04 form.

The following figure illustrates the billing relationship before and after the June 25, 2010, clarification. On the left side of the illustration, the two freestanding entities, the medical practice and the ambulatory surgery center (ASC), are directly owned by the hospital. All services would have been billed on their own before June 25, 2010. On or after June 25, 2010, the services performed within the three days must be sent to the hospital and combined on the inpatient UB-04 form. Because most health system or hospital systems do not have integrated billing and electronic medical records across all the disparate entities, it is often a manual work around.

![Figure 0.1](image-url)
To clarify, if the freestanding organizations are not owned or operated directly by the hospital (as illustrated in Figure 0.2), this consolidation of the EKG is not required. The following figure illustrates how a foundation or other organization that owns the hospitals as well as the freestanding medical practices or ASCs circumvents the requirement to consolidate the billing of these services within the three-day window prior to the admission.

**FIGURE 0.2**

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**Reference**

The Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.3

Advance Beneficiary Notice

An advance beneficiary notice (ABN) is a Centers for Medicare & Medicaid Services (CMS) form (CMS-R-31) used before a Medicare beneficiary receives Part A (hospital) or Part B (outpatient) service(s) or charge(s) that may not be covered by Medicare. The patient may not be under duress when the ABN is signed.

An ABN is used to advise and inform the Medicare beneficiary that he or she may be responsible for payment of services. This is based on expected or known denial activity by Medicare, based on the service not meeting medical necessity or the service not being reasonable and necessary.

The ABN serves multiple purposes:

- Provides Medicare beneficiaries the option to receive services and take financial responsibility for paying for the services/treatments if Medicare does not pay for the specific service.
- Validates when the Medicare beneficiary was informed prior to receiving services that Medicare might not pay.
- Offers protection to the Medicare beneficiary and gives him or her the right to appeal Medicare’s decision to not cover a service.
- Note that an ABN is not required if services are not or were never covered as a Medicare benefit. Some examples of excluded items are hearing aids, eye exams, and dental services.

Billing Requirements

There are certain billing requirements when a procedure is provided that requires an ABN. Providers must utilize the following Medicare Modifiers:

- GA—Waiver of Liability Statement Issued as Required by Payer Policy. This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
- GX—Notice of Liability Issued, Voluntary Under Payer Policy. Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
• GY—Notice of Liability Not Issued, Not Required Under Payer Policy. This modifier is used to obtain a denial on a noncovered service. Use this modifier to notify Medicare that you know this service is excluded.

• GZ—Item or Service Expected to Be Denied as Not Reasonable and Necessary. When an ABN may be required but was not obtained, this modifier should be applied.

References

CMS Transmittal 1587, September 5, 2008

CMS Transmittal 2782, September 65, 2013
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