COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 28, Number 5. February 11, 2019
Some Insurers Are Denying Separate Charges, Citing Medicare; 'They're Doing it Wrong'

By Nina Youngstrom

Auditors for some commercial payers are denying payment for items and services charged separately on hospital bills, and in some cases bending the Medicare *Provider Reimbursement Manual* to do it, according to a hospital official and a consultant. The auditors contend that hospitals are unbundling charges for equipment, supplies and devices used in surgery that should be included in the cost of the procedure, but the auditors are wrong, the hospital official and consultant say. Hospitals may not realize they're losing money because sometimes payers make contractual adjustments based on the audit findings, but often they see it plainly in line-item denials. Either way, the premise for the denials is incorrect because CMS has said that hospitals may list surgical items and services separately on their itemized statements as long as they're reasonably related to the costs.

"It's increasing in intensity and focus," says the hospital official, who prefers not to be identified. "I get so frustrated." The losses are mounting, and in the millions of dollars. The hospital official and consultant think hospitals should appeal the denials and perhaps escalate them to senior leaders at the third-party payers.

The audits affect some hospitals with percentage-of-charge payer contracts and Medicare Advantage contracts that pay DRGs and separate charges when cases qualify for outlier payments.

The auditors, who have been hired by various payers, contend that hospitals can't charge separately for routine and ancillary services used in procedures. They cite the Medicare *Provider Reimbursement Manual*, including Sec. 2202.6, which states that "Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the room and board charge...Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

One auditor hired by several payers sent a document to the hospital that quoted sections of the manual, but added the phrase "or procedure charges" to Sec. 2202.6 to support its unbundling denials, the hospital official says. "They are citing Medicare charging regulations, but they are doing it wrong. They are making up crap."

This strengthened the hospital official's resolve to fight the audits because the hospital has been charging appropriately all along. For example, if a patient receives 200 expensive sutures—not the norm—the auditor will say the hospital can't bill them separately because they're included in operating room charges (e.g., the room, staffing and basic supplies that every patient receives, such as sheets and drapes). "But we will charge separately for the sutures because not every patient gets 200, so it's not right to average those costs into your room."

CMS: 'Hospitals Can List Services' Separately

The problem is, insurers, some Medicare administrative contractors and some consultants are convinced that hospitals cannot ever charge separately for any items or services used in procedures and surgeries, says Michael Lewis, president of Financial Review Services in Houston, Texas. They have repeated this myth for years to the

detriment of hospital revenue. But CMS refutes the idea, according to emails he has received over the years, including in 2018.

In 2004, Lewis received an email from Herb Kuhn, then-director of the Center for Medicare Management, which stated that for ancillary departments, section 2202.8 of the *Provider Reimbursement Manual* "does not specifically address which items and services are part of the basic 'routine' charge and which are charged in addition to the basic charge. Therefore, we do not see an issue in your examples of a hospital's having a basic ancillary department charge for the room with additional charges for other items and services furnished to patients depending on the procedure, as long as the various charges are reasonably and consistently related to the cost of the services to which they apply and are uniformly applied." Lewis received a similar response in 2006 from John Eppinger, then in CMS's Division of Cost Reporting, who said, "Our office does not see an issue with a hospital's having a basic ancillary department charge for use of a department, with additional charges for other items and services furnished to patients, depending on the procedure, as long as the various charges are reasonably and consistently related to the cost of the services and are uniformly charged to all patients."

And last year, again Lewis asked CMS about separate billing for ancillary services. In response, Rhonda Jones, an accountant in the Medicare Financial Management Branch, said "hospitals can list services such as surgical instruments, surgery packs and supplies separately on the itemized statement, but these items should be rolled up and reported under the appropriate revenue code according to billing guidelines."

Lewis explained that reporting items in the same revenue code doesn't mean they are bundled for payment purposes. Some items and services can be charged separately, and there's a good reason to do this, even though many hospitals have a hard time wrapping their heads around this idea, he contends.

Suppose two patients have their gallbladders removed, one in an open procedure and the other laparoscopically. The hospital bills the same amount of OR time for both cases even though the surgeon who performed the open surgery used a $5,000 tray of surgical instruments, which has a long shelf life, and the other surgeon used a $140,000 laparoscopic setup, which includes the laparoscope, video, light source and insufflator. "Because the insurance companies and consultants have convinced the hospital they can't charge separately for surgical equipment, they don't," Lewis says. "So you have the same price for the two cases," but hospitals could get paid more for the expensive laparoscopic equipment if they put it down as a separate line item on the itemized statement. As long as charges are related to costs, that's permitted by the *Provider Reimbursement Manual* (Sec. 2203). "It's in plain English," Lewis says.

In fact, averaging the costs, which essentially undercharges the laparoscopic surgery and overcharges the open gallbladder surgery, skews charge data, he explains. That's bad for everybody. "Eppinger says CMS wants hospitals to charge everything because it allocates costs based on charges made to each patient class—Medicare and non-Medicare—and from this allocation the cost-to-charge ratios are developed," Lewis explains. CMS settles up with hospitals on their cost reports based on the cost-to-charge ratio (CCR). If the CCR is inaccurate, "hospitals could be shorting themselves on reimbursement or putting themselves at risk with Medicare."

The hospital official added that auditors are potentially shooting the payers in the foot with line-item denials. "It's stupid. If I put it on a separate line, you won't pay me, but if I bundle it, you pay me? Fine, I'll bundle it together and give you one OR charge and average the costs. But you lose a lot of data that's helpful in looking at how we are doing things, what supplies we are using, what physician preferences are costing more money. You bundle it, and you lose the ability to analyze how you can improve."

Contact Lewis at mplewis@wt.net. ✧