2014 MASTER™ *Medicare Guide*

Wolters Kluwer
Law & Business

2014 Master Medicare Guide

Wolters Kluwer Law & Business Health Editorial

Wolters Kluwer
Law & Business

Portfolio Managing Editor
Nicole T. Stone, J.D., M.B.A.

Contributing Editors
Sarah Baumann, J.D.
Harold M. Bishop, J.D.
Jenny M. Burke, J.D., M.S.
Danielle Capilla, J.D.
Paul T. Clark
Jeff Erickson
Trinidad G. Legaspi, J.D., LL.M
Sheila Lynch-Afryl, J.D., M.A.
Jay Nawrocki, M.A.
Anthony H. Nguyen, J.D.
Michelle L. Oxman, J.D., LL.M.
Jennifer Ridell
Kelly J. Rooney, J.D.
Patricia Ruiz, J.D.
Susan L. Smith, J.D., M.A.

Production
Sarah Gunn

ISBN: 978-0-8080-3742-2

4025 W. Peterson Ave.
Chicago, IL 60646-6085
800 344 3734
wolterskluwerlb.com

Printed in the United States of America

Introduction

The *2014 Master Medicare Guide* is our 10th annual comprehensive one-volume desk reference packed with timely and useful information for providers, attorneys, accountants, and consultants who need to stay on top of one of the most complex programs maintained by the federal government. This year's edition includes over 500 explanatory paragraphs on all aspects of the Medicare program, from enrollment and eligibility, to reimbursement and appeals, to compliance and program integrity.

The explanations reflect all the major changes made to the Medicare program through laws, regulations, and significant judicial and administrative decisions in 2013. The explanations also have been updated to reflect the "Bipartisan Budget Act of 2013," passed by Congress on December 18, 2013.

Highlights of the "Bipartisan Budget Act of 2013." The legislation extends the 2 percent sequester cut for some Medicare payments for two years until 2023; includes a temporary fix for Medicare physician payments for the first three months of 2014; delays the start of reductions in Medicaid disproportionate share payments; extends the sunset deadlines for other Medicare payments; and reinforces Medicaid's status as the payer of last resort for health care services.

Physician reimbursement fix. The statutory formula for the annual physician fee schedule (PFS) update has resulted in a negative update for the PFS conversion factors for the last decade, although Congress has always intervened to avoid actual draconian payment cuts to physicians. The Bipartisan Budget Act of 2013 provides for a 0.5 percent update to the conversion factor for the first three months of 2014; physicians faced about a 20 percent cut in Medicare reimbursement for 2014 prior to Congress' action. The law notes that "it is appropriate to reform physician reimbursements under the Medicare program" but that further reform legislation will have to wait until 2014. Congress urged CMS to focus its efforts to facilitate reform by doing the following: (1) simplifying and reducing administrative burdens on physicians; (2) providing timely feedback for physicians; and (3) encouraging the development of new models.

Medicaid DSH payments. Under Medicaid, hospitals that serve a disproportionate number of low-income people receive additional payments. The number of low-income people without any form of insurance coverage was presumed to decrease in 2014 with the implementation of the Affordable Care Act, so under Social Security Act sec. 1923(f) disproportionate share hospital (DSH) payments were scheduled to be reduced each year from 2014 to 2022. This law delays the start of these reductions until 2016, in part because many states elected not to expand their Medicaid programs, and hospitals in those states were concerned about decreased reimbursements if the Medicaid DSH cuts started in 2014.

Therapy services. Therapy services furnished in an outpatient hospital setting have traditionally been exempt from the application of the annual dollar cap on Medicare reimbursement for these services. However, this law extends the requirement that Medicare temporarily apply the therapy caps to therapy services furnished in an outpatient hospital until March 31, 2014. Congress also provided that exceptions to the payment limitation may be made when provision of additional therapy services is determined to be medically necessary. This exceptions process was initially effective only for services provided in calendar year 2006, but a series of laws have extended the sunset date for the exceptions process; this new law extends it to March 31, 2014.

2014 edition overview. The first four chapters of the *Master Guide* provide an overview of the four parts of the Medicare program. Chapter 1 focuses on Medicare Part A—hospital insurance. This chapter covers entitlement to Medicare, the enrollment process, deductibles and coinsurance, covered inpatient services, and limitations

on Part A coverage. Chapter 2 discusses eligibility and enrollment in Medicare Part B—the voluntary supplemental medical insurance program—as well as Part B benefits and beneficiary cost sharing. Chapter 3 is an overview of Part C—Medicare Advantage. This discussion of the various managed care options provided under Medicare focuses on issues relevant to beneficiaries, providers, and health plans. Chapter 4 highlights Medicare Part D—the voluntary prescription drug benefit program.

The subject of Chapter 5 is the financing and administration of the Medicare program. First, we look at the various taxes and beneficiary contributions to the different parts of the Medicare program, as well as the health insurance trust funds. Next, we look at the various administrative bodies that manage the program, including the Department of Health and Human Service (HHS) and the Centers for Medicare and Medicaid Services (CMS), as well as newer entities such as the Center for Medicare and Medicaid Innovation and the Independent Medicare Advisory Board. This chapter also focuses on quality improvement initiatives in the Medicare program, demonstration programs, and the interaction between private health insurance plans and Medicare.

Chapter 6 describes the laws and regulations regarding provider agreements and conditions of participation in Medicare, focusing on specific providers. Chapter 7 highlights the process for developing national and local coverage determinations and includes a discussion of exclusions from Medicare coverage.

Chapter 8 provides an overview of 12 different prospective payment systems that determine Medicare reimbursement for different types of services—inpatient and outpatient hospital services; inpatient and outpatient rehabilitation facility services; services provided by long-term care hospitals, psychiatric hospitals and units, ambulatory surgical centers, and skilled nursing facilities, and federally qualified health centers; and end-stage renal disease, home health and hospice services.

Chapter 9 focuses on reimbursement for critical access hospitals, and other hospitals and providers excluded from the various prospective payment systems. This chapter also focuses on new alternative payment systems under Medicare provided for under the health care reform law, such as accountable care organizations and the demonstration program on payment bundling.

Chapter 10 discusses various aspects of Part B reimbursement, with a particular emphasis on the physician fee schedule.

Chapter 11 highlights the most relevant program integrity and fraud and abuse issues facing Medicare program participants. Chapter 12 discusses all aspects of the cost reports that must be filed by many Medicare participating providers. Chapter 13 focuses on the claims filing process and includes a discussion on the topics of underpayments and overpayments. Chapter 14 is broken up into discussions of medical data privacy and security and electronic health records (EHR); this discussion focuses in particular on the standards and incentive payments for meaningful use of EHR by providers.

All of these discussions include cross-references to relevant laws, regulations, CMS manual sections, administrative and judicial decisions, as well as to explanations and annotations in the CCH MEDICARE AND MEDICAID GUIDE.

The *Guide* has two appendices—a list of common abbreviations connected with the Medicare program; and a table that provides readers with a convenient cross-reference between Social Security Act sections related to Medicare and the corresponding sections of the U.S. Code.

March 2014

Table of Contents

2014 Master Medicare Guide

Wolters Kluwer Law & Business Health Editorial

Wolters Kluwer
Law & Business

Introduction

The *2014 Master Medicare Guide* is our 10th annual comprehensive one-volume desk reference packed with timely and useful information for providers, attorneys, accountants, and consultants who need to stay on top of one of the most complex programs maintained by the federal government. This year's edition includes over 500 explanatory paragraphs on all aspects of the Medicare program, from enrollment and eligibility, to reimbursement and appeals, to compliance and program integrity.

The explanations reflect all the major changes made to the Medicare program through laws, regulations, and significant judicial and administrative decisions in 2013. The explanations also have been updated to reflect the "Bipartisan Budget Act of 2013," passed by Congress on December 18, 2013.

Highlights of the "Bipartisan Budget Act of 2013." The legislation extends the 2 percent sequester cut for some Medicare payments for two years until 2023; includes a temporary fix for Medicare physician payments for the first three months of 2014; delays the start of reductions in Medicaid disproportionate share payments; extends the sunset deadlines for other Medicare payments; and reinforces Medicaid's status as the payer of last resort for health care services.

Physician reimbursement fix. The statutory formula for the annual physician fee schedule (PFS) update has resulted in a negative update for the PFS conversion factors for the last decade, although Congress has always intervened to avoid actual draconian payment cuts to physicians. The Bipartisan Budget Act of 2013 provides for a 0.5 percent update to the conversion factor for the first three months of 2014; physicians faced about a 20 percent cut in Medicare reimbursement for 2014 prior to Congress' action. The law notes that "it is appropriate to reform physician reimbursements under the Medicare program" but that further reform legislation will have to wait until 2014. Congress urged CMS to focus its efforts to facilitate reform by doing the following: (1) simplifying and reducing administrative burdens on physicians; (2) providing timely feedback for physicians; and (3) encouraging the development of new models.

Medicaid DSH payments. Under Medicaid, hospitals that serve a disproportionate number of low-income people receive additional payments. The number of low-income people without any form of insurance coverage was presumed to decrease in 2014 with the implementation of the Affordable Care Act, so under Social Security Act sec. 1923(f) disproportionate share hospital (DSH) payments were scheduled to be reduced each year from 2014 to 2022. This law delays the start of these reductions until 2016, in part because many states elected not to expand their Medicaid programs, and hospitals in those states were concerned about decreased reimbursements if the Medicaid DSH cuts started in 2014.

Therapy services. Therapy services furnished in an outpatient hospital setting have traditionally been exempt from the application of the annual dollar cap on Medicare reimbursement for these services. However, this law extends the requirement that Medicare temporarily apply the therapy caps to therapy services furnished in an outpatient hospital until March 31, 2014. Congress also provided that exceptions to the payment limitation may be made when provision of additional therapy services is determined to be medically necessary. This exceptions process was initially effective only for services provided in calendar year 2006, but a series of laws have extended the sunset date for the exceptions process; this new law extends it to March 31, 2014.

2014 edition overview. The first four chapters of the *Master Guide* provide an overview of the four parts of the Medicare program. Chapter 1 focuses on Medicare Part A—hospital insurance. This chapter covers entitlement to Medicare, the enrollment process, deductibles and coinsurance, covered inpatient services, and limitations

on Part A coverage. Chapter 2 discusses eligibility and enrollment in Medicare Part B—the voluntary supplemental medical insurance program—as well as Part B benefits and beneficiary cost sharing. Chapter 3 is an overview of Part C—Medicare Advantage. This discussion of the various managed care options provided under Medicare focuses on issues relevant to beneficiaries, providers, and health plans. Chapter 4 highlights Medicare Part D—the voluntary prescription drug benefit program.

The subject of Chapter 5 is the financing and administration of the Medicare program. First, we look at the various taxes and beneficiary contributions to the different parts of the Medicare program, as well as the health insurance trust funds. Next, we look at the various administrative bodies that manage the program, including the Department of Health and Human Service (HHS) and the Centers for Medicare and Medicaid Services (CMS), as well as newer entities such as the Center for Medicare and Medicaid Innovation and the Independent Medicare Advisory Board. This chapter also focuses on quality improvement initiatives in the Medicare program, demonstration programs, and the interaction between private health insurance plans and Medicare.

Chapter 6 describes the laws and regulations regarding provider agreements and conditions of participation in Medicare, focusing on specific providers. Chapter 7 highlights the process for developing national and local coverage determinations and includes a discussion of exclusions from Medicare coverage.

Chapter 8 provides an overview of 12 different prospective payment systems that determine Medicare reimbursement for different types of services—inpatient and outpatient hospital services; inpatient and outpatient rehabilitation facility services; services provided by long-term care hospitals, psychiatric hospitals and units, ambulatory surgical centers, and skilled nursing facilities, and federally qualified health centers; and end-stage renal disease, home health and hospice services.

Chapter 9 focuses on reimbursement for critical access hospitals, and other hospitals and providers excluded from the various prospective payment systems. This chapter also focuses on new alternative payment systems under Medicare provided for under the health care reform law, such as accountable care organizations and the demonstration program on payment bundling.

Chapter 10 discusses various aspects of Part B reimbursement, with a particular emphasis on the physician fee schedule.

Chapter 11 highlights the most relevant program integrity and fraud and abuse issues facing Medicare program participants. Chapter 12 discusses all aspects of the cost reports that must be filed by many Medicare participating providers. Chapter 13 focuses on the claims filing process and includes a discussion on the topics of underpayments and overpayments. Chapter 14 is broken up into discussions of medical data privacy and security and electronic health records (EHR); this discussion focuses in particular on the standards and incentive payments for meaningful use of EHR by providers.

All of these discussions include cross-references to relevant laws, regulations, CMS manual sections, administrative and judicial decisions, as well as to explanations and annotations in the CCH MEDICARE AND MEDICAID GUIDE.

The *Guide* has two appendices—a list of common abbreviations connected with the Medicare program; and a table that provides readers with a convenient cross-reference between Social Security Act sections related to Medicare and the corresponding sections of the U.S. Code.

March 2014

Table of Contents

Detailed Table of Contents

CHAPTER 1—MEDICARE PART A COVERAGE

Entitlement to Part A Benefits

Deductibles and Coinsurance

Inpatient Hospital Services

Covered Inpatient Hospital Services

Limitations on Inpatient Hospital Coverage

Skilled Nursing Facility Services

Covered SNF Services

Limitations on SNF Coverage

Home Health Services

Conditions of Coverage for Home Health Services

Covered Home Health Services

Limitations on Home Health Coverage

Hospice Services

CHAPTER 2—MEDICARE PART B COVERAGE

Eligibility, Enrollment and Period of Coverage

Benefits Under the Part B Program

Beneficiary Cost Sharing

CHAPTER 3—MEDICARE PART C COVERAGE

CHAPTER 4—Medicare Part D Coverage

CHAPTER 5—FINANCING AND ADMINISTRATION

Government Financing

Administration of the Medicare Program

Medicare Contractors

Quality Improvement Organizations

Quality Improvement Initiatives

Experiments and Demonstrations

Private Health Insurance Plans

CHAPTER 6—PROVIDER AGREEMENTS—CONDITIONS OF PARTICIPATION

Provider Agreements