HCPro Medicare Boot Camp® – Hospital Version: Oct. 22-26

Date: October 22, 2018       Time: 8:00 AM

Location:
IHA Naperville
1151 East Warrenville Road
Naperville

October 22-26, 2018
8 am - 4:30 pm

Registration:

IHA members
First person per organization: $1,995
Each additional registrant from the same organization: $1,895

Non-IHA members
First person per organization: $2,495
Each additional registrant from the same organization: $2,395

Tuition includes all program materials, including an extensive program notebook, continental breakfast, lunch and refreshments each day. Travel expenses are the responsibility of the registrant.

Registration closes on Wednesday, Sept. 5. Space is limited so please reserve your place as soon as possible. This class is offered in a small classroom setting. Minimum and maximum enrollments apply.

Cancellations after August 17 will be charged 50 percent of the registration fee. Registrants who do not cancel and do not attend are liable for the entire fee.
CONTINUING EDUCATION

Continuing education credit is available for coders, health information management professionals, nurses, case managers, clinical documentation professionals, compliance professionals and certified public accountants (CPAs). Please see the registration website for details.

Changes to the inpatient-only list, new guidance on charity care and Medicare coverage limitations are just a few complex regulations from the Centers for Medicare & Medicaid Services (CMS) this year. This HCPro Medicare Boot Camp® will guide you through the details of several Medicare regulations so you can more confidently tackle regulations that may challenge your organization’s Medicare billing and compliance.

You’ll gain expert insight by attending this nationally recognized program covering:

- Medicare benefit and payment rules and their applications; and
- Tools and skills needed to research Medicare questions long after the program ends.

Through a combination of lectures, class discussions and hands-on exercises, you’ll learn how to comply with the latest Medicare rules and regulations, prevent missed revenue opportunities, minimize denials and prepare for program integrity audits.

**New for this course:** Expert faculty will provide implementation insights for 2018 changes to the inpatient-only list. Participants will also discuss how Local and National Coverage Determinations (NCDs and LCDs) affect coverage of cases that meet the Two-Midnight Benchmark.

AGENDA

**New for 2018:** Course exercises will be presented as illustrative case studies and incorporated into the instructor’s presentation. This change comes from participant feedback showing a preference for discussing the exercises as a group.

- **Module 1: Medicare Overview and Contractors**
  - Overview of Medicare Part A, B, C and D
  - Medicare contractors, including the MAC, RAC and QIO
• **Module 2: Medicare Research and Resources**
  - Finding Medicare source laws, including statutes, regulations and final rules
  - Finding Medicare sub-regulatory guidance, including manuals and transmittals
  - Medicare Coverage Center, including LCDs, NCDs, CED and Lab Coverage Manual
  - Links to Medicare resources and resources for staying current

• **Module 3: Coverage of Hospital Outpatient Services**
  - Incident-to coverage of outpatient therapeutic services
  - Physician supervision requirements and definitions
  - Coverage of observation services
  - Coverage of drugs, including self-administered drugs
  - Coverage requirements for outpatient diagnostic services

• **Module 4: Coverage of Hospital Inpatient Services**
  - Inpatient order and certification requirements
  - Inpatient criteria and the Two-Midnight Benchmark
  - Admission on a case-by-case basis
  - Documentation and use of screening tools
  - Utilization review determinations and short stay audits
  - Inpatient Part B payment

• **Module 5: Medicare Notices**
  - Delivery of the Medicare Outpatient Observation Notice (MOON)
  - Important Message from Medicare (IMM) and Detailed Notice of Discharge
  - Limitations of liability statute and notice requirements
  - The Advance Beneficiary Notice (ABN) form and instructions
• Hospital Issued Notices of Non-Coverage (HINN)

• Module 6: Medicare Claims Submission Fundamentals
  • Claim fields with special instructions
  • Medicare Secondary Payer principles, including liability claims
  • Adjustment claims and automated reopenings
  • Medicare claims flow

• Module 7: Medicare Edit Systems
  • Outpatient Code Editor (OCE) and Medicare Code Editor (MCE)
  • National Correct Coding Initiative (NCCI)
  • Procedure to Procedure (PTP) edits and modifiers
  • Medically Unlikely Edits (MUE) and Add-on code edits

• Module 8: Medicare Billing Issues
  • Outpatient repetitive, non-repetitive and recurring services
  • Three-day payment window; outpatient services billed on inpatient claims
  • Billing of non-covered outpatient services
  • Treatment of conditions arising during or from a non-covered stay

• Module 9: Medicare Outpatient Payment Systems
  • Outpatient Prospective Payment System (OPPS)
  • Addendum B and D to determine the payment status of a HCPCS code
  • Addendum A and Ambulatory Payment Classifications (APCs)
  • Comprehensive APC (C-APC) basic rules
  • Payment under the OPPS, including patient coinsurance and outlier
  • Payment for therapy under the Physician Fee Schedule, including therapy caps
- “Sometimes” and “always” therapy codes
- Payment for labs under the Laboratory Fee Schedule, including reference lab

**Module 10: Outpatient Surgical Services, Including Implantable Devices**

- Inpatient-only procedures
- Surgical C-APCs, including complexity adjustment
- Multiple procedure discount for minor surgical services
- Terminated/discontinued and bilateral procedures
- Device intensive procedures and procedure-to-device edit
- Pass-through devices
- Value code FD for free and reduced-cost devices

**Module 11: Outpatient Visits and Observation Services**

- Coding for clinics, emergency departments, critical care and trauma activation
- Proper use of modifier 25
- Payment for off-campus “non-excepted” department services
- Billing of observation services
- Observation Comprehensive APC Payment

**Module 12: Special Billing Issues for Outpatient Diagnostics, Drugs and Therapy**

- Packaged, pass-through and non-pass-through drugs and biologicals
- Proper use of modifier JG and TB
- Discarded Drugs
- Biosimilar products
- Biological skin substitutes
- Radiation Therapy

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• Imaging Family Composite APCs

• Special Radiology Modifiers

• Laboratory billing and coding issues, including date of service

• Blood and blood products

• Outpatient therapy functional status reporting

• **Module 13: Inpatient Payment and Patient Responsibility**

  • Inpatient Part A payment and the Inpatient Prospective Payment System (IPPS)

  • Medicare-severity diagnosis related groups (MS-DRG)

  • Complications and co-morbidities and the effect of a hospital-acquired condition (HAC)

  • Inpatient deductible, coinsurance and lifetime reserve days

• **Module 14: Inpatient Prospective Payment System (IPPS) Adjustment Factors**

  • Standardized amount adjustments: Hospital Quality Reporting Program and Electronic Health Record (EHR) Meaningful Use

  • Quality adjustments: Value-Based Purchasing (VBP) Program, Hospital Readmissions Reduction Program (HRRP) and HAC Reduction Program

  • Payment add-on for New Technology

  • Medicare inpatient pricer

  • Payment for transfers and post-acute care transfers

*Course Agenda/Outline is subject to change.*

**OBJECTIVES**

At the conclusion of this program, participants will be able to:

• Locate key sources of Medicare authority on the Internet.
• Interpret Medicare guidance and apply it to the services provided.

• Describe how Medicare covers inpatient and outpatient services at hospitals.

• Describe limitations on coverage under the Medicare program.

• Recognize the effect of coding rules on the services the provider reports.

• Explain how Medicare pays for inpatient and outpatient services.

• Explain Medicare deductibles and copayments for hospital inpatient and outpatient services.

• Employ inpatient and outpatient status rules and regulations.

WHO SHOULD ATTEND

This program is designed for hospital revenue cycle, finance and reimbursement, and compliance staff, including:

• Government billing specialists

• Patient Financial Services supervisors and managers

• Auditors and analysts

• Chargemaster coordinators

• Compliance officers

• Recovery Audit Contracting liaisons

• Case managers

• Coders

• Legal Department Personnel

Health information management, patient access management, and clinical managers and department heads also will benefit from this course.

SPEAKERS

©2018 Illinois Health and Hospital Association
Judith L. Kares, JD
Adjunct Instructor, HCPro Medicare Boot Camp® – Hospital Version and Critical Access Hospital Version

An expert in Medicare rules and regulations, Kares spent several years in private law practice representing hospitals and other healthcare clients and as in-house legal counsel at Blue Cross and Blue Shield of Arizona and Blue Cross and Blue Shield of the National Capital Area. In both in-house positions, she had primary responsibility for contracting and regulatory compliance, including oversight of federal and state healthcare programs. She is also an adjunct faculty member at the University of Phoenix, where she teaches courses in business and health care law and ethics.