Argus CLAIM REVIEW™

ARGUS Advantage Series

# The ARGUS Advantage Series:
# Understanding More About CMS Guidelines

ARGUS Claim Review's responsibility to our clients is to be sure the services performed by providers are billed accurately and that the claim amounts are justified. We take seriously the responsibility to manage our client dollars, but also recognize that providers and facilities need to be compensated appropriately for services performed. That is why **we use a number of different benchmarks** to be sure compensation is fair and appropriate.

One of the benchmark tools we use is the **Centers for Medicare and Medicaid Services (CMS) Outpatient Coding Guidelines**. When we receive claims for non-PPO network charges, our analysis typically includes a comparison to the CMS Guidelines. The standard procedure is to compute the **allowable charges as 200% of the CMS allowed rate** for the local wage index of the charges billed by the facility. Any charges in excess of that 200% amount are considered non-allowable and the given claim is reduced by that excess amount.

Although facilities frequently claim that CMS underpays them, and may result in cost shifting the amounts they are underpaid to private insurance, in reality, CMS pays facilities between 93%-97% of their actual cost. The American Hospital Association (AHA), reports that 42% of facilities actually *make a profit* on CMS patients.

This is because CMS "rewards" facilities for performing services under what they determine to be the actual cost for providing that service. When a claim is priced by CMS for reimbursement using the Diagnosis Related Group (DRG) methodology, CMS will pay that facility the same amount regardless of the cost to the hospital.

Therefore, if the DRG is priced by CMS at $20,000, but the actual cost to the hospital is $30,000, **they lose $10,000.** However, conversely, if the DRG is priced by CMS at $20,000 and the actual cost to the hospital is only $10,000, the hospital **makes a profit of $10,000.**

On March 17, Glenn Hackbarth, chairman of The Medicare Payment Advisory Commission (MedPAC), testified before the House Ways and Means Committee that the heart of the matter is that **some hospitals are inefficient and their costs are too high, not that CMS underpays them.** Therefore, allowing 200% of the CMS allowed amount on out-of-network claims is not only reimbursing the facility closer to what their actual cost to provide the service is, but also gives them double their cost.

**ARGUS continually monitors industry-related guidelines, costs and other factors to ensure we are always using best practices to ensure claims are accurate, ultimately resulting in savings and effective cost-containment for our clients.**

**If you have any questions about CMS, ARGUS Claim Review or other benefits-related topics, feel free to contact us – we're happy to answer any questions you have.**