Hi, I’m Mike Passanante, your host for the Hospital Finance Podcast. I’m joined today by Vinny Farina who is a Senior Manager on our Revenue Cycle Team here at Besler. Welcome Vinny.

Vinny Farina: Thank you.

Michael: So Vinny is going to walk us through various aspects of IME shadow billing and how that entire process works within your hospital. So Vinny, let me open it up with the first question. It’s kind of a long one so bear with me.

We’re interested in what the two types of additional payments from Medicare through the Part A Program that teaching hospitals receive from Medicare Advantage acute inpatient discharges are. Can you walk us through those?

Vinny: Sure! The two types of payments are for Indirect Medical Education (IME) and for Direct Graduate Medical Education (DGME). IME payments are received after a shadow claim is submitted with the appropriate condition codes 04, 69. Direct Graduate Medical Education funds are received through the cost report settlement process.

Teaching facilities are entitled to both IME and DGME for the Medicare Advantage Part C Patient they treat for the Medicare Part A Program since the IME component is excluded from the Medicare Advantage DRG payment.

Michael: So Vinny, explain to us what are shadow claims.

Vinny: Well, shadow billing is synonymous with no-pay or information-only claims. Both are unofficial terms that refer to the process wherein hospitals submit claims to their MAC, medicare administrative contractor, for inpatient services provided to Medicare beneficiaries who are enrolled in a Medicare Advantage Plan Part C.
A shadow claim contains the same data elements as that of a Medicare UB04 claim. The main difference is there are additional condition codes added to the claim to identify it as a shadow bill.

The two condition codes are 04 which is used to identify that you’re submitting an information-only claim and condition code 69 which is teaching hospitals only.

All these claims are going to be captured on the PSNR118 report.

Michael: So are shadow claims only used for acute inpatient discharges?

Vinny: No, they’re actually also used for non-IPPS hospitals like long-term care, rehabilitation, psychiatric, children and cancer that have teaching programs are also reimbursed for the DGME portion through their cost report and require submission of a shadow bill in order to receive reimbursement credit.

Non-teaching hospitals are required to submit shadow bills for purposes of accumulating Medicare Advantage patient days for inclusion in the DSH SSI ratio. Also, any hospital that operates approved nursing and allied health education programs, NAH’s, and treats Medicare Advantage patients also must submit shadow bill claims in order to receive add-on NAH payments.

Non-teaching facilities will only use condition codes 04, whereas teaching facilities will also use the 69.

Michael: Okay. Can you talk us through why someone at a hospital will want to track and submit the shadow claims?

Vinny: Basically, there are three main reasons – compliance, financial and Medicare Advantage growth. For compliance, CMS requires all providers to submit the shadow claims for tracking purposes and data collection. Financially, facilities receive payments for IME and reimbursement through the cost report settlement for the DGME portion payment.
Note that the average IME claim is worth approximately $1,000. So we’re talking some significant money for certain facilities. DGME reimbursement is about 25% of your IME claim. You do the math. It starts to add up.

So there is a double financial incentive to submit claims and there’s the compliance requirement.

Now, you also got to keep in mind that Medicare Advantage growth continues year after year. So why are you going to put at risk the funds that your teaching facility is entitled to? This population is just going to continue to grow as the MA population grows, so the funds are tied to that growth.

**Michael:** Yeah, it sure is. Do you only submit a shadow claim? How does this work?

**Vinny:** Unlike other billing submission processes, a shadow claim is sent to Medicare Part A in addition to the claim submitted to the Medicare Advantage Program. So there are actually two claims going out the door.

The coding requirements are the same. However, the clear distinction between the claims is that a Medicare Advantage plan requires the beneficiary identification number. A shadow claim requires the patient’s HIC number, the health insurance claim number. The two IDs are not the same and may or may not be on the Medical Advantage bill.

**Michael:** Okay. So where do you find the patient’s ID?

**Vinny:** The patient will come in, will have a Medicare Advantage Plan ID card and hopefully, their Medicare Part A ID card. The insurance numbers are located on those two documents.

**Michael:** Then what’s the disconnect? What’s the issue here?
Vinny: The number issue is we find across all of our reviews is that patients Medicare HIC numbers required for Medical Part A billing wasn’t collected at the time of service. It was just missed. So regardless if it’s a best practice facility or review that will do for a one-time fine-tuning of the process, the main reason a shadow claim is not submitted is because the HIC number was not captured and recorded in the hospital system.

The process for this is distinct and unique. Processes must be in place and staff trained to recognize the double ID collection requirement. Once captured, it needs to be recorded in the system so that a claim will have it for the billing component.

Michael: So can you just expand on this a little bit and tell us what the best practice facilities are doing to make that happen?

Vinny: Sure! They have processes in place to identify and document Medicare Advantage patients at the time of registration. They’re able to distinguish those patients from any other government payer type plans. They correctly utilize the internal plan code and identifiers to track patients. They’re going to submit, follow up, collect and review the shadow bills for this population. Nothing gets ignored.

Realize that there are hundreds of plans staff handle. It’s a complex insurance maze out there in which providers must operate and requires attention. So your staff must be prepared and have the tools to deal with the billing aspects and intricacies of Medicare Advantage.

Michael: Tell me more about underpayments.

Vinny: Oh, again, the number one issue is the inability to collect Medicare HIC numbers. Facilities have to make sure to have a process in place to capture that info and many of the underpayments will be resolved. If not captured initially, then have a
process to review the accounts that are missing it and track down the HIC number through the eligibility tools available to providers.

A second issue is when a system is unable to produce a shadow bill because the system does not recognize that the plan is a Medicare Advantage plan. A simple example is one in which a commercial plan code is used at the time of registration instead of the Medicare Advantage plan code. The system doesn’t trigger a shadow claim in this case, thus an underpayment will occur.

Issues will arise between automation and manual shadow billing processes. Many older systems require manual intervention to generate the shadow bill. With staff turnover and outdated policies and procedures, missed shadow bills unfortunately are going to occur.

So providers end up submitting claims without their required condition codes. Without them, the claims won’t be processed for IME and you’re going to end up getting rejected. So thus will start another follow-up process.

So not having a process in place to track those rejections and the claims that are in the return to provider (otherwise known as RTP), Medicare Advantage shadow bills will go through the same billing edits and processes as a traditional medical claim. So without having a process in place for RTP, all those are just going to sit in your receivable and rot.

So claims with errors may be flagged and placed in RTP status for correction or be denied altogether. Claims not resolved in RTP within a certain period will be dropped altogether from RTP. Without a process to track these claims, you’ll be lost within the accounts receivable.

The last reason and one of the most common reasons is failure to adhere to the 12-month timely filing deadline. It’s an easy fix. Get the claim out the door within the proper timeframe.
Unfortunately, there are no exceptions to the timely filing window for IME claims submissions. Claims must be submitted within the required 12-month period from the discharge date in order to be considered for processing. Some providers submit the Part C and shadow claims simultaneously. Others wait to submit the shadow claim until a payment is received from the Medicare Advantage plan. Processes must be in place in either case to recognize that, indeed, a claim was submitted regardless of when it’s supposed to occur.

Michael: How would hospitals know that their submission process is working?

Vinny: Well, start with a thorough IME shadow billing review. That usually will identify the operational and technical root causes of the missed bills. Essentially, an IME review provides business office leadership with a complete roadmap to process improvement. Potential changes to the process may include new registration procedures, employee education and billing system modifications. I’ve worked with best practice facilities who capture greater than 99% of all their claims and other facilities who are still developing their process. Ultimately, one needs to recognize that an independent review and audit a couple of times a year will help evaluate whether the current process is effective. Again, why risk losing out on funds that the facility is entitled to? Every dollar is extremely important and should be accounted for.

Michael: You bet! Well, Vinny, great information. It was great having you on the program today. Thanks for coming by.