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CMS FINAL RULE PROVIDING ADDITIONAL PART B PAYMENT TO HOSPITALS DENIED PART A INPATIENT PAYMENT

On August 19, 2013, the Centers for Medicare and Medicaid Services ("CMS") published the acute care hospital and long-term care hospital inpatient prospective payment system final rule for fiscal year 2014 ("Final Rule"). Under one new provision in the Final Rule, if a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was deemed not reasonable and necessary, or if a hospital on post-discharge self-audit finds an inpatient admission was not reasonable and necessary, the hospital (including a critical access hospital) may submit a subsequent Part B inpatient claim for many additional services not previously covered, if such services would have been reasonable and necessary had the Medicare beneficiary been treated as a hospital outpatient, rather than admitted as an inpatient, unless those services specifically require an outpatient status.

SUMMARY OF THE RULE

According to CMS, there are some 15,000 HCPCS codes and approximately 500 revenue codes payable under Part B. Under the Final Rule, "the vast majority of Part B services will be finalized as payable Part B inpatient services." However, CMS clarified that services that require "outpatient status" would not be payable under the Final Rule because the patient originally was deemed an inpatient (a status not subject to amendment after discharge). CMS identified observation services; outpatient visits, including emergency department visits; and outpatient diabetes self-management training services as examples of such outpatient services, and others may be added subject to future rulemaking. However, if these excluded services are provided to outpatients in the pre-admission three-day payment window (or one-day payment window for non-IPPS hospitals), hospitals may bill for said services on a Part B outpatient claim following denial of the Part A inpatient claim, if all other Medicare payment rules are met.

CMS's new payment policy applies if the beneficiary is a Part B recipient and the hospital timely files claims for the Part B services. Claims for hospital admissions taking place after the effective date of the Final Rule, generally, must be filed within one calendar year of the actual dates of service. However, CMS stated in the Final Rule that hospitals can continue to follow the Part B billing time frames established in CMS Ruling 1455-R ("Administrative Ruling")[1] after the effective date of the Final Rule (October 1, 2013) if either the Part A claim denial was one to which the Administrative Ruling originally applied (effective from March 13, 2013 through September 30, 2013), or the Part A inpatient claim has a date of admission before October 1, 2013 and is denied after September 30, 2013 on the grounds that the medical care was reasonable and necessary but the inpatient admission was not.

The Final Rule follows a proposed rule ("Proposed Rule") and the Administrative Ruling, both of which were released on March 13, 2013. The interim Administrative Ruling and the Proposed Rule reversed previous payment policies, which permitted hospitals to bill "Part B inpatient" for only the very limited set of largely ancillary inpatient services set forth in Section 10, Chapter 6 of the Medicare Benefit Policy Manual.

The Final Rule is effective October 1, 2013. On that date, the Administrative Ruling will expire. The Administrative Ruling was intended to provide for fairer reimbursement to hospitals, consistent with recent Medicare Appeals Council and administrative law judge decisions ordering payment under Part B for denied inpatient admissions, as well as greater protection of beneficiaries for an interim period until the Proposed Rule was finalized.

For additional information on the Proposed Rule and the Administrative Ruling, click here.

The different policies addressing additional Part B payments for hospitals denied inpatient payment and new inpatient admission guidelines are related. These provisions are intended to work together to reduce the frequency of inappropriate extended observation care (and its attendant financial burdens on beneficiaries), as well as reduce inappropriate hospital admissions and hospital inpatient claim denials. The Final Rule can be found here.

BACKGROUND TO THE FINAL RULE

The Final Rule is the end result of CMS's efforts to protect Medicare beneficiaries from incurring unnecessary Medicare-related financial costs (e.g., co-pays) as a result of extended observation services. Prior to this rulemaking, if a hospital claim for inpatient payment under Part A

was denied as not reasonable and necessary, the hospital could submit a subsequent Part B inpatient claim for *only very limited services, which did not cover the hospital's costs*. The key here is that once a patient is discharged, the patient status cannot be changed from "inpatient" to "outpatient." This made hospitals reluctant to admit beneficiaries as inpatients in certain borderline cases. If a Part A inpatient admission was denied by a RAC as not being reasonable and necessary, the inpatient reimbursement under Part B was much lower than outpatient reimbursement under Part B. Accordingly, the trend was to treat beneficiaries for upwards of 48 hours as observation outpatients to ensure adequate reimbursement under Medicare outpatient Part B. The problem with this practice was that beneficiaries who may have been treated more appropriately as hospital inpatients incurred higher costs as designated outpatients because the cost sharing formulas for inpatients and outpatients are different. For example, in addition to a deductible common to both inpatients and outpatients, beneficiaries must pay co-pays under Part B. Also, in order for a beneficiary to qualify for Part A coverage of post-hospital care in a skilled nursing facility ("SNF"), the beneficiary must have a qualifying three-day inpatient stay. Since observation treatment does not count toward this three-day requirement, a patient placed under observation and then discharged to a SNF for extended care would incur significant charges for the SNF admission. These concerns gave rise to the Medicare Part A to Part B Rebilling Demonstration and eventually to the Final Rule.

PRACTICAL TAKEAWAYS

The Final Rule paves the way for additional Part B payment to hospitals denied inpatient payment under Part A and should have the effect of decreasing long observation stays. Hospitals should take note of the following caveats:

- Hospitals may not simultaneously submit an inpatient Part A claim *and* an inpatient Part B claim to hedge their bets in the event of an inpatient admission denial. A "no pay/provider liable" claim must be present in the claims system in order for a subsequent Part B claim to be processed. In other words, a Part A claim denial must be posted in the claims history *before* a Part B claim may be *submitted*.
- When a hospital submits an inpatient Part B claim after an inpatient Part A denial, an affected beneficiary will be responsible for any applicable additional cost-sharing liability under Part B. This is the case even though, under the Medicare A/B Rebilling Demonstration Project (expired March 13, 2013), CMS had the statutory authority to waive the post-discharge cost-sharing liability. Seemingly inconsistent, however, CMS clarified in commentary that SNF coverage is:

  "*not necessarily invalidated by a retroactive denial of the qualifying hospital stay, as long as the care provided . . . can still meet the relatively broad definition of medical necessity. . . Accordingly, the denial of the hospital stay would affect coverage of the related SNF stay only in those instances where it is further determined that 'hospitalization for 3 days represents a' 'substantial departure from normal medical practice.*'"

  In summary, CMS stated that the status of the beneficiary does not change from inpatient to outpatient even after an inpatient Part A denial so the denial itself does not necessarily foreclose the possibility of a covered SNF stay.
- CMS was not particularly sympathetic to comments suggesting it was "unreasonable" and "unfair" for CMS not to have aligned the one-year timely filing requirements for rebilling under Part B with the RAC audit review period of three years from the date of service. Stakeholders are concerned that the time period to re-file a claim under Part B may well have passed by the time a RAC audit identifies an inappropriate inpatient admission. CMS responded that hospitals have the ability to avoid "being disadvantaged" by the one-year time limit to file claims if they correctly bill from the start by following Medicare's hospital inpatient admission guidelines, which also have been expanded and clarified in the Final Rule. In light of CMS's position, a hospital's best strategy might be to harness all the powers of its utilization review committee and, in almost all cases, bill correctly the first time rather than rely on expanded Part B inpatient reimbursement.

If you have any questions or would like additional information about this topic, please contact:

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[1] Under the Administrative Ruling, Part B inpatient and Part B outpatient claims that are filed later than one-calendar year after the date of service will not be rejected as untimely by Medicare's claims processing system as long as the corresponding denied Part A inpatient claim was filed timely in accordance with 42 CFR 424.44.