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CMS PUBLISHES ADMINISTRATIVE RULING AND PROPOSED RULE PROVIDING ADDITIONAL PART B PAYMENT TO HOSPITALS DENIED INPATIENT PAYMENT

EXECUTIVE SUMMARY

On March 13, 2013, CMS concurrently released an immediately effective administrative ruling ("CMS Ruling 1455-R" or "Ruling") and a proposed rule ("Proposed Rule") reversing CMS policy precluding hospitals from billing on an outpatient basis for inpatient services denied payment on grounds the services should have been provided on an outpatient basis. Under the new policy, when an audit determines an inpatient service was not medically necessary, a hospital may be able to rebill Medicare Part B for outpatient services. The Ruling is effective on an interim basis until the Proposed Rule is finalized. Both will be published in the Federal Register on or about March 19, 2013. Interested parties wishing to submit comments should do so in accordance with instructions set forth in the Proposed Rule referencing file code CMS-1455-P. Comments are due no later than 5 P.M., 60 days after the date of publication in the Federal Register.

THE RULING

Effective March 13, 2013, when a Medicare Part A claim for a hospital inpatient admission is denied by a Medicare claims review contractor (e.g., a MAC, RAC or CERT contractor) as not being reasonable and necessary, the hospital subsequently may submit a Part B inpatient claim for additional services over and above those set forth in Section 10, Chapter 6 of the Medicare Benefit Policy Manual ("MBPM"), *providing* the services furnished were, indeed, reasonable and necessary. The hospital (including critical access hospitals) may submit a Part B inpatient claim for payment of Part B services that would have been payable had the Beneficiary been designated as an outpatient rather than an inpatient, *unless* those services specifically require an "outpatient status." Outpatient visits, emergency department visits and observation services are examples of services that require an outpatient status so would not be payable under the new policy because the patient originally was *deemed* an inpatient (a status not subject to amendment after discharge), notwithstanding the eventual denial of the inpatient admission claim.

The Ruling only applies to inpatient claims denied on the basis that the inpatient admission was not reasonable and necessary as long as the denial was made: (i) during the period the Ruling is in effect; (ii) prior to March 13, 2013 if the period to file an appeal has not expired; or (iii) prior to March 13, 2013 where an appeal is pending. The Ruling does not apply to other circumstances in which there was no payment under Medicare Part A, such as when a Beneficiary has exhausted his/her Part A benefits or is not eligible to receive Part A benefits. The Ruling also does not apply to inpatient admissions determined to be not reasonable and necessary by the hospital, for example, through utilization review or other self-audit process. In contrast with the provisions of the Proposed Rule summarized below, under the Ruling, Part B inpatient and Part B outpatient claims that are submitted later than one calendar year after the date of service will *not* be rejected by Medicare so long as the associated denied Part A inpatient claims were timely filed. Significantly, the Ruling terminates the Part A to Part B Rebilling Demonstration Project and effectively extends the benefits of that project to all hospitals. The Ruling will remain in effect until the effective date of the rule finalizing the Proposed Rule.

BACKGROUND TO THE RULING

Prior to the Ruling, if a Medicare claims review contractor denied the Part A inpatient claim, a hospital would be permitted to submit a Part B inpatient claim for only a limited set of medical and other health services known as "Part B inpatient" or "Part B only" services, even if additional services furnished would have been medically necessary had the patient been treated as an outpatient at the outset. This long-standing Medicare payment policy resulted in hospitals being significantly underpaid for services rendered if the patient's inpatient admission was denied. As a result of these denials, more and more hospitals have filed appeals to the Medicare Appeals Council and administrative law judges ("ALJs"). Increasingly, the Medicare Appeals Council and ALJs have upheld the Medicare claims review contractors' denial of Part A inpatient claims but have ordered payment to the hospitals for the services they rendered at an outpatient or observation level of care. Effectively, the administrative decisions have required Medicare to pay for all Part B services that would have been payable had the Beneficiary been classified and treated as an outpatient, rather than a very limited set of Part B "inpatient services" identified in the MBPM. The Ruling establishes a uniform mechanism for implementing the administrative decisions and for managing pending claims and appeals while CMS considers a permanent policy to be established as a final rule. The Proposed Rule is the first step toward effectuating a

permanent new policy that provides for fairer reimbursement to hospitals and, potentially, greater protection of Beneficiaries.

THE PROPOSED RULE

The Proposed Rule is quite similar to the Ruling with two important differences:

1. Under the Proposed Rule, a hospital that self-determines, post-discharge, that an inpatient admission was not reasonable and necessary would be eligible to resubmit a claim for most Part B services that would have been reasonable and necessary had the Beneficiary been treated as an outpatient rather than admitted as an inpatient. In contrast, the Ruling does not apply to inpatient admissions deemed *by the hospital* (versus a Medicare claims review contractor) to be not reasonable and necessary.

2. Under the Proposed Rule, CMS would continue applying the timely filing restriction to the subsequent billing of all Part B inpatient services, meaning the Part B services would need to be filed within one year from the date of services. Under the Ruling, hospitals may submit claims for Part B services later than one calendar year after the date of services as long as the denied Part A claim was timely filed.

BACKGROUND TO THE PROPOSED RULE

In addition to the financial burden on hospitals unable to recoup expenses associated with denied inpatient admissions, Beneficiaries' financial interests also are at stake. Hospitals eager to avoid inpatient denials have been trending toward treating more patients on an outpatient/observation basis for extended periods of time. Medicare Parts A and B provide for different cost-sharing responsibilities for Beneficiaries; thus, the patient status is significant to Beneficiary interests. For example, in addition to a deductible, Beneficiaries must pay copays under Part B. Also, in order for a Beneficiary to qualify for coverage for post-hospital care in a skilled nursing facility, the Beneficiary must have a three-day inpatient stay. Since observation treatment does not count toward this three-day requirement, a patient treated for an extended period on an observation basis and then discharged to an SNF would incur significant charges for the SNF admission. These concerns gave rise to the Part A to Part B Rebilling Demonstration and eventually to the Proposed Rule.

PRACTICAL TAKEAWAYS

The Ruling and Proposed Rule address a vital issue for hospitals – fair reimbursement. Following are key points and recommendations:

- Hospitals currently participating in the Part A to Part B Rebilling Demonstration should review all forthcoming notices addressing the early termination of the program.

- Hospitals should look for future operational and regulatory guidance addressing how they should bill for Part B inpatient and Part B outpatient services under the Ruling. For example, hospitals denied payment for inpatient services may bill separately on a Part B outpatient claim for any outpatient services provided during the three-day payment window (or one-day payment window for non-IPPS hospitals).

- A hospital denied payment for an inpatient admission must *choose* between submitting a Part B claim for reasonable and necessary services rendered *or* maintaining its request for payment of services on a Part A claim. Hospitals cannot simultaneously maintain requests for payment under both Parts A and B for the same services, provided to one Beneficiary on the same dates of service.

- Hospitals should consider submitting comments on the Proposed Rule.

- Once the Proposed Rule is finalized, the Ruling will expire. There may be differences in the policies incorporated in the Final Rule.

Possible False Claims Act Implications

The confusion in hospital billing for observation patients has been a field ripe for plucking by False Claims Act ("FCA") whistleblowers. The lack of clarity, combined with Medicare's previous position that such claims were improperly billed and non-payable, leads to FCA complaints that cannot be defeated at the Motion to Dismiss and that are even likely to survive Motions for Summary Judgment. The new policy, which effectively acknowledges inaccurate inpatient billing as a correctable mistake rather than a fraudulent bill, adds an additional and persuasive layer to the defense of an FCA action. Where the issue is the defendant's knowledge of the falsity of a claim, the combination of Medicare's repeated and inconsistent attempts to clarify the rule with its new policy that an inaccurate claim is not non-payable and to be rejected outright, but rather payable at a lower rate upon resubmission, may provide a persuasive basis for a finding that the original bill, even if for more than would ultimately be paid, is a mistake rather than a knowing fraud. This, depending upon the facts of each individual case, might

be enough to allow a defendant to prevail at the summary judgment stage, rather than face the risks of a trial or get forced into expensive settlement to avoid those risks.

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

- Adele Merenstein at 317-752-4427 or amerenst@hallrender.com;
- Keith Barber at 317-977-1428 or kbarber@hallrender.com;
- David Honig at 317-977-1447 or dhonig@hallrender.com; or
- Your regular Hall Render attorney.