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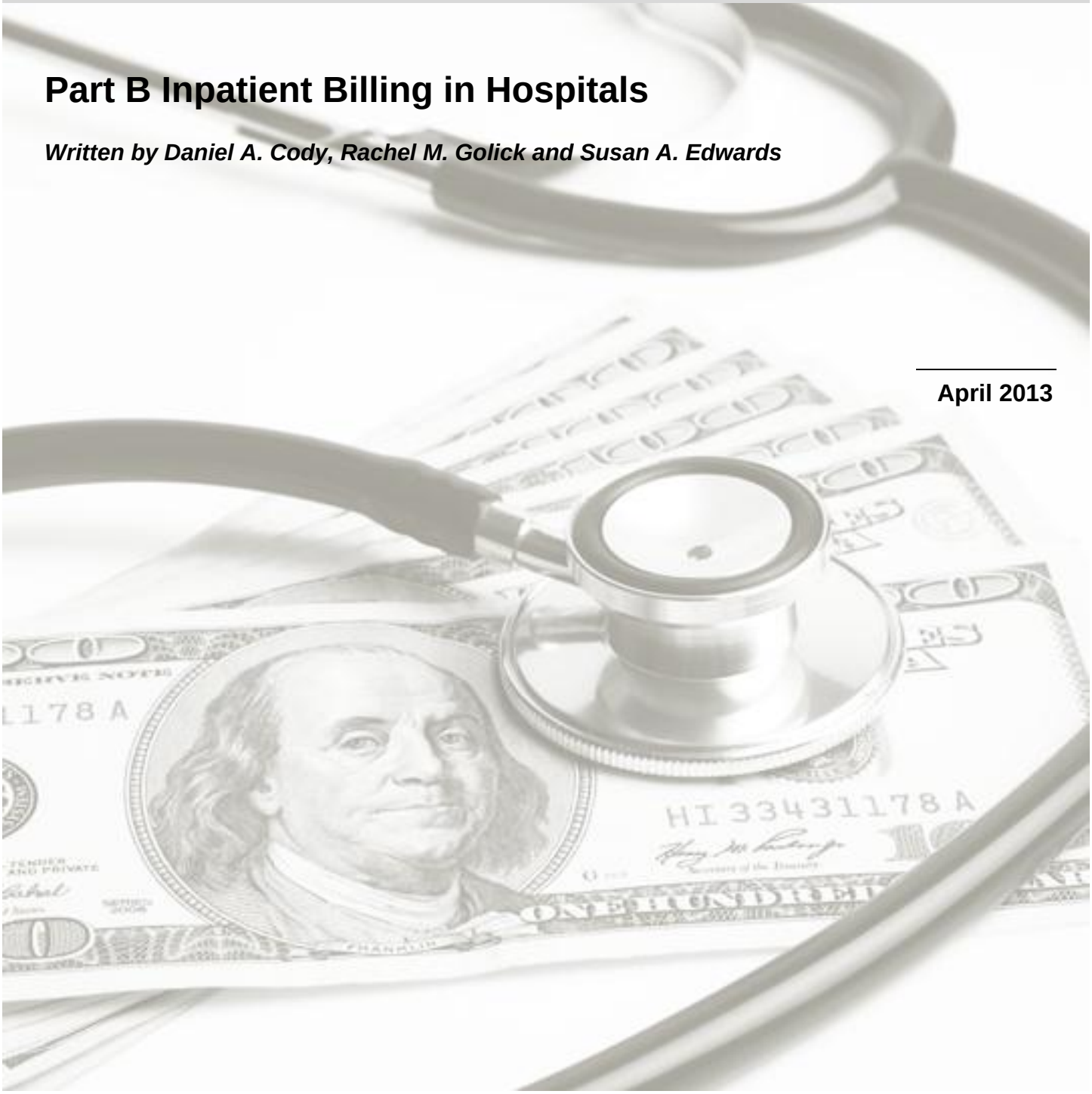
Part B Inpatient Billing in Hospitals

Written by Daniel A. Cody, Rachel M. Golick and Susan A. Edwards



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Introduction

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) concurrently issued CMS Ruling Number CMS-1455-R (the Administrator's Ruling) and a proposed rule, "Part B Inpatient Billing in Hospitals" (the Proposed Rule).[1] The Administrator's Ruling and Proposed Rule address the submission of Medicare Part B inpatient claims where a Medicare Part A claim for a hospital inpatient admission is denied by a Medicare review contractor, on the grounds that the inpatient admission was not "reasonable and necessary." The Proposed Rule also would apply to situations where a hospital determined, through a self-audit, that an inpatient admission was not "reasonable and necessary." The Administrator's Ruling, effective as of the issuance date, establishes an interim policy to handle payment for Medicare Part B inpatient claims until CMS finalizes the Proposed Rule. The Proposed Rule would set forth a permanent regulatory scheme to permit hospitals to rebill Medicare for a wider range of Part B services than is currently permitted following denial of a Part A claim.

The impact and utility of the Proposed Rule is substantially diminished by the timeframe in which providers are allowed to resubmit Part B claims – one year after the date of service. In many cases, providers do not receive denials of Part A claims within one year of the date of service. Consequently, the one year deadline would restrict some providers wanting to resubmit Part B claims from taking advantage of the more permissive Part B resubmission framework contemplated by the Proposed Rule. Pursuant to the Proposed Rule, hospitals would be able to either: (1) appeal the denied Part A claim; *or* (2) resubmit Part B claims. Because a hospital's resubmission of Part B claims would bar a Part A appeal, the Proposed Rule may deter hospitals, eager for a successful Part A appeal, from resubmitting Part B claims. Finally, pending legislation would mandate a reduction in the number of Medicare audit contractor reviews conducted on a facility annually, potentially leading to even greater delays between the date of service and an audit contractor's decision that a Part A claim is not "reasonable and necessary." The potential consequence of the aforementioned pending legislation creates even further doubt regarding the practicality of the Proposed Rule.

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[1] CMS Ruling, CMS-1455-R (Mar. 13, 2013), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf; Part B Inpatient Billing in Hospitals, 78 Fed. Reg. 16632 (proposed Mar. 18, 2013) (to be codified at 42 C.F.R. §§,414.5, 419.21, 419.22), available at http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf.

Background

Current CMS policy permits hospitals to rebill for only a limited set of medical and other health services in a subsequent Part B inpatient claim, after a Medicare review contractor determines that the inpatient admission was not "reasonable and necessary."[2] According to the Proposed Rule's preamble, hospitals have expressed concern that current CMS policy, allowing rebilling for only the limited list of Part B services - listed in Chapter 6, Section 10 of the *Medicare Benefit Policy Manual* - does not adequately cover the resources expended for the care furnished to patients.[3] Hospitals have also indicated that they often lack the time and resources to confirm a physician's decision to admit a patient as an inpatient, and thus are unable to change the status of certain short-stay patients from "inpatient" to "outpatient" prior to discharging such patients.[4]

The preamble to the Proposed Rule also discusses the increasing trend of hospitals furnishing observation services to Medicare beneficiaries for more than 48 hours, noting that in 2011, approximately 8 percent of Medicare beneficiaries received observation services in excess of 48 hours.[5] CMS comments that this practice may be in response "to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be determined not reasonable and necessary and denied upon contractor review."[6] CMS also notes that there could be "significant financial implications" for beneficiaries receiving hospital care as an outpatient rather than an inpatient, both because of beneficiaries' different cost-sharing responsibilities under Part A and Part B, and Medicare's three-day hospital inpatient stay requirement in order for a beneficiary to qualify for Part A coverage of a post-hospital skilled nursing facility (SNF) stay.[7]

In addition to the above, CMS has witnessed an influx of Administrative Law Judge (ALJ) and Medicare Appeals Council (MAC) decisions upholding Medicare review contractors' decisions denying inpatient admissions as not

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[2] *Internet Only Manual* (IOM) Pub. 100-02, *Medicare Benefit Policy Manual* (MBPM), Ch. 6, § 10. Note that CMS permits hospitals to rebill a limited set of Part B inpatient services, or "ancillary services" when there was no Part A coverage for other reasons as well, such as the patient was not otherwise eligible for, or entitled to coverage under Part A.

[3] 78 Fed. Reg. 16632, 16634 (Mar. 18, 2013).

[4] *Id*.

[5] *Id*.

[6] *Id*.

[7] *Id.* at 16634-16635.

"reasonable and necessary" under Part A, but ordering payment of *all* services at issue under Part B as though they were rendered at an outpatient level of care. In those cases, the ALJs and MAC have required payment regardless of whether the subsequent Part B inpatient claim is submitted within the otherwise applicable time limit for filing a Part B claim.[8]

The Administrator's Ruling

The Administrator's Ruling notes that ALJ and MAC decisions upholding the Part A denial, but ordering payment of *all* services at issue under Part B as though they were rendered at an outpatient level of care regardless of when the hospital furnished the services, defy current Medicare regulations and guidance limiting such payment to a small set of outpatient services during a set, timely filing timeframe. Yet in the ruling, CMS' acting administrator acquiesces, at least temporarily, to the approach taken by the ALJs and the MACs, allowing hospitals to submit Part B inpatient claims for payment for nearly all reasonable and necessary services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient (with the exception of Part B services that specifically require outpatient status, such as outpatient visits, emergency department visits, and observation services).[9]

Among other interim changes meant to alleviate operational difficulties caused by the ALJ and MAC decisions, pending promulgation of final regulations addressing this issue, the Administrator's Ruling also allows hospitals to bill separately for certain outpatient services, provided during the three-day payment window prior to the denied inpatient admission, as the outpatient services they were, including observation and other services.[10] These services may not be included on the Part B inpatient claim, but may be billed on a Part B outpatient claim.

The Administrator's Ruling applies to Part A hospital inpatient claims denied by review contractors as not "reasonable and necessary," so long as the denial was made: (1) while the Administrator's Ruling was in effect; (2) prior to the Administrator's Ruling's effective date, but while the timeframe to file an appeal remains open or an appeal is currently pending. The Administrator's Ruling does *not* apply to inpatient admissions that the hospital, itself, has deemed to be not "reasonable and necessary" through, for example, a self-audit.[11]

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[8] CMS Ruling, CMS-1455-R (Mar. 13, 2013), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf.

[9] *Id.* at 7.

[10] *Id.* at 10-11.

[11] *Id.* at 11.

Under the Administrator's Ruling, hospitals may choose to withdraw pending appeals of inpatient admission denials (or choose not to pursue an appeal to the next level) and submit Part B inpatient claims instead.[12] In that instance, the hospital must submit its request for withdrawal of a pending Part A appeal to the adjudicator with whom the appeal is pending (e.g., ALJ or MAC). Hospitals may not use both procedures simultaneously, and once a hospital decides to submit a Part B claim, it will be barred from appealing the Part A denial. Hospitals will have 180 days to submit a Part B claim following:

- The date of receipt of a final or binding unfavorable review decision, where the hospital does not appeal
- The date of receipt of an appeal dismissal, where the hospital withdraws
- The date of receipt of an unfavorable appeal decision where the hospital does not withdraw[13]

Even where hospitals choose to submit Part B claims, the beneficiary's status would remain as an inpatient as of the time of the inpatient admission, and would not be changed to outpatient.[14]

For purposes of the Administrator's Ruling, subsequent Part B rebilling is achieved using adjustment billing, meaning Part B claims filed later than one calendar year after the date of services will not be rejected as untimely, so long as the corresponding Part A inpatient claim was timely filed under 42 C.F.R. Section 424.44.[15]

Finally, the Administrator's Ruling limits ALJ and MAC review of Part A inpatient claim denials to the claims at issue, barring them from ordering payment of Part B services that have not yet been billed.[16] Appeals of Part A claim denials that were remanded from the ALJ level to the qualified independent contractor (QIC) level will be returned to the ALJ for adjudication of the Part A claim appeal consistent with this scope of review.[17]

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[12] *Id.*

[13] *Id.* at 11-14.

[14] *Id.* at 15.

[15] *Id.* at 13.

[16] *Id.* at 14-15.

[17] *Id.* at 11-12.

The Proposed Rule

As stated above, current Medicare policy allows hospitals to rebill Medicare Part B for only a limited set of "ancillary services," listed in chapter 6, section 10 of the *Medicare Benefit Policy Manual*, when Part A coverage is denied for certain reasons. The Proposed Rule would expand the services that hospitals could rebill as Part B inpatient services when Part A coverage is denied as not "reasonable and necessary," or when a hospital determines, through a self-audit, that a beneficiary should have received outpatient services rather than inpatient services. Notably, the rebilling option would not apply when Part A coverage is denied for reasons other than the claim is not "reasonable and necessary."

The Proposed Rule would allow for hospital rebilling and payment of reasonable and necessary services that CMS pays for under the Hospital Outpatient Prospective Payment System (OPPS), but would exclude any such services that specifically require an outpatient status, including: outpatient physical therapy services, outpatient speech-language pathology services, emergency department visits, and observation services. Part B payment for any reasonable and necessary Part B services would be made pursuant to the respective Part B fee schedules or, for certain services, the other applicable payment methodologies.[18]

Similar to the Administrator's Ruling, the preamble to the Proposed Rule clarifies that the Proposed Rule would permit hospitals to bill separately for certain outpatient services provided during the three-day payment window prior to the denied admission. However, unlike the Administrator's Ruling, the Proposed Rule would impose a one-year timely filing deadline. In other words, a hospital would have to bill Part B claims within one calendar year of the date of service. The Proposed Rule's preamble includes the reminder that a provider may not appeal a determination that the provider failed to submit a claim timely.

As stated above, pursuant to the Proposed Rule, when a contractor denies a Part A claim, hospitals would be able to either: (1) appeal the denied Part A claim; *or* (2) resubmit Part B claims. The Proposed Rule's preamble explains that prior to a hospital submitting a Part B claim, it must ensure that there is no appeal pending related to the associated Part A claim, including an appeal filed by a beneficiary. If a hospital submits a Part B claim and there is an appeal pending related to the Part A claim, the Medicare contractor would deny the Part B claim as a duplicate.

The Proposed Rule's preamble also discusses beneficiary liability under the Proposed Rule, noting that a beneficiary would be liable for the applicable deductible and co-payment amounts for any Part B services a

[18] 78 Fed. Reg. 16632, 16637 (Mar. 18, 2013). Services for which payment is made under other payment methodologies include: ambulance services and clinical diagnostic services.

hospital rebills pursuant to the Proposed Rule. This means that beneficiaries could receive unexpected hospital bills for up to a year after a hospital furnished services. While the Proposed Rule does not specifically address whether services a hospital rebills as Part B inpatient services could satisfy the three-day hospital inpatient stay requirement for Part A coverage of a post-hospital SNF stay, according to an article published by *Inside Health Policy*, CMS has stated that because claims would be rebilled as inpatient services, a three-day or longer hospital stay could fulfill the aforementioned requirement.[19]

The Proposed Rule would apply to all hospitals billing Part A services, including short-term acute care hospitals, hospitals paid under the OPPS, long-term acute care hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, critical access hospitals, children's hospitals, cancer hospitals, and Maryland waiver hospitals. CMS solicits comments from hospitals that do not submit claims for outpatient services under Medicare Part B regarding what types of Part B inpatient services such hospitals potentially would bill under CMS' proposal to expand the Part B inpatient services hospitals may rebill.[20]

Comments to the Proposed Rule are due May 17, 2013.

Implications of the Proposed Rule

The Proposed Rule's Short Timeframe for Submitting Part B Claims Substantially Reduces the Utility of the Rule

As discussed above, under the Proposed Rule, a hospital wishing to submit a Part B claim following denial of a Part A inpatient admission claim must do so within one year of the date of service for the underlying claim.[21] In addition, hospitals are forced to choose between appealing the decision – and potentially obtaining the full Part A payment – or foregoing the appeal and rebilling for a lower Part B payment.

However, hospitals' ability to take advantage of the Proposed Rule's expansion of Part B services eligible for payment after a Part A denial is severely hindered by the slow pace of Medicare contractor review. Due to the high volume of reviews being undertaken by Medicare contractors, claims are typically not reviewed by a Medicare contractor until *more than* one year after the date of service. As a result, in many cases, hospitals will not receive a Part A inpatient denial within the timeframe in which the hospital is permitted to rebill those services

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[19] Michelle M. Stein, "Seniors Could Be Hit With Unexpected Bills A Year After Hospitalizations Under Proposed Rule," *Inside Health Policy*, Mar. 26, 2013.

[20] 78 Fed. Reg. 16632, 16638 (Mar. 18, 2013).

[21] Id. at 16640.

as Part B claims under the Proposed Rule. Moreover, the Proposed Rule bars hospitals from concurrently appealing the Medicare review contractor's decision and resubmitting a Part B claim.[22]

CMS acknowledges that the one-year filing deadline imposed by the Proposed Rule would substantially reduce the number of Part B claims that could be rebilled by hospitals and insists the Proposed Rule, as drafted, will offset the cost of the prior ALJ and MAC decisions and the Administrator's Ruling.[23] The American Hospital Association (AHA), one of many critics of the short timeframe for resubmission of Part B claims, filed a lawsuit in November 2012 challenging Medicare's current policies for the rebilling of denied hospital inpatient claims.[24] The AHA alleges that CMS' policy is contrary to 42 U.S.C. Section 1395k(a)(2), which requires coverage of all reasonable and necessary medical services, and argues that Medicare review contractors are not questioning the *necessity* of the care, but take issue only with the inpatient setting of care.[25] Upon issuance of the Proposed Rule, CMS sought a stay of the lawsuit from the D.C. District Court, but on March 22, 2013, the court granted AHA leave to file an amended complaint. AHA has stated it will continue to pursue the litigation.

High Success Rates on Appeals of Denied Claims Provide Little Incentive to Risk Foregoing Appeal Rights

Further compounding the problems inherent in the restrictive deadlines of the Proposed Rule is the high rate of successful appeals reported by hospitals challenging Medicare review contractor (such as Recovery Audit Contractor (RAC)) denials on medical necessity and other grounds. While CMS does not consistently make public data regarding the impact of the RAC program (or other such audit programs) on hospitals, the AHA conducts a voluntary survey of hospitals experiencing RAC audits and appeals (the "RACTrac"). According to the Q4 2012 RACTrac survey, hospitals participating in the survey faced significant increases in RAC denials and medical record requests.[26] Hospitals subject to complex reviews of medical records reported that the most

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[22] *Id.*

[23] *Id.* at 16643.

[24] *See American Hospital Assoc., et al. v. Sebelius*, Case No. 1:12-cv-01770 (D.D.C., Complaint filed Nov. 1, 2012) ("Complaint").

[25] *See, e.g.*, Complaint at ¶¶ 86-90.

[26] Exploring the Impact of the RAC Program on Hospitals Nationwide: Results of AHA RACTrac Survey, 4th Quarter 2012 at 14 (Mar. 8, 2013) (noting 1,233 hospitals nationwide participated in the RACTrac survey during 4Q 2012), available at www.aha.org/content/13/12Q4ractracresults.pdf (RACTrac Results).

common reason cited for denials following complex reviews was "short-stay medically unnecessary."[27] Of these denials, nearly 70 percent were denied because the care was provided in the wrong setting (i.e., inpatient as opposed to outpatient), not because the care was not medically necessary.[28]

One-third of hospitals surveyed that chose to appeal RAC denials, reported having a denial reversed during the discussion period.[29] While many appeals languish in the administrative appeal process, according to AHA's RACTrac survey, 72 percent of all denials appealed by surveyed hospitals nationwide were overturned in the provider's favor during the fourth quarter of 2012.[30] Of these, more than 50 percent of reporting hospitals had a RAC denial reversed because the care was found to be medically necessary on appeal.[31]

Notably, however, CMS, in its fiscal year 2011 report to Congress regarding Recovery Auditing in the Medicare and Medicaid programs, estimated the nationwide rate of overturn for all denied Part A and Part B claims appealed by providers to be closer to 44 percent during fiscal year (FY) 2011.[32] According to CMS, complex reviews only have a 20 percent overturn rate on appeal.[33]

While data from the audits and appeal process of other Medicare review contractor programs may not be widely available or consistent, the RACTrac survey and CMS' report to Congress indicate that hospitals challenging Part A denials for lack of medical necessity have a fair chance of obtaining a reversal of the denial on appeal. As a result, hospitals may have less incentive to forego their appeal rights, as is required under the Proposed Rule, to enable them to resubmit the claims under Part B.

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[27] *Id.* at 33.

[28] *Id.* at 35.

[29] *Id.* at 46.

[30] *Id.* at 51 (this figure is not limited to appeals for lack of medical necessity).

[31] *Id.* at 53.

[32] *See* RAC Report at 10.

[33] *Id.* at 11. Note, however, that CMS' statistics from FY 2011 are based on providers' appeal of 52,422 claims through at least the first level of the appeal process. The RACTrac survey is based on approximately 106,000 appeals filed by 2012. The 72 percent overturn rate cited by the AHA is based only on appeals actually decided to date and does not include nearly 80,000 appeals still pending as of the survey date.

Potential Impact of Proposed Legislation to Cap Audits of Medicare Claims

On March 19, 2013, one day after publication of the Administrator's Ruling and Proposed Rule, Congressmen Sam Graves (R-MO) and Adam Schiff (D-CA) reintroduced a bill that would restrict Medicare review contractor audits of hospitals' Medicare claims.[34] As originally introduced, the legislation would apply to RACs, Medicare administrative contractor, zone program integrity contractors (ZPICs), and Comprehensive Error Rate Testing (CERT) contractors.[35] The proposed legislation, titled "Medicare Audit Improvement Act," also seeks to financially penalize Medicare contractors for failing to follow mandated procedures, such as regulatory timeframes for completing audits.[36] The legislation was prompted by the recent spike in document requests issued by RACs seeking to recover purported overpayments. In so doing, RACs have increased exponentially the administrative demands on hospitals of all sizes.

FY 2011 was the first year recovery auditors actively reviewed short-stay inpatient hospital admissions, which the Secretary of the Department of Health and Human Services asserts represent a "significant" portion of Medicare's fee-for-service error rate.[37] While these legislators seek to limit the impact of RAC audits, CMS continues to explore options for expanding the RAC program.[38]

Under the proposed legislation, Medicare auditors would only be permitted to request additional documents relating to two percent of the hospitals' Medicare claims, with a maximum of 500 additional document requests

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[34] *See* H.R. 6575 (introduced Oct. 16, 2012), available at http://www.gpo.gov/fdsys/pkg/BILLS-112hr6575ih/pdf/BILLS-112hr6575ih.pdf (Original Bill).

[35] *Id.* at 3. The text of the bill as reintroduced March 19, 2013, H.R. 1250, was not publicly available as of the date of writing.

[36] *Id.* at 5-6; *see also* Website of Congressman Sam Graves, "Reps. Graves and Schiff Introduce Bipartisan Legislation to Improve Medicare Audit System," Mar. 19, 2013, available at http://graves.house.gov/latest-news/reps-graves-and-schiff-introduce-bipartisan-legislation-to-improve-medicare-audit-system/ (Graves Statement).

[37] Recovery Audit Contracting in the Medicare and Medicaid Programs for Fiscal Year 2011: FY 2011 Report to Congress as Required by Section 1893(h) of the Social Security Act for Medicare and Section 6411c of the Affordable Care Act for Medicaid (Feb. 5, 2013), available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/rac/ (RAC Report).

[38] RAC Report at 14.

during any 45-day period (this number would be capped at a lower number of requests for smaller hospitals).[39] The bill may also limit auditors' ability to conduct reviews of hospitals lacking a history of incorrect claims and require physicians to authorize payment denials made by non-physician contractors on the grounds that treatment was not medically necessary.[40]

The bill, as noted above, also seeks to increase transparency of contractor activity. Contractors would be required to post their performance figures annually and would suffer financial penalties for failure to follow regulatory requirements (e.g., meeting audit deadlines, timely communication with providers).[41] Contractors, which are currently compensated at a rate of 9 to 12 percent of all overpayments they recover, would also be required to pay a fee to any hospital prevailing in an appeal of the contractor's determination.[42]

While the precise impact and likelihood of passage of this proposed legislation is currently unclear, it would at a minimum, reduce audit activity for hospitals and other providers.

[39] Original Bill at 2; *see also* Graves Statement.

[40] Original Bill at 28-32.

[41] Original Bill at 6.

[42] *Id.* at 6-7; *see also* RAC Report at 3.