PUBLICATION

CMS Revises Part B Billing Policy for Unnecessary Inpatient Admissions [Ober|Kaler]

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For many years, CMS policy has been that, if an inpatient admission was denied for medical necessity reasons, the hospital could bill under Part B for only a limited set of services that, significantly, included neither therapeutic procedures nor observation or other services requiring an outpatient status. Many hospitals that have appealed these denials have convinced the ALJs that, even if the inpatient admission was denied, the hospital should nonetheless be paid as if the patient was an outpatient, providing payment for the full range of outpatient services.

In response to these ALJ decisions, CMS has now taken steps to address this issue of how hospitals may bill for Part B services for those inpatient admissions that have been found to be medically unnecessary. On March 13, 2013, CMS issued both Ruling CMS-1455-R and a proposed rule, which were published in the Federal Register on March 18, 2013. While these purport to provide a modicum of relief to hospitals, that relief is not as broad as might first appear.

The Ruling

The Ruling, which is effective immediately and until such time as a final rule is published, applies to situations where:

- a Medicare contractor has denied a claim because the inpatient admission is determined to be not reasonable and necessary; and
- the denial occurs while the Ruling is in effect, or prior to the effective date of the Ruling but for which either an appeal is pending or the timeframe for appeal has not expired.

For these situations, the hospital may submit two kinds of Part B claims. The first is a "Part B inpatient claim" for services that would have been payable had the beneficiary originally been treated as an outpatient, **except for** services that specifically require an outpatient status (e.g., observation, emergency department visits, and outpatient visits). This would include any therapeutic procedures. The second is a separate outpatient Part B claim for any services provided prior to the inpatient admission, including pre-admission services that were rolled into the inpatient admission under the 3-day window rule. On its face, this would include any observation services, ED and other outpatient visits.

Any such Part B bills must be submitted within the following timeframes:

- if a hospital withdraws a pending appeal for an inpatient denial, within 180 days of the date of receipt of the dismissal notice;
- if a hospital does not withdraw a pending appeal for an inpatient denial, within 180 days of a final, binding unfavorable decision; or
- if a hospital receives a denial and there is no pending appeal and the hospital will not file such an appeal, within 180 days of the initial or revised determination.

Significantly, the Ruling also restricts the ability of ALJs and the Medicare Appeals Council to award payment under Part B if they uphold the denial of the Part A admission, by limiting their scope of review to the medical necessity of the Part A inpatient admission. CMS's position is that Part B outpatient claims are not before the ALJ as part of the appeal of the Part A stay.

Notably, the Ruling only applies to claims denied by a Medicare contractor and does not apply to unnecessary admissions identified by the hospital through self-audit. CMS appears to have wanted to prevent an onslaught of bills from hospitals for the expanded set of Part B services.

Finally, the Ruling indicates that the patient's status remains as “inpatient” as of the date of the admission, even though the inpatient admission has been denied. CMS states that the beneficiary “is considered an outpatient for services billed on the Part B outpatient claim, and is considered an inpatient for services billed on the Part B inpatient claim.” The patient status as inpatient is important, as it will permit patients who have been in the hospital for three days to qualify for post-discharge skilled nursing facility (SNF) care. Prior to the Ruling, many beneficiaries were surprised to learn they did not have a 3-day qualifying hospital stay, and therefore did not have coverage for their SNF stay, even though they had been physically present in a hospital bed for three or more days.

The Proposed Rule

In its proposed rule, CMS purports to codify much of the policy set forth in the Ruling: hospitals that receive medical necessity denials from the Medicare contractor would be able to submit a Part B inpatient bill for the expanded list of Part B services. They would also be able to submit a Part B outpatient claim for services requiring outpatient status, including preadmission services that were rolled into the admission under the 3-day window rule.

Unlike the Ruling, however, the proposed rule would permit a hospital to bill for the expanded list of Part B services in situations where the hospital determines on its own, prior to billing but after a patient is discharged, that the admission was not medically necessary. While this sounds like a great expansion, there is a catch: under the proposed rule, **any Part B claims must be submitted within one year of the date of service**. Needless to say, the initial denial of a Part A claim may not even take place within one year, and it is not conceivable that the hospital could obtain an ALJ decision on that denial within one year of the date of service. Thus a hospital must, in effect, choose between billing under Part A and appealing any subsequent medical necessity denial on the one hand, or billing the initial claim under Part B and foregoing the Part A stay on the other hand.

Additionally, as with the Ruling, the proposed rule purports to limit the scope of review by ALJs and the Medicare Appeals Council to the medical necessity of the Part A inpatient admission. The ALJ and Medicare Appeals Council would not be permitted to award payment for post-admission Part B services if they uphold the denial of the Part A claim.

Comments

CMS's Ruling and proposed rule were accompanied by agency statements that heralded the actions as good news for providers. According to these statements, CMS was acquiescing to the many ALJ and Appeals Council decisions that had ruled against the agency and had awarded Part B payments for a broad number of outpatient services following a Medicare contractor's denial of a Part A admission as medically unnecessary. To be sure, there is some good news in the CMS Ruling and proposed rule in that CMS has expressed a willingness to make payment for a somewhat broader scope of Part B services than it has been willing to pay

in the past. That said, the conditions that CMS has placed on providers' obtaining this relief are numerous and significantly lessen the benefits that the revised policies confer. Providers would be well-advised to study both documents carefully and to take the opportunity to comment on the content of the proposed rule. **Comments are due by May 17, 2013.**