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# BILLING FOR AND APPEALING DENIALS OF INPATIENT HOSPITAL SERVICES

*Where have we been? Where are we now? What does the future hold?*

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Over the past eight years, hospitals' submission of short stay inpatient claims has been subject to progressively-increasing scrutiny, predominantly due to the high error rate identified by Comprehensive Error Rate Testing ("CERT") contractors related to the setting of care as well as the aggressive auditing efforts of recovery auditors (previously named Recovery Audit Contractors ("RACs")) and more recently by Medicare Administrative Contractors ("MACs"). This article examines the requirements for inpatient admissions versus outpatient hospitalizations and the corresponding reimbursement implications, as well as the history of the Centers for Medicare & Medicaid Services ("CMS") recovery audit program, its focus on Part A inpatient hospital claims, and its effect on inpatient claim denials and appeals. This article also describes recent changes to federal regulations and CMS policy related to billing for inpatient admissions and inpatient claim appeals, which will impact hospitals' decisions regarding whether to admit patients as "inpatients" and potentially impact reimbursement.

## Background

### Reimbursement for Medicare Part A and Part B Claims

In order to appreciate the rationale supporting the heightened scrutiny of inpatient hospital claims, one must consider the differences in CMS reimbursement for Medicare Part A and Part B claims. Generally speaking, the CMS Fee-for-Service ("FFS") program provides hospital insurance (Medicare Part A) and supplementary medical insurance (Medicare Part B) to eligible beneficiaries. Medicare Part A provides coverage for inpatient hospital services.<sup>1</sup> Medicare Part B provides coverage for "medical and other health services" that are not covered by Part A, including outpatient services.<sup>2</sup> CMS excludes from coverage (under both Medicare Part A and Part B) items or services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."<sup>3</sup> This exclusion includes services provided in an inappropriate setting.<sup>4</sup>

For many hospitals (i.e., those compensated via the prospective payment system ("PPS")), reimbursement

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for Medicare Part A claims is based on a predetermined rate-per-discharge, classified by Diagnosis Related Group (“DRG”). The DRG reimbursement rate is intended to provide payment in full to the hospital for its inpatient operating costs.<sup>5</sup> Significantly, DRG reimbursement is not related to a patient’s length of stay in the hospital (i.e., a hospital receives the same DRG reimbursement regardless of whether the patient’s hospital course spans one day or spans several days). Because of this, a hospital receives more valuable reimbursement for inpatient admissions of shorter duration.

Conversely, hospitals are not reimbursed according to a predetermined rate-per-discharge for outpatient services. Rather, CMS assigns all HCPCS codes<sup>6</sup> for which Medicare Part B payment may be made into groups known as Ambulatory Payment Classifications (“APCs”). Hospitals may be paid for more than one APC during a hospital stay, depending on the services rendered.<sup>7</sup> In most cases, CMS reimbursement for a Medicare Part A inpatient claim based on an assigned DRG is higher than the reimbursement for a Medicare Part B outpatient claim based on assigned APCs for the same care.<sup>8</sup>

CMS processes over one billion Medicare Part A and Part B claims each year.<sup>9</sup> According to data compiled by the Department of Health and Human Services (“HHS”), during fiscal year 2011, approximately 8.6 percent of Medicare Part A and Part B claims resulted in improper payments.<sup>10</sup> Of these, a significant percentage (i.e., over 20 percent) were found to be “improper payments,” not because the services rendered were medically unnecessary, but rather because the care was provided in an inappropriate “setting” (i.e., inpatient versus outpatient). In other words, the claims most likely would have been approved (and would not have resulted in “improper payments”)

if billed as outpatient claims under Medicare Part B.<sup>11</sup> The purported improper payment rate is particularly staggering for Part A inpatient hospital claims of short duration. With respect to claims submitted during fiscal year 2012 (during which time the Medicare FFS program was estimated to have an 8.5 percent error rate),<sup>12</sup> CMS determined that Part A claims for inpatient hospital stays spanning one day or less resulted in an improper payment rate of 36.1 percent. This improper payment rate declined to 13.2 percent for two-day hospital stays, 13.1 percent for three-day hospital stays, and eight percent for hospital stays spanning four days or more.<sup>13</sup>

Because of the robust reimbursement hospitals receive for short stay inpatient hospital claims, hospitals’ submission of Medicare Part A inpatient claims (particularly for one-to-two day hospital stays) has been subject to intense and progressively increasing audit scrutiny.<sup>14</sup> Notably, when a CMS contractor denies a Medicare Part A claim for inpatient hospital services because it finds that care was provided in an inappropriate “setting” (i.e., the inpatient “setting” rather than the outpatient “setting”), the contractor does not adjust the claim to provide coverage for the services rendered as if the care were provided in the appropriate “setting.” Rather, the claim is fully denied and the hospital does not receive any reimbursement whatsoever for the care provided.

Historically, following an inappropriate “setting” denial, CMS has allowed hospitals to re-bill the Part A claim under Medicare Part B, but only for “ancillary services” – not emergency department (“ED”) services, observation services or surgical procedures – and only if timely filing regulations were satisfied,<sup>15</sup> a policy that has been described by industry stakeholders as CMS’ “Payment Denial Policy.”<sup>16</sup> Given the practical

effects of the timely filing limitations, in practice the CMS Payment Denial Policy has totally denied hospitals reimbursement for services rendered, a result particularly troubling given that in many cases the recovery auditors (as well as MACs and qualified independent contractors (“QICs”))<sup>17</sup> acknowledge that the care rendered was appropriate (i.e., the specific interventions provided were reasonable and medically necessary). Prior to March 13, 2013, following an inappropriate “setting” denial, hospitals were able to pursue appropriate reimbursement through the five-stage Medicare appeals process. CMS has abandoned its absolute Payment Denial Policy; however, given the contents of the 2014 Inpatient Prospective Payment System (“IPPS”) Final Rule (the “2014 IPPS Final Rule”), which was effective October 1, 2013, it is unclear whether hospitals will be afforded the opportunity in the future to receive complete reimbursement for medically necessary care provided in the event that they receive denials based on an inappropriate “setting.”<sup>18</sup>

## Statutory, Regulatory and CMS Policy Standards for Billing of Inpatient Admissions and Outpatient Services

In order to avoid Part A inpatient claim denials based on the “setting” of care, hospitals must rely on applicable provisions of the Social Security Act, implementing regulations and CMS policy setting forth the criteria for appropriate billing of inpatient admissions and outpatient or outpatient observation services. The applicable authorities are often found by hospitals to be vague, overlapping and inconsistently applied by auditors and appellate review entities, creating challenges for hospitals attempting to remain in compliance with CMS requirements and avoid Medicare Part A claim denials.

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## Inpatient

Medicare Part A provides benefits for “hospital, related post-hospital, home health services and hospice care” to those meeting certain requirements<sup>19</sup> and covers “inpatient hospital services.” The term “inpatient hospital services” is defined to mean the following items and services furnished by a hospital to an inpatient of the hospital:

1) bed and board;

2) such nursing services and other related services, such as the use of hospital facilities and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements.<sup>20</sup>

Clearly, services meeting the definition of “inpatient hospital services” can be provided to hospital outpatients as well as to inpatients. Therefore, in determining whether an inpatient admission is medically necessary, it is essential to focus on the status of the patient as an inpatient or an outpatient, rather than to focus on the services provided.

Neither the Social Security Act nor applicable implementing regulations define the term “inpatient.”<sup>21</sup> CMS has defined the term “inpatient” in the Medicare Benefit Policy Manual (CMS Publication 100-02), Chapter 1, Section 10:

An **inpatient** is a person who has been admitted to a hospital for bed

occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital

for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital...<sup>22</sup>

This definition of “inpatient” is arguably vague and circular. Consequently, one of the key factors in determining whether an inpatient admission is medically necessary has been the 24-hour benchmark (i.e., the admitting physician’s clinical judgment that a patient will require 24 hours or more of inpatient hospital services). The importance of the 24-hour benchmark is highlighted by CMS criteria governing minor surgeries<sup>23</sup> and “Inpatient Only” procedures,<sup>24</sup> each based in part on the admitting physician’s expectation that a patient will, or will not, require 24 hours or more of “inpatient hospital services.”<sup>25</sup> However, the Medicare Benefit Policy Manual is also clear that admissions of patients are not covered or noncovered solely on the basis of the length of time the patient spends in the hospital. Accordingly, historically there has been no presumption of coverage for inpatient admissions satisfying the 24-hour benchmark.

Intended to provide guidance to medical reviewers of Medicare Part A inpatient hospital claims, the Medicare Program Integrity Manual (CMS Publication 100-08), Chapter 6, Section 6.5.2 describes appropriate inpatient admissions as follows:

The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity

that they can be furnished safely and effectively only on an inpatient basis....

Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.... . See Pub. 100-02, chapter 1, §10 for further detail on what constitutes an appropriate inpatient admission.<sup>26</sup>

Similar language is present in the Medicare Quality Improvement Organization Manual.<sup>27</sup> In many audit-related cases, CMS contractors argue that the Medicare Program Integrity Manual and Medicare Quality Improvement Organization Manual provisions cited herein ought to be applied over the criteria set forth in the Medicare Benefit Policy Manual to determine the appropriateness of an inpatient admission.<sup>28</sup> The contractors in essence focus their retrospective analysis on the specific services provided during the hospital stay, rather than on the appropriateness of the inpatient admission at the time the decision to admit was made.<sup>29</sup>

However, as noted by the Medicare Appeals Council, the foremost criteria to apply in considering whether an inpatient admission is medically necessary (i.e., whether inpatient status is appropriate) are those criteria set forth in the Medicare Benefit Policy Manual (CMS Publication 100-02), Chapter 1, Section 10.<sup>30</sup> As acknowledged by the Medicare Appeals Council, additional CMS Internet-Only Manual provisions, including those in the Medicare Program Integrity Manual and Medicare Quality Improvement Organization Manual, are "of secondary importance, and their contents...overlap with the provisions in section 10, Chapter 1, of the MBPM."<sup>31</sup> Of note, the Medicare Program Integrity Manual (CMS Publication 100-08), Chapter 6, Section 6.5.2 specifically instructs

medical reviewers to consider the criteria set forth in the Medicare Benefit Policy Manual.

#### *Outpatient*

Medicare Part B provides coverage for "medical and other health services," including outpatient services,<sup>32</sup> and excludes items or services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."<sup>33</sup>

Federal regulations define the term "outpatient" as follows:

*Outpatient* means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.<sup>34</sup>

Outpatient hospital services include diagnostic services and "other services that aid the physician in the treatment of the patient."<sup>35</sup> Observation services are one type of outpatient hospital service. The Medicare Benefit Policy Manual (CMS Publication 100-02), Chapter 6, Section 20.6 defines "outpatient observation services" as follows:

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another

individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours....<sup>36</sup>

Highlighting the imprecision of CMS' guidelines, observation services, as defined in the Medicare Benefit Policy Manual (i.e., "short term treatment, assessment and reassessment") also satisfy the statutory, regulatory and CMS policy definitions of "inpatient hospital services" (i.e., diagnostic and therapeutic services ordinarily provided to inpatients). Note that some CMS contractors<sup>37</sup> have expressly acknowledged that in many facilities, there is no distinction between the actual services provided to hospital inpatients and to hospital outpatients receiving observation services, and the distinction is one of billing category, rather than of intensity of services provided.<sup>38</sup>

## **Where Have We Been?**

### **The RAC Demonstration Program**

Medicare Part A short stay inpatient hospital claims scrutiny gained momentum beginning with the RAC demonstration program.<sup>39</sup> The substantial majority (i.e., over 84 percent) of overpayments identified during the RAC demonstration program were based on denials of Medicare Part A inpatient hospital claims.<sup>40</sup> Forty-one percent of the overpayment findings related to Medicare Part A inpatient hospital claims resulted from "the service being rendered in a medically unnecessary setting.... . These are

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situations where the beneficiary needed care but did not need to be admitted to the hospital to receive that care.<sup>41</sup>

Deviating from its historic Payment Denial Policy, during the RAC demonstration program CMS permitted hospitals receiving denials based on the “setting” of services to resubmit Medicare Part B outpatient claims in place of the denied Medicare Part A inpatient claims, irrespective of Medicare’s timely claim submission requirements.<sup>42</sup> However, hospitals were limited to re-billing only the outpatient ancillary services provided (and not the full range of outpatient services rendered), thus providing relatively anemic relief to hospitals.<sup>43</sup>

In order to receive more complete reimbursement for the reasonable and medically necessary care provided, hospitals were limited to pursuing relief through the five-stage Medicare appeals process.<sup>44</sup> In many cases, hospitals were successful.<sup>45</sup> However, in those instances where hospitals were unsuccessful in convincing Administrative Law Judges (“ALJs”) that payment for the services rendered ought to be made under Medicare Part A, some ALJs issued “partially favorable” decisions, ordering the MACs to work with hospitals to allow submission of Medicare Part B claims for the full range of services provided, including, but not limited to, observation services.

CMS took issue with these decisions and pursued what became the landmark case of *In the case of O’Connor Hospital* (decided February 1, 2010) to the Medicare Appeals Council.<sup>46</sup> In this case, a RAC denied a claim for a short stay inpatient hospital admission for the reason that inpatient hospital services were not medically necessary. However, the RAC found that outpatient observation services would have been medically necessary for the care of the beneficiary. Despite

this finding, the RAC denied the claim entirely and did not provide credit for any of the medically necessary services provided. The hospital appealed, and at the ALJ stage of appeal the ALJ issued a “partially favorable” decision. Specifically, the ALJ upheld the denial of Medicare coverage for inpatient hospital services but found that the “observation and underlying care are warranted.” Citing CMS manuals (the provisions of which remain in effect as of the publication date of this article – at a minimum with respect to hospital admissions prior to October 1, 2013),<sup>47</sup> the Medicare Appeals Council found that the ALJ did not err as a matter of law in rendering the partially favorable decision. The Medicare Appeals Council directed the AdQIC<sup>48</sup> to process the ALJ’s partially favorable decision and process a claim for outpatient observation services. Although Medicare Appeals Council decisions do not have precedential value, the analysis contained within the *O’Connor Hospital* decision provided support for many partially favorable decisions throughout the RAC demonstration program and into the permanent recovery audit program, where ALJs and the Medicare Appeals Council ordered reimbursement as if an appellant hospital had submitted a Part B claim for the hospital care provided (including observation services).<sup>49</sup>

## The Permanent Recovery Audit Program

Pursuant to the recovery audit Statement of Work, the mission of the recovery audit program is “to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments.”<sup>50</sup> “Improper payments” are defined to mean, “collectively...overpayments and underpayments.”<sup>51</sup> In their

attempts to identify, detect and reduce “improper payments,” recovery auditors participating in the permanent recovery audit program<sup>52</sup> have maintained a continued focus on inpatient hospital claims. In fact, the top issue audited by each RAC nationwide is whether hospitals have provided services in the correct “setting.”<sup>53</sup>

Consistent with CMS’ Payment Denial Policy, recovery auditors have fully denied claims in situations where the recovery auditors determined that care was provided in an inappropriate “setting.” It should be noted that this result is inconsistent with the recovery auditors’ obligations under the recovery auditors’ Statement of Work.<sup>54</sup> Despite a contract with CMS to the contrary, the recovery auditors have fully denied Part A claims for inpatient hospital services, and have not granted Part B reimbursement for services rendered as if the claims originally were billed as outpatient claims.<sup>55</sup> Arguably, the recovery auditors’ effectuation of the CMS Payment Denial Policy has resulted in a windfall to CMS and to the recovery auditors. A hospital provides medically necessary care; the recovery auditor denies the Medicare Part A claim alleging that the medically necessary care was provided in an inappropriate “setting”; CMS recoups the entire Part A payment; the recovery auditor receives a contingency fee (between 9 and 12.5 percent)<sup>56</sup> based on the entire Part A payment; and the hospital forfeits all compensation for the services rendered.

Contrary to its position during the RAC demonstration program, CMS declined to extend its waiver of the timely filing requirements for re-billing Part B ancillary services in the permanent recovery audit program. In most instances, recovery auditors do not issue overpayment determinations within the one year timeframe for timely filing.

Therefore, prior to March 13, 2013, re-billing under Part B was not an option in most cases following a recovery auditor denial.<sup>57</sup> In order to receive reimbursement for medically necessary services rendered following an inappropriate “setting” denial, hospitals had no option other than to pursue relief through the Medicare appeals process.<sup>58</sup> According to data maintained by the American Hospital Association (“AHA”), hospitals have experienced a 72 percent success rate in the Medicare appeals process,<sup>59</sup> supporting the hospitals’ position that recovery auditors’ findings are often incorrect.

Similar to the way in which recovery auditors review Medicare Part A inpatient claims, MACs at the first stage of the Medicare appeals process and QICs at the second stage of appeal<sup>60</sup> historically have not issued “partially favorable” determinations or even considered hospitals’ alternative requests for reimbursement under Medicare Part B. In contrast, prior to March 13, 2013, citing to federal regulations and the numerous Medicare Internet-Only Manual provisions addressing this issue cited herein,<sup>61</sup> many ALJs found, and the Medicare Appeals Council consistently ordered (in at least 16 published cases dating back to 2005),<sup>62</sup> that where a Part A claim for inpatient hospital services is denied, Part B payment is nonetheless available for reasonable and medically necessary items or services provided.

CMS publicly disagreed with these ALJs’ and the Medicare Appeals Council’s interpretations of the regulations and published Medicare guidance.<sup>63</sup> However, recognizing that its contractors must effectuate ALJ and Medicare Appeals Council decisions, on July 13, 2012, CMS issued a memorandum to its MACs instructing them how to carry out partially favorable ALJ and Medicare Appeals Council decisions.<sup>64</sup>

On March 13, 2013, CMS changed course by publishing CMS

Ruling 1455-R (the “Ruling”), which in part reversed CMS’ longstanding Payment Denial Policy. However, the Ruling also limited the scope of ALJ review, ruling that ALJs may no longer order reimbursement under Part B as an offset against a finding of overpayment under Part A.<sup>65</sup> This position was maintained by CMS in the 2014 IPPS Final Rule.<sup>66</sup>

### Recovery Audit Pre-payment Review Demonstration

On November 15, 2011, CMS announced its recovery audit pre-payment review demonstration aimed to “strengthen Medicare by eliminating fraud, waste, and abuse.”<sup>67</sup> The recovery audit pre-payment review demonstration began on August 27, 2012 in 11 states altogether: the seven states with high populations of fraud and error-prone providers (California, Florida, Illinois, Louisiana, Michigan, New York and Texas) and four states with a high volume of short-stay inpatient hospitalizations (Missouri, North Carolina, Ohio and Pennsylvania). The recovery audit pre-payment review demonstration is scheduled to last three years, ending on August 26, 2015.<sup>68</sup> Under the pre-payment review demonstration, recovery auditors are authorized to review claims before they are paid to ensure that hospitals comply with Medicare payment rules.<sup>69</sup>

Hospitals may find that the recovery audit pre-payment review demonstration creates administrative burdens. The recovery audit pre-payment review demonstration is not intended to replace MAC pre-payment review of Medicare Part A inpatient hospital claims, and such reviews will continue; however, CMS notes that “contractors will coordinate review areas to not duplicate effort.”<sup>70</sup> Additionally, CMS indicates that “for now, limits on pre-payment and post-payment reviews won’t typically exceed current post-payment ADR limits,”<sup>71</sup> which raises questions as to how “typical” the “atypical” situation of exceeding post-payment

ADR limits could become (a result particularly troubling to hospitals that have seen the approved ADR limits increase significantly over time).<sup>72</sup> This auditing is in addition to all other audit programs (e.g., CERT audits, post-payment recovery audits, MAC audits, Supplemental Medical Review Contractor (“SMRC”) audits, Medicaid audits, etc.), further burdening hospitals across the country.

## Where Are We Now?

### Billing for and Appealing Inpatient Hospital Claims After March 13, 2013

On March 13, 2013, CMS concurrently issued its Ruling<sup>73</sup> and a proposed rule (the “Part B Inpatient Billing Proposed Rule”)<sup>74</sup> to revise Medicare Part B billing policies in the event of Part A inpatient claim denials based on the medical necessity of an inpatient admission. While the Ruling and Part B Inpatient Billing Proposed Rule purport to provide hospitals with a mechanism to receive reimbursement for services rendered in the event of a Medicare Part A inpatient claim denial, both the Ruling and Part B Inpatient Billing Proposed Rule were limited, providing an incomplete solution for hospitals.

### CMS Ruling 1455-R

The Ruling was intended to serve as interim guidance effective until CMS finalized its Part B Inpatient Billing Proposed Rule and was made applicable to denials issued (1) while the Ruling was in effect; (2) prior to the effective date of the Ruling where appeal rights had not expired; and (3) prior to the effective date of the Ruling for which an appeal was pending.

The Ruling reiterated CMS’ position that ALJ and Medicare Appeals Council decisions allowing Part B reimbursement for services rendered as an offset against a Part A overpayment were contrary to CMS policy. However, the Ruling acknowledged that CMS was “acquiescing” to such

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ALJ and Medicare Appeals Council decisions.<sup>75</sup> Under the Ruling, when a Part A claim for inpatient hospital services is denied as medically unnecessary, hospitals are permitted to rebill under Medicare Part B as follows:

- The hospital may submit a Part B inpatient claim for services that would have been payable had the patient originally been treated as an outpatient rather than admitted as inpatient. While permissible billing extends beyond “ancillary services,” under the Ruling the hospital *may not bill* for services deemed to require an outpatient status (e.g., emergency department (“ED”) visits and outpatient observation services).<sup>76</sup> Excluding services “requiring an outpatient status,” such as outpatient observation services, from permissible Part B rebilling marks a significant departure from services permitted to be rebilled by many ALJs and the Medicare Appeals Council in the previous appeals environment.<sup>77</sup>
- The hospital may submit a Part B outpatient claim for medically necessary services furnished during the three-day payment window prior to the original inpatient admission, including ED visits and outpatient observation services.<sup>78</sup>

Under the Ruling, Part B billing is not available in situations involving a hospital’s own determination that a service should have been billed under Part B based on a self-audit or utilization review determination.<sup>79</sup>

In order to submit a claim for reimbursement under Part B, a hospital is required to either withdraw any pending Part A appeal or await a final appeal decision.<sup>80</sup> The Office of Medicare Hearings and Appeals posted on its website instructions for withdrawing a Request for ALJ hearing under the Ruling.<sup>81</sup> Under the Ruling, a hospital has 180 days from the date of

the dismissal of appeal previously submitted or most recent unfavorable Part A appeals determination (as applicable) to bill under Part B.<sup>82</sup>

Prior to publication of the Ruling, many ALJs remanded cases to the QIC stage of appeal with orders for the QIC to consider whether the hospitals were entitled to reimbursement under Part B in cases where a Part A inpatient hospital claim was denied as medically unnecessary. Under the Ruling, these cases were ordered to be returned to the ALJ and adjudicated according to the new scope of review defined by the Ruling.<sup>83</sup>

In particular, the Ruling prohibits ALJs from ordering reimbursement under Part B as an offset against a finding of overpayment under Part A. ALJs are permitted only to decide if the Part A claim was medically necessary.<sup>84</sup> This portion of the Ruling is particularly problematic, raising questions as to whether CMS has authority via a ruling (and not formal regulation through notice-and-comment rulemaking) to strip an ALJ of jurisdiction to consider the issues before him or her. Although CMS framed this position as a “clarification” of its longstanding policy, arguably the Ruling changed or restricted (rather than clarified) ALJs’ scope of review, rendering CMS’ position on this issue unsupportable as a matter of law.<sup>85</sup> However, barring federal court intervention, ALJs and the Medicare Appeals Council likely will abide by the Ruling’s provisions.

## *Proposed Rule for Part B Inpatient Billing in Hospitals*

On March 13, 2013 CMS also released its Part B Inpatient Billing Proposed Rule, intended to supersede the Ruling once finalized. The Part B Inpatient Billing Proposed Rule retained many provisions of the Ruling, including the right for hospitals to bill for a more complete range of services under Part B if a Part A claim

for inpatient hospital services is denied as medically unnecessary. However, under the Part B Inpatient Billing Proposed Rule, the circumstances for billing under Part B were significantly narrowed. CMS acknowledged that provisions of the Part B Inpatient Billing Proposed Rule would “greatly limit the capacity in which a hospital could rebill.”<sup>86</sup>

The most limiting (and the most troubling, from the hospitals’ perspective) portion of the Part B Inpatient Billing Proposed Rule was CMS’ position that Part B claims may only be filed within one year from the date of service, irrespective of any subsequent audit determination or appeal pursued.<sup>87</sup> Under the Part B Inpatient Billing Proposed Rule, if an audit determination is not made within one year from the date of service (which will be the circumstance in most audit determinations outside of pre-payment review), a hospital would not be able to avail itself of Part B inpatient billing if a Part A claim is denied as medically unnecessary. CMS would treat the billing as an original claim, not as an adjustment<sup>88</sup> (contrary to the analyses included as part of many of the Medicare Appeals Council decisions cited herein). This provision essentially nullifies the ability of hospitals to be appropriately compensated for medically necessary care provided.

Notably, in the recovery audit program the recovery auditors are authorized to review claims within three years from the claims’ initial payment date.<sup>89</sup> Recovery auditors are compensated on a contingency fee basis, based on the principal amount of overpayment collection (not the overpayment amount identified).<sup>90</sup> Accordingly, the recovery auditors will be financially incentivized to review claims beyond one year from the date(s) of service, prohibiting hospitals from billing under Part B, maximizing the amount of collection

and therefore the amount of their contingency fees.

Deviating from the Ruling, the Part B Inpatient Billing Proposed Rule proposed to allow hospitals that discover inpatient hospital admissions to be medically unnecessary in the course of utilization reviews (i.e., “self-audits”) to rebill these claims under Part B. CMS anticipates that hospitals will increase “self-audits” and rebill under Part B, saving the Medicare program money by reducing the number of Part A claims. CMS also anticipates lower appeal volumes.<sup>91</sup>

#### *2014 IPPS Final Rule*

On August 2, 2013, CMS published its 2014 IPPS Final Rule, which, for the most part adopts the provisions of the Part B Inpatient Billing Proposed Rule without change.<sup>92</sup> The 2014 IPPS Final Rule became effective on October 1, 2013.<sup>93</sup>

##### *– Payable Part B Inpatient Services*

Following a Part A claim denial for an unreasonable and unnecessary inpatient admission, like the Ruling and the Part B Inpatient Billing Proposed Rule, the 2014 IPPS Final Rule allows Part B inpatient rebilling, with certain specified exclusions for services that “should only be furnished to hospital outpatients,” including observation services, outpatient diabetes self-management training (“DSMT”), and hospital outpatient visits (including ED visits).<sup>94</sup> Consistent with the Ruling, to the extent that such services are provided to outpatients in the three-day (one-day for non-IPPS hospitals) payment window preceding inpatient admission, such services may be billed on a Part B outpatient claim.<sup>95</sup> Therapy services are not excluded from Part B inpatient billing under the 2014 IPPS Final Rule.<sup>96</sup>

##### *– Self-Audits*

The 2014 IPPS Final Rule upholds CMS’ proposal to allow Part B inpatient billing in the event that a hospital determines that an inpatient admission was not medically

necessary under Medicare’s utilization review requirements,<sup>97</sup> even if this determination is made following a patient’s discharge from the hospital (i.e., “self-audit”).<sup>98</sup> Although it would seem that this provision of the 2014 IPPS Final Rule replaces the need for and use of “Condition Code 44,”<sup>99</sup> from an operational standpoint if a hospital determines prior to a patient’s discharge that the patient’s status ought to be that of outpatient rather than inpatient and uses Condition Code 44 to effectuate this change, then the hospital will receive more prompt reimbursement for services rendered. In particular, under the 2014 IPPS Final Rule, if a hospital determines that an inpatient admission was not medically necessary pursuant to a self-audit following a patient’s discharge, the following chronology applies:

- The hospital first submits a “no pay/provider liable” Part A claim.
- The hospital then awaits the Part A claim denial.
- Once the Part A claim denial is received, the hospital may submit its Part B inpatient claim.<sup>100</sup>

##### *– Beneficiary Impact*

CMS has acknowledged that the Part B inpatient billing policies formally adopted by the 2014 IPPS Final Rule ultimately may have an adverse financial impact on Medicare beneficiaries,<sup>101</sup> a peculiar result given that one of the primary purposes CMS cites for abandoning its Payment Denial Policy and revising its inpatient admission criteria was the adverse financial impact on Medicare beneficiaries resulting from hospitals’ increased use of outpatient observation services (rather than admitting beneficiaries as inpatients).<sup>102</sup>

Under the 2014 IPPS Final Rule, if a Part A inpatient admission is denied as not reasonable and medically necessary, and a determination is made that the beneficiary is not financially liable under Section 1879

of the Social Security Act, the hospital is required to refund any amounts paid by the beneficiary for the hospital stay at issue (e.g., deductible and copayment amounts). However, if the hospital subsequently submits a Part B inpatient claim, the beneficiary is responsible for applicable deductible and copayment amounts associated with the Part B inpatient claim.<sup>103</sup> It is CMS’ position that it “cannot... hold beneficiaries harmless for the financial responsibility related to Part B coinsurance and deductible for covered claims.”<sup>104</sup> As noted elsewhere herein, beneficiary financial liability is often higher for Part B claims than for Part A claims.<sup>105</sup>

Commenters raised concerns related to patients’ financial liability in cases where a patient had a three-day qualifying inpatient stay (and was thereafter transferred to a skilled nursing facility (“SNF”) for Part A services), and the inpatient stay was subsequently denied as not medically necessary.<sup>106</sup> However, CMS attempted to resolve these concerns by noting that “the status of the beneficiaries themselves does not change from inpatient to outpatient under the Part B inpatient billing policy. Therefore, even if the admission itself is determined to be not medically necessary under this policy, the beneficiary would still be considered a hospital inpatient for the duration of the stay – which, if it occurs for the appropriate duration, would comprise a ‘qualifying’ hospital stay for SNF benefit purposes so long as the care provided during the stay meets the broad definition of medical necessity...”<sup>107</sup>

##### *– Timely Filing Provisions*

Over 300 commenters to the Part B Inpatient Billing Proposed Rule objected to the proposal that claims for Part B inpatient services be rejected as untimely if submitted later than one calendar year following the dates of service at issue. Just one commenter supported the proposal.<sup>108</sup> Despite this significant industry

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backlash, CMS moved forward with the timely filing limitation, revised for the near-term as follows:

[W]e will permit hospitals to follow the Part B billing timeframes established in the Ruling after the effective date of this rule, provided (1) the Part A claim denial was one to which the Ruling originally applied; or (2) the Part A inpatient claims [sic] has a date of admission before October 1, 2013, and is denied after September 30, 2013 on the grounds that although the medical care was reasonable and necessary, the inpatient admission was not.<sup>109</sup>

Therefore, claims for hospital admissions following the effective date of the 2014 IPPS Final Rule (i.e., October 1, 2013) are governed by the timely filing provisions of the regulations.

## – Scope of Review

The 2014 IPPS Final Rule also upholds CMS' proposal to limit adjudicators' scope of review of a Part A claim for inpatient hospital services to the Part A claim (i.e., in this situation, the adjudicator is prohibited from ordering payment for items and services rendered under Part B).<sup>110</sup> The 2014 IPPS Final Rule again describes its limitation as one of clarification, rather than a change in policy (i.e., "many commenters expressed concerns about CMS' *clarification* of the scope of review of an appeals adjudicator during appeals of Part A inpatient admission claim denials in the context of Part B billing...").<sup>111</sup> In support of its limitation, CMS states that "[n]either the Medicare statute nor the Secretary's implementing regulations grant ALJs or other adjudicators the authority to order equitable remedies."<sup>112</sup> In addition, citing its "longstanding Medicare policy,"<sup>113</sup> CMS declined to permit reopening and adjustment of Part A claims into Part B claims (which

would obviate the need for application of the timely-filing regulations) due to the present operational limitations of CMS.<sup>114</sup>

## Impact on Hospitals

The one-year claims filing limitation, coupled with provisions of the 2014 IPPS Final Rule taking away an ALJ's authority to consider whether Part B payment would be appropriate, puts hospitals in a difficult situation. Hospitals that have provided clinically appropriate, medically necessary care will be forced to decide (1) whether to accept reduced payment for services rendered (provided that timely filing requirements are satisfied); or (2) whether to pursue Part A reimbursement through the Medicare appeals process, thus possibly losing all reimbursement for services rendered. While the 2014 IPPS Final Rule offers some relief from CMS' long-held Payment Denial Policy (provided that timely filing requirements are satisfied), many in the hospital community find this relief insufficient, as it fails to ensure accurate reimbursement is made to hospitals for all of the medically necessary care provided.<sup>115</sup>

## The 2014 Inpatient Prospective Payment System ("IPPS") Final Rule

On May 10, 2013, CMS issued a proposed rule related to the Medicare Program; Hospital Inpatient Prospective Payment Systems et seq. (the "2014 IPPS Proposed Rule").<sup>116</sup> The 2014 IPPS Proposed Rule included key revisions to CMS requirements related to inpatient hospital admissions. First, the 2014 IPPS Proposed Rule "clarified" CMS' documentation requirements related to physician orders and certifications. In addition, the 2014 IPPS Proposed Rule proposed to create a time-based threshold (i.e., a 2 midnight length of stay) to establish a presumption of medical necessity of inpatient status (or inpatient

"setting") for Part A inpatient hospital claims.<sup>117</sup> Generally speaking, many of the requirements set forth in this 2014 IPPS Proposed Rule were finalized without revision as part of the 2014 IPPS Final Rule.<sup>118</sup>

## Physician Orders

In its 2014 IPPS Final Rule, CMS finalized its proposal to formally require an admission order to initiate an inpatient hospitalization as a condition of payment under Medicare Part A.<sup>119</sup> Although as a practical matter hospitals historically have obtained practitioner orders to initiate inpatient hospital stays (and although it was CMS' expectation that practitioners would complete such orders), it should be noted that inpatient admission orders were not explicitly required by previous regulations or prior CMS written guidance.<sup>120</sup>

Inpatient admission orders may be made by a physician or other practitioner meeting the following requirements: (1) the practitioner is licensed by the state to admit inpatients to hospitals; (2) the practitioner has been granted privileges by the hospital to admit inpatients to the facility; and (c) the practitioner has knowledge of the patient's hospital course, plan of care, or condition at the time of admission.<sup>121</sup> Many physicians or other practitioners may potentially meet this knowledge requirement, including the admitting physician of record (or a physician on call for him or her); primary or covering hospitalists caring for the patient in the hospital; the patient's primary care practitioner; a surgeon responsible for a major surgical procedure on the patient (or a surgeon on call for him or her); an emergency or clinic practitioner caring for the patient at the point of admission; and other practitioners qualified to admit inpatients and actively treating the patient at the point of the admission decision.<sup>122</sup> According to CMS, physician members

of the hospital's utilization review committee do not have direct responsibility for the care of patients while serving in that role and therefore do not meet the requisite knowledge requirement for purposes of completing the inpatient admission order.<sup>123</sup>

Under the 2014 IPPS Final Rule, admission orders may be made verbally or in writing.<sup>124</sup> Practitioners lacking the qualifications to admit patients may document verbal inpatient admission orders made by a qualified ordering practitioner, provided that the ordering practitioner is identified and the order is authenticated (signed, dated and timed) by either the ordering practitioner or by another practitioner with the requisite admitting qualifications prior to the patient's discharge (unless state law or hospital bylaws require an earlier timeframe).<sup>125</sup>

In a departure from previous written CMS policy,<sup>126</sup> the preamble of the 2014 IPPS Final Rule documents CMS' desire that admission orders include the term "inpatient" to specify hospital admissions "to or as an inpatient."<sup>127</sup> CMS subsequently softened this position, and as part of sub-regulatory guidance published on September 5, 2013, CMS stated that a hospital admission order may meet the regulatory requirements even if the term "inpatient" is not included in the order, provided that the admitting physician's intent to admit the patient to the hospital as an inpatient is clear and consistent with the medical record. Specifically, pursuant to the September 5, 2013 sub-regulatory guidance, CMS stated the following:

Orders that specify admission to an inpatient unit (e.g., "Admit to 7W", "Admit to ICU"), admission for a service that is typically provided on an inpatient basis ("Admit to Medicine"), or admission under the care of an admitting practitioner ("Admit to Dr. Smith"), and orders that do not specify beyond the word "Admit," will be considered to specify

admission to an inpatient status provided that this interpretation is consistent with the remainder of the medical record....<sup>128</sup>

Despite this change, it remains a "best practice" for practitioners ordering inpatient admission to include the term "inpatient" as part of their inpatient admission orders. If this terminology is not included, it is plausible that recovery auditors (with a financial incentive to deny) and MACs could take the position that interpreting an order as an inpatient admission order would be inconsistent with the remainder of the medical record.

With respect to admission orders, as finalized, 42 C.F.R. § 412.3 (a) reads as follows:

For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c) and 485.638(a)(4)(iii) of this chapter for a critical access hospital. This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A....<sup>129</sup>

#### *Physician Certifications*

The 2014 IPPS Final Rule also creates a requirement that physicians complete certifications of medical necessity for all inpatient admissions as a condition of payment.<sup>130</sup> Although commenters argued that CMS' proposal to require certifications for all inpatient hospital admissions (and not just for extended hospital stays) is not supported by the legislative history of the statute and regulations,<sup>131</sup> CMS ultimately found these arguments unpersuasive.

The certification statements must be signed and dated by the physician responsible for the inpatient admission or by another physician with knowledge of the case<sup>132</sup> and must be completed before a patient's discharge from the hospital. In contrast to the requirements for inpatient admission orders, the certification may only be completed by the following practitioners: (1) an M.D. or D.O., (2) a dentist in certain circumstances, and (3) a doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.<sup>133</sup> In contrast to the requirements governing inpatient admission orders, a physician member of the utilization review committee who has reviewed the case may complete the certification statements.

With respect to certifications, as finalized, 42 C.F.R. § 424.13(a)(2) will require the following:

- a) *Content of certification and recertification.* Certification begins with the order for inpatient admission. Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facilities services) only if a physician certifies and recertifies the following:
  - 1) That the services were provided in accordance with § 412.3 of this chapter.
  - 2) The reasons for either –
    - i. Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or
    - ii. Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of Part 412 of this chapter).
  - 3) The estimated time the patient will need to remain in the hospital.<sup>134</sup>
  - 4) The plans for posthospital care, if appropriate.<sup>135</sup>

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The physician order is a required component of the certification<sup>136</sup> and must be made at the time of a beneficiary's admission to the hospital.<sup>137</sup> The certification must be signed and documented in the medical record prior to the patient's discharge.<sup>138</sup>

CMS states that it is "not finalizing new documentation requirements"<sup>139</sup> with respect to certification statements. Although certification statements must be documented via a separate signed statement within the medical record, a specific form is not required to satisfy the certification requirements.<sup>140</sup> Certification statements may be present on any documentation within the patient file as long as the method chosen permits verification.<sup>141</sup> In the absence of a specific certification form, CMS and its contractors will look for the requisite elements within the medical file (e.g., the inpatient order, diagnosis, plan, discharge planning instructions, etc.).<sup>142</sup>

Borrowing from language of previous guidance materials, i.e., HCFA Ruling 93-1, in the 2014 IPPS Final Rule, CMS clarified that, although now required for payment, no presumptive weight will be given to physician orders and certifications. Orders and certifications must be supported by the admission notes and progress notes in order for a claim to be paid under Medicare Part A.<sup>143</sup>

## *Establishing the Medical Necessity of an Inpatient Admission*

In addition to clarifying documentation requirements, in the 2014 IPPS Final Rule CMS finalized criteria to establish the medical necessity of an inpatient admission. By finalizing its proposal that an inpatient admission would be generally deemed appropriate and payment made under Medicare Part A when the physician expects a patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based on that expectation, or if the patient is

undergoing a procedure on the Inpatient-Only list.<sup>144</sup> Note that the 2014 IPPS Final Rule does not include exceptions to this standard based on the intensity of services rendered: "[O]ur 2-midnight benchmark policy is not contingent on the level of care required,"<sup>145</sup> even if an admission is made directly to a hospital's intensive care unit or telemetry floor.<sup>146</sup>

The new "2-midnight rule" serves to provide clarity to physicians and other healthcare practitioners making decisions as to whether inpatient care (as opposed to outpatient care) is medically necessary. In an apparent contradiction to CMS' preamble commentary related to the decision-making significance of the level of care required, by way of its sub-regulatory guidance published on November 4, 2013, CMS opened the door to create additional exceptions (other than procedures on the Inpatient-Only list) to its 2-midnight rule. Specifically, CMS stated the following:

We recognize that there could be rare and unusual circumstances that we have not identified that justify inpatient admission absent an expectation of care spanning at least 2 midnights. As we continue to work with facilities and physicians to identify such other situations, we reiterate that we expect these situations to be rare and unusual exceptions to the general rule. If any such additional situations are identified, we will include them in sub-regulatory instruction, and we will expect that in these situations the physician at the time of admission must explicitly document the reason why the specific case requires inpatient care as opposed to hospital services in an outpatient status.<sup>147</sup>

CMS is instructing its MACs to deny such claims (where the admitting practitioner does not expect the

patient to require hospital care crossing 2 midnights), but such claims will be submitted to CMS' Central Office for further review. "If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process."<sup>148</sup>

## *Medical Review*

With respect to medical review, the IPPS Final Rule establishes two distinct, but related, medical review policies: a 2-midnight *presumption* and a 2-midnight *benchmark*.

### *– Presumption*

"Under the 2-midnight *presumption*, inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption."<sup>149</sup> The physician order initiates the inpatient admission for purposes of applying the 2-midnight presumption.<sup>150</sup>

Note, however, the 2014 IPPS Final Rule is clear that inpatient hospital claims satisfying the 2-midnight presumption will still be assessed by medical review contractors in the following circumstances: (1) to ensure the services provided were medically necessary; (2) to ensure that the hospitalization was medically necessary; (3) to validate provider coding and documentation; (4) when a CERT contractor is directed to review such claims; or (5) if directed by CMS or other entity to review such claims.<sup>151</sup> In other words, although the medical review contractors will not focus medical review efforts on claims satisfying the 2-midnight presumption

for the purposes of determining whether inpatient status was appropriate for the beneficiaries, the claims may nonetheless be reviewed to determine whether any of those five circumstances apply. The 2014 IPPS Final Rule states the following with respect to this point: "We note that it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that if the stay was necessary, it was appropriately provided as an inpatient stay... [S]ome medical review is always necessary...."<sup>152</sup>

*– Benchmark*

On the other hand, CMS' medical review contractors will direct its medical review focus on inpatient hospital admissions with lengths of stay crossing 1 midnight or less.<sup>153</sup> With respect to the 2-midnight benchmark CMS states the following:

If the physician admits the beneficiary as an inpatient but the beneficiary is in the hospital for less than 2 midnights after the order is written, CMS and its medical review contractors will not presume that the inpatient hospital status was reasonable and necessary for payment purposes, but may instead evaluate the claim pursuant to the 2-midnight benchmark. Medical review contractors will (a) evaluate the physician order for inpatient admission to the hospital, along with the other required elements of the physician certification, (b) the medical documentation supporting the expectation that care would span at least 2 midnights, and (c) the medical documentation supporting a decision that it was reasonable and necessary to keep the patient at the hospital to receive such care, in order to determine whether payment under Part A is appropriate....

[I]f it was reasonable for the physician to expect the beneficiary to

require a stay lasting 2 midnights, and that expectation is documented in the medical record, inpatient admission is generally appropriate, and payment may be made under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances such as beneficiary death or transfer (so long as the physician's order and certification requirements are also met)."<sup>154</sup>

With respect to the 2-midnight benchmark, the ordering physician may consider time a beneficiary spent receiving outpatient services (including observation services, treatment in the ED and outpatient procedures) when determining whether the 2-midnight benchmark is met, justifying an inpatient admission.<sup>155</sup> The 2014 IPPS Final Rule summarizes the application of the benchmark as follows:

Medical reviewers will consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary. For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital.<sup>156</sup>

Given the opportunity to bill inpatient services under Part B, if a hospital stay does not cross 2 midnights (including a patient's time spent receiving outpatient services), hospitals may choose to either utilize Condition Code 44 to change the patient's status prior to discharge, or use the Part B billing option based on self-audit by the hospital's Utilization Review committee – given that the claim has a higher likelihood to be reviewed by a medical review entity

and the inpatient admission will not be presumed to be medically necessary. The 2014 IPPS Final Rule states that "hospital stays expected to last less than 2 midnights are generally inappropriate for inpatient hospital admission and Part A payment absent rare and unusual circumstance to be further detailed in sub-regulatory instruction."<sup>157</sup>

As noted by the regulatory language cited above, the 2-midnight benchmark places great emphasis on the physician's documentation regarding his or her expectation of length of stay. Therefore, it is essential that all hospital physicians are educated regarding the importance of documentation within the medical record.

CMS actuaries have estimated that its revised inpatient admission guidelines will result in a net increase to inpatient hospital claims submitted under Part A.<sup>158</sup> In particular, citing to data from fiscal years 2009 to 2011, CMS actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient under the 2014 IPPS Proposed Rule, and 360,000 encounters would shift from inpatient to outpatient (resulting in a net shift of 40,000 encounters, resulting in a 1.2 percent increase in IPPS expenditures).<sup>159</sup> These estimates are somewhat counterintuitive, as CMS basically is shifting its 24-hour benchmark to support an inpatient admission to a 2 midnight threshold, which presumably would result in a net increase of outpatient claims rather than inpatient claims. As most beneficiaries are not discharged from the hospital in the middle of the night, in many instances the 2014 IPPS Final Rule would have the effect that many beneficiaries will require over 48 hours of hospital care before an inpatient admission would be presumed to be medically necessary,<sup>160</sup> a result clearly not anticipated by prior CMS guidance.

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## What Does The Future Hold?

### Litigation<sup>161</sup>

On November 1, 2012, the AHA along with four health systems<sup>162</sup> filed suit against Kathleen Sebelius, in her official capacity as Secretary of HHS (the “AHA Complaint”), challenging the “unlawful government practice” of “refusing to pay hospitals for hundreds of millions of dollars’ worth of care provided to patients, even though all agree that the care provided was reasonable and medically necessary....”<sup>163</sup> The AHA Complaint describes this policy as CMS’ “Payment Denial Policy.”<sup>164</sup> The AHA Complaint alleged that CMS’ Payment Denial Policy violated the Administrative Procedure Act, which generally prohibits any agency from acting in a manner not in accordance with law or in an arbitrary and capricious manner.

Following publication of the AHA’s first amended complaint in December 2012 (filed to add one additional plaintiff hospital to the action), the court issued a scheduling order, requiring CMS to make its first substantive filing by March 15, 2013.<sup>165</sup> Rather than doing so, CMS instead abandoned its Payment Denial Policy, and on March 13, 2013, concurrently issued its Ruling and Part B Inpatient Billing Proposed Rule, concluding that “under section 1832 of the [Social Security] Act, Medicare should pay” for reasonable and necessary services rendered.

As the Ruling and Part B Inpatient Billing Proposed Rule proved unpalatable to hospitals (given the anticipated incomplete reimbursement), the AHA filed a second amended complaint on April 19, 2013, arguing that application of the Ruling and Part B Inpatient Billing Proposed Rule would be unlawful as contrary to the Administrative

Procedure Act.<sup>166</sup> CMS moved to dismiss the AHA’s second amended complaint, and the AHA answered.<sup>167</sup> On October 28, 2013, CMS and the AHA submitted supplemental filings.<sup>168</sup> The Court has yet to rule on CMS’ Motion to Dismiss.

### Medicare Audit Improvement Act of 2013, H.R. 1250, S. 1012

On March 19, 2013 and May 22, 2013 respectively, identical bills were introduced to the U.S. House of Representatives (H.R. 1250) and U.S. Senate (S. 1012), proposing legislation known as the Medicare Audit Improvement Act of 2013. The purposes of this proposed legislation include “[t]o amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.”

The primary function of this proposed legislation is to reduce the overwhelming administrative burden placed on hospitals subject to ever-increasing audits of inpatient hospital claims, in the context of the vast majority of claim denials being overturned on appeal. Key provisions of this proposed legislation include the following:

- **A requirement that the Secretary of HHS set a per-hospital limitation on the number of medical records MACs, recovery auditors, or CERT contractors may request per year for audit, taking into account both pre-payment and post-payment reviews.**<sup>169</sup> Note that this combined ADR limit would not apply to Zone Program Integrity Contractors (“ZPICs”). As noted above, presently there are limitations on the number of medical records recovery auditors may request as part of their auditing

activities; however, this limitation does not account for any other requests for documentation other contractors may issue to hospitals, and recovery auditors are authorized to exceed this ADR limit provided that CMS approves.<sup>170</sup>

- **Requirements for mandatory terms and conditions of contracts by and between CMS and recovery auditors and by and between CMS and MACs**, including the following: (A) penalties for failing to timely perform audits and/or communicate with audited hospitals; (2) penalties for overturned appeals; (3) post-payment and pre-payment review requirements – in particular, a requirement that the Secretary not approve the conduct of a post-payment or pre-payment medical necessity audit, unless such audit addresses a “widespread” payment error rate and ceases when the payment error rate is no longer “widespread” (as defined by the legislation) taking into account appeals results; and (4) guidelines for pre-payment reviews.<sup>171</sup> Under the current recovery audit program, medical necessity audits of inpatient hospital short stay claims may persist indefinitely, regardless of hospitals’ appeals success.<sup>172</sup>
- **A requirement that certain recovery auditor performance metrics be publicized on the CMS recovery audit website**, including audit rates, denials and appeals outcomes at each of the stages of appeal in the Medicare appeals process, as well as independent performance evaluations of the recovery auditors.<sup>173</sup> At present, CMS publishes some of this information on its recovery audit website, but not all.<sup>174</sup>
- **Categorizing all claims selected for audit by a recovery auditor or MAC to be “reopened,” permitting a hospital to re-submit a Part B claim against a finding of overpayment**

**under Part A, irrespective of timely filing regulations.**<sup>175</sup> Under the Ruling (remaining applicable to inpatient admissions prior to October 1, 2013), if a Part A claim is denied because a hospital stay is found not to be medically reasonable and necessary, but a Part B claim would have been payable, hospitals are permitted to rebill for the majority of services provided under Part B and the timely filing requirements are waived.<sup>176</sup> However, under the 2014 IPPS Final Rule, CMS reinstated the timely filing restriction for billing of Part B inpatient services to mandate that such claims be submitted within one year from the date of service (irrespective as to whether a Part A claim was reopened and revised following one year from the date of service).<sup>177</sup>

- **Requiring a physician to validate medical necessity denials.**<sup>178</sup> Under the Recovery Audit Statement of Work presently in effect, each recovery auditor is required to employ one full-time equivalent contractor medical director ("CMD") (in particular, a Doctor of Medicine or Doctor of Osteopathy), who is required to serve as "a readily available source of medical information to provide guidance in questionable claims review situations."<sup>179</sup> The Statement of Work does not require the medical directors to be involved in rendering medical necessity denials (i.e., in fact, medical necessity determinations are required to be made by registered nurses); however, "If the provider requests to speak to the CMD regarding a claim(s) denial the Recovery Auditor shall ensure the CMD participates in the discussion."<sup>180</sup>
- **Granting administrative and judicial review of the Secretary's compliance with the regulations and guidelines for reopening and revising claims.**<sup>181</sup> Pursuant to regulations codified at 42 C.F.R. § 405.980 (b) (1)-(3), a contractor is permitted to reopen an initial determination (1) within one year for any reason;

(2) within four years from the date of initial determination or redetermination for good cause; or (3) at any time if there exists reliable evidence that the initial determination was procured by fraud or similar fault. During the RAC demonstration program, many hospitals successfully challenged overpayment findings made by RACs, arguing that the RACs failed to demonstrate "good cause" to reopen and revise claims. However, pursuant to 42 C.F.R. § 405.980 (b) (5), a contractor's decision whether to reopen is binding and not subject to appeal.<sup>182</sup> Citing this portion of the regulations in *In the case of Memorial Hospital of Long Beach* (DAB July 23, 2008), the Medicare Appeals Council issued a decision finding an ALJ erred in basing its favorable decision on the fact that the RAC improperly reopened the claim at issue. Although Medicare Appeals Council cases are non-precedential, following publication of this decision, ALJs no longer considered hospitals' arguments that the RACs improperly reopened audited claims without having good cause for doing so. This portion of the Medicare Audit Improvement Act of 2013 would grant hospitals the ability to again challenge recovery auditors' reopening of claims.

While the bipartisan legislative effort to pass the Medicare Audit Improvement Act of 2013 has been lauded by industry stakeholders such as the AHA<sup>183</sup> and the American Health Information Management Association,<sup>184</sup> to no surprise it also has received criticism from the Medicare auditing community. The American Coalition for Healthcare Claims Integrity ("ACHCI"), an organization whose founding members consist of "partners in critical accountability initiatives including the federal Recovery Audit Contractor (RAC), Zone Program Integrity Contractor (ZPIC) and Medicaid Integrity Contractor (MIC)

programs,"<sup>185</sup> released a statement in June 2013 arguing that recovery auditors are entities that have recovered significant monies for the Medicare Trust Funds "... at no cost to hospitals or the industry," and the proposed legislation would undermine their efficacy.<sup>186</sup> Given the countless resources dedicated to addressing the onslaught of record requests, appeals and other issues discussed herein as a result of the unprecedented audit activity, hospitals would certainly take issue with the claim that the recoveries have come "at no cost to hospitals."

On June 25, 2013, the U.S. Senate Finance Committee held hearings on the recovery audit program and heard from industry stakeholders, including hospital representatives and representatives from one of the recovery auditors (CGI Federal, Inc.).<sup>187</sup> Although it is unknown whether the Medicare Audit Improvement Act of 2013 will be admitted into law, these U.S. Senate Finance Committee hearings gave healthcare providers a venue to discuss issues faced with recovery auditors outside of discussions with CMS representatives.

## Conclusion

The regulatory, legal and operational landscape surrounding the billing of short stay inpatient hospital claims and pursuing appeals of denials of such claims has evolved over time. Hospitals have dedicated countless resources to addressing the unprecedented audit activity targeting short stay inpatient admission billings and likely will see little relief in the years to come. While the 2014 IPPS Final Rule arguably provides more clarity regarding CMS expectations with respect to inpatient hospital claims, auditing activity of short stay claims will continue, and hospitals will likely encounter new issues during the appeals process related to the regulatory changes (e.g., defending the admitting practitioner's

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expectation that a patient would require hospital care crossing 2 midnights, in the event the expected length of stay does not transpire, defending the services rendered as medically necessary rather than defending the “setting” of care in the case of stays meeting the 2-midnight presumption). In addition to continuing the dedication of financial resources to audits and appeals, it is anticipated that many hospitals will encounter a myriad of challenges, including training and educational challenges, when operationalizing the requirements contained within the 2014 IPPS Final Rule.

Healthcare attorneys representing hospitals in these areas must be mindful of the evolving regulatory issues and interplay of the topics discussed in this article. Legal counsel providing appeals support to their hospital clients must make efforts to comprehensively address all issues, including but not limited to making substantive arguments addressing the correct application of CMS inpatient billing requirements as well as making legal arguments that may be necessary to preserve certain rights if taking appeals to later stages of the appeals process. For example, this may involve including legal challenges to CMS’ position on rebilling as part of the appeal filings. Moreover, healthcare legal counsel can assist hospitals operationalizing the new requirements in a manner that provides guidance to best position the hospitals to withstand anticipated future auditing and pursue any necessary appeals.



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## Endnotes

<sup>1</sup> See Sections 226, 1811 and 1812 of the Social Security Act, 42 U.S.C. § 426, 42 U.S.C. § 1395c and 42 U.S.C. § 1395d (a) (1).

<sup>2</sup> See Sections 1831 and 1832 of the Social Security Act, 42 U.S.C. § 1395j and 42 U.S.C. § 1395k.

<sup>3</sup> See Section 1862 (A) (1) (a) of the Social Security Act, 42 U.S.C. § 1395y (a) (1) (A).

<sup>4</sup> See e.g., the Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 13, § 13.5.1 defining “Reasonable and Necessary.” This portion of the Medicare Program Integrity Manual describes the circumstances under which an item or service is considered reasonable and necessary under Section 1862 (A) (1) (a) of the Social Security Act, and includes services “Furnished in a setting appropriate to the patient’s medical needs and condition.”

Although recovery auditors and MACs routinely deny coverage for Part A inpatient hospital claims as medically unnecessary under Section 1862 (A) (1) (a) of the Social Security Act for the reason that the services were provided in an inappropriate setting (i.e., the inpatient setting rather than the outpatient setting), it is noteworthy that the

actual “setting” in many cases does not differ for inpatient hospital services and outpatient services. That is, many hospitals do not have an “outpatient observation” unit, and inpatients receive inpatient hospital services side by side with patients receiving outpatient and outpatient observation services.

<sup>5</sup> See Section 1886 of the Social Security Act, 42 U.S.C. § 1395ww (a) (4) and Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 3, § 20.

<sup>6</sup> HCPCS codes (Healthcare Common Procedure Coding System codes) represent medical services and procedures furnished by physicians and other healthcare professionals comprising the American Medical Association’s Current Procedural Terminology (CPT-4) coding system, as well as products, supplies and services not included in the CPT-4 codes. See [http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPSC\\_Coding\\_Questions.html](http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPSC_Coding_Questions.html) (last accessed November 4, 2013).

<sup>7</sup> See Section 1833 of the Social Security Act, 42 U.S.C. § 1395l and Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 4, § 10.2.

CMS has published a MLN Matters educational document related to the Hospital Outpatient Prospective Payment System, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf> (last accessed November 4, 2013).

<sup>8</sup> Patients’ financial obligations are often higher for claims submitted under Part B as opposed to claims submitted under Part A. Beneficiary financial liability under Medicare Part B includes not only Medicare Part B copayments but also may include the cost of self-administered drugs that are not covered under Part B and the cost of any necessary post-hospitalization skilled nursing facility (“SNF”) care (which requires a three day inpatient hospital admission prior to Part A coverage). On the other hand, under Medicare Part A beneficiaries are responsible for a one-time deductible for all inpatient hospital services provided during the first 60 days in a hospital of the benefit period. Therefore, an inpatient deductible does not necessarily apply to every hospitalization. Medicare Part A coinsurance applies after the 60th day in the hospital. See 78 Fed. Reg. at 27644.

See also, “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” available at [www.medicare.gov/Pubs/pdf/11435.pdf](http://www.medicare.gov/Pubs/pdf/11435.pdf) (last accessed July 11, 2013).

<sup>9</sup> Medicare Fee-for-Service, available at [www.paymentaccuracy.gov/programs/medicare-fee-service](http://www.paymentaccuracy.gov/programs/medicare-fee-service) (last accessed June 24, 2013).

<sup>10</sup> *Id.*

<sup>11</sup> Medicare Fee-for-Service 2011 Improper Payments Report at p. 20, available at [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf) (last accessed June 24, 2013).