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Medicare

CMS Publishes 2014 IPPS Final Rule: Revises Reimbursement Criteria Related To Patient Status

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On August 2, 2013, the Centers for Medicare & Medicaid Services (CMS) published the highly anticipated 2014 Inpatient Prospective Payment System (IPPS) Final Rule (2014 IPPS Final Rule), which will become effective on October 1, 2013.^[1] The 2014 IPPS Final Rule encompasses two key provisions that will considerably impact hospital operations and of which legal counsel representing hospitals and health systems must be aware: First, the 2014 IPPS Final Rule revises CMS criteria for coverage of Part A inpatient hospital claims. Second, the 2014 IPPS Final Rule adopts CMS' proposal to allow Part B billing of many hospital services following the denial of a Part A inpatient admission based on medical necessity.

Criteria for Coverage of Part A Inpatient Hospital Claims

Perhaps most significantly, the 2014 IPPS Final Rule establishes new requirements for coverage of Part A inpatient hospital claims, in particular by formalizing requirements for physician orders and certifications and by establishing new guidelines to justify the medical necessity of an inpatient hospital admission under Part A.

Physician orders and certifications

In the 2014 IPPS Final Rule, CMS finalized its proposal to require a physician order and certification as a condition of payment for a Part A inpatient hospital claim.^[2] Admission orders may be made verbally or in writing.^[3] Departing from previously-published guidance,^[4] under the 2014 IPPS Final Rule an admission order must expressly document the admitting physician's intent to order inpatient status (i.e., "the order for inpatient admission must specify admission 'to or as an inpatient.'")^[5] Borrowing language from HCFA Ruling 93-1, the 2014 IPPS Final Rule also makes clear that although required for payment, physician orders will not be given presumptive weight to establish the medical necessity of inpatient admissions; physician orders must be supported by admission notes and progress notes in order for Part A claims to be paid^[6]

With respect to physician orders, as finalized, 42 C.F.R. § 412.3(a) will require the following:

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...^[7]

The 2014 IPPS Final Rule also creates a requirement for physician certifications meeting the requirements of 42 C.F.R. § 424.14.^[8] Commenters to the 2014 IPPS Proposed Rule argued that the requirement for certifications for admissions other than extended hospital stays is not supported by the legislative history of the statute or by the existing regulations; CMS acknowledged the issues raised by commenters but nonetheless adopted its proposal to require physician certifications in addition to physician orders for all inpatient admissions.^[9] The 2014 IPPS Final Rule requires that certifications be documented via a separate signed statement within the medical record (except for delayed certifications).^[10]

Regarding certifications, as finalized, 42 C.F.R. § 424.13(a)(2) will read as follows:

(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).^[11]

The physician order is a requisite component of the certification^[12] and must be made at the time of a beneficiary's admission to the hospital.^[13] The 2014 IPPS Final Rule requires that the certification be signed and documented in the medical record prior to the hospital discharge.^[14] As a practical matter, it would make operational sense for hospitals to adopt and implement into their admission procedures a combined "Physician Order and Certification" document, to be completed at the time of a patient's inpatient admission addressing the regulatory requirements set forth herein.

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Legal Representation

In finalizing its 2014 IPPS Final Rule, CMS believes that it has not created “any new documentation requirements.”^[15] However, given that CMS has made clear that physician orders and certifications are now conditions of payment for Part A inpatient claims, and given that payment will be tied to physician documentation generally (supporting the inpatient order and certification), it is essential that admitting physicians and hospitalists are educated regarding CMS’ “clarified” requirements, to ensure that hospitals receive payment for medically necessary care provided. Hospitals may experience significant challenges operationalizing these requirements, as the requirements represent a departure from the way many admitting physicians are currently documenting.

Establishing Medical Necessity of Inpatient Admissions

In the 2014 IPPS Final Rule, CMS also finalized criteria to establish the medical necessity of inpatient admissions. In particular, CMS finalized 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 two 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.^[16]

Note that the 2014 IPPS Final Rule does not include exceptions to this policy based on the intensity of services rendered, even for services rendered in the intensive care unit: “We do not believe beneficiaries treated in an intensive care unit should be an exception to this standard, as our 2-midnight benchmark policy is not contingent on the level of care required.”^[17] Many in the hospital community will likely find this statement counterintuitive, given that:

- Internally, many hospitals rely on propriety industry guidelines, such as McKesson InterQual Level of Care Criteria, to support the admitting physician’s clinical judgment that an inpatient admission is medically necessary. These industry guidelines reflect the generally-accepted standards of practice in the medical community and are dependent on the severity of illness with which a patient presents *as well as the intensity of service provided*;^[18]
- At least one Medicare Administrative Contractor (i.e., Palmetto GBA) relies on McKesson InterQual Level of Care Criteria as its primary screening tool in conducting redetermination reviews of inpatient hospital admissions and routinely bases payment denials on hospitals’ failure to meet McKesson InterQual Level of Care Criteria;
- Recovery auditors and qualified independent contractors participating in administrative law judge (ALJ) hearings have historically argued that inpatient admissions were not medically necessary because the particular services provided could have been safely provided on an outpatient basis (regardless of the length of stay);^[19] and
- The Medicare Appeals Council has published decisions in which it found that inpatient admissions were not medically necessary based on the intensity of the services performed during the subject hospital admission.^[20]

Despite all of this, in its 2014 IPPS Final Rule, CMS stated that “We... expect that physicians will apply the revised benchmark as they have previously applied the existing benchmark, providing any medically necessary services in an inpatient status whenever the benchmark is met and in all other instances providing *identical services* to patients staying at the hospital in a day or overnight outpatient status. While we have historically referenced a 24-hour benchmark, we now specify that the 24 hours relevant to inpatient admission decisions are those encapsulated by 2 midnights.”^[21] In summary, CMS concluded, “the beneficiary’s required ‘level of care’ is not part of the guidance regarding hospital inpatient admission decisions... the decision of whether to admit a beneficiary as an inpatient or keep as an outpatient is based on the physician’s expectation of the beneficiary’s required length of stay.”^[22]

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

“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.”^[23]

Note, however, the 2014 IPPS Final Rule is clear that inpatient hospital claims satisfying the two-midnight presumption will still be reviewed in certain circumstances: (1) to ensure the services provided were medically necessary; (2) to ensure that a hospitalization was medically necessary; (3) to validate provider coding and documentation; (4) when a CERT Contractor is directed to do review such claims; or (5) if directed by CMS or other entity to review such claims.^[24] In other words, although the medical review contractors will not focus medical review efforts on claims satisfying the two-midnight presumption for the purposes of determining whether inpatient status was appropriate for the beneficiaries, the claims may nonetheless be reviewed to determine whether the particular services rendered were medically necessary or an admission to the hospital

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was medically necessary, etc. 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..."^[25] While at first glance it would appear that hospitals should avoid audit scrutiny for those inpatient claims satisfying the two-midnight presumption, CMS' statements are clear that medical necessity reviews of such claims will continue. Many in the hospital community have expressed concern to CMS on this issue during recent CMS open door forums, and thus it will be important to monitor future audit activity to determine how CMS contractors will be proceeding.

The 2014 IPPS Final Rule directs CMS' medical review contractors to focus on inpatient hospital admissions with lengths of stay crossing one midnight or less and 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."^[26]

However, with respect to the two-midnight *benchmark*, the 2014 IPPS Final Rule provides the following guidance:

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..."^[27]

Of particular importance, with respect to the two-midnight benchmark, the ordering physician may consider the time a beneficiary spent receiving outpatient services (including observation services, treatment in the emergency department (ED) and time receiving outpatient procedures) to determine whether the two-midnight benchmark is met, justifying an inpatient admission. "[T]he starting point for medical review purposes will be from the time the patient starts receiving any services after arrival at the hospital."^[28] Therefore, by way of example, physicians may consider the time a patient spends in the ED of a hospital in determining whether the two midnight benchmark has been satisfied.

Payment of Part B Hospital Inpatient Services

In addition to revising the criteria to justify the medical necessity of a Part A inpatient claim, the 2014 IPPS Final Rule also finalizes CMS' proposal to allow Part B billing of certain services following the denial of a Part A inpatient admission as medically unnecessary.

By way of background, on March 13, 2013, CMS concurrently issued Ruling CMS-1455-R (Ruling)^[29] and a proposed rule (Part B Inpatient Billing Proposed Rule)^[30] to revise Medicare Part B billing policies in the event of Part A inpatient claim denials based on medical necessity. The 2014 IPPS Final Rule essentially adopts most of the elements of the Part B Inpatient Billing Proposed Rule, with a few clarifications.

Payable Part B Inpatient Services

Following a Part A claim denial because an inpatient admission was deemed not reasonable and medically necessary, the 2014 IPPS Final Rule allows Part B inpatient billing of services rendered, with certain specified exclusions for services that "should only be furnished to hospital outpatients," including observation services, outpatient diabetes self-management training, and hospital outpatient visits (including ED visits).^[31] However, 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.^[32] Therapy services (i.e., physical, occupation, and speech) are not excluded from Part B inpatient billing in the 2014 IPPS Final Rule.^[33]

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.^[34] even if this determination is made following a patient's discharge from the hospital (i.e., "self-audit").^[35] Although it would seem that this provision of the 2014 IPPS Final Rule replaces the need for and use of "Condition Code 44,"^[36] from an operational standpoint using Condition Code 44 rather than the "self-audit" provisions of the 2014 IPPS Final Rule to effectuate a change in a patient's status will facilitate hospital reimbursement. 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, it must first submit a "no pay/provider liable" Part A claim, await a denial, and then bill a Part B inpatient claim,[\[37\]](#) creating an additional layer of administrative burden to the hospital and delaying payment.

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,[\[38\]](#) a perhaps surprising result given that one of the primary purposes CMS cites for allowing for payment of Part B hospital inpatient services and revising its inpatient admission criteria was the adverse financial impact on Medicare beneficiaries resulting from hospitals' increased use of outpatient observation services in an attempt to avoid Part A inpatient hospital claim denials.[\[39\]](#)

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.[\[40\]](#) It is CMS' position that it "cannot... hold beneficiaries harmless for the financial responsibility related to Part B coinsurance and deductible for covered claims."[\[41\]](#) Notably, beneficiary financial liability is often higher for Part B claims than for Part A claims.[\[42\]](#)

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 SNF for Part A services), where the inpatient stay was subsequently denied as not medically necessary.[\[43\]](#) 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..."[\[44\]](#)

Timely Filing Provisions

Over 300 commenters on the Part B Inpatient Billing Proposed rule objected to CMS' proposal that claims for billed Part B inpatient services would be rejected as untimely if submitted later than one calendar year following the dates of service at issue. Just one commenter supported the proposal.[\[45\]](#) Despite this significant industry 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.[\[46\]](#)

Therefore, claims for hospital admissions following the effective date of the 2014 IPPS Final Rule (i.e., October 1, 2013) will be 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).[\[47\]](#) The 2014 IPPS Final Rule 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..."), a position with which many legal representatives of hospitals and health systems would disagree. 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."[\[48\]](#) In addition, citing its "longstanding Medicare policy," 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.[\[49\]](#)

For all of the reasons set forth above, the increasing importance of thorough physician documentation in the context of Part A inpatient hospital claims cannot be overstated. Compliance with the 2014 IPPS Final Rule may involve the adoption of new forms (e.g., Admission Order and Certification), and must involve complete documentation of the need for inpatient hospital services, the physician's expectations regarding length of stay (i.e., at least two midnights for the purposes of Part A inpatient claims), and the rationale for the admitting physician's clinical judgments. Hospitals and health systems must be mindful of CMS' revised policies and take steps to educate admitting physicians and hospitalists regarding such policies. Note that CMS anticipates providing additional "sub-regulatory guidance," presumably by updating the Medicare Benefit Policy Manual (CMS Internet-Only Publication 100-02), Chapter 1. The 2014 IPPS Final Rule certainly will change the way CMS medical review contractors approach Part A claim reviews and may alter the way providers approach appeals of Part A claim denials. Legal representatives of hospitals and health

systems must be mindful of the revised criteria for coverage of Part A inpatient claims and assist their hospital and health system clients to operationalize the revised criteria to best position their clients to withstand future auditing activity and successfully pursue appeals.

[1] Display version of 2014 IPPS Final Rule *available at* <http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/080913/IPPS.pdf>. The rule was published in the *Federal Register* on August 19, 2013. <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>. (page sites herein are to display version).

[2] 2014 IPPS Final Rule at 1796. As part of the 2013 IPPS Proposed Rule, CMS described its proposal to require a physician inpatient admission order as a "clarification" of its existing policy. However, it should be noted that prior to the 2014 IPPS Final Rule, applicable regulations and CMS written policy did not expressly require a physician inpatient admission order. Applicable existing hospital conditions of participation (CoPs) require medical records to contain information to justify admission (42 C.F.R. § 482.24 (c) and physicians' orders (42 C.F.R. § 482.24 (c) (4) and 42 C.F.R. § 485.638 (a) (4) (iii)); however, there is no explicit requirement for physicians' orders related to inpatient status. Hospital CoPs further require hospitals' governing bodies to ensure all patients are admitted "on the recommendation of" a practitioner permitted by state law to admit patients (42 C.F.R. 482.12 (c) (2)) and are treated "under the care of" a physician (42 C.F.R. § 482.12 (c) (1) (i)). The Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 10 defining the term "inpatient" requires that an individual be "formally admitted as an inpatient"; however, there is no express requirement that such formal admission come as a result of an inpatient admission order. As part of the 2014 IPPS Proposed Rule, CMS acknowledged that the CoPs cited herein do not expressly require an "inpatient admission order" as a requisite piece of documentation; however, CMS concluded that "it is an accepted standard of practice in hospitals and CAHs that such an order must be given before a patient can be admitted to a hospital or CAH." 78 Fed. Reg. 27486, 27646 (May 10, 2013).

[3] *Id.* at 1793.

[4] See CMS Transmittal 107, Change Request 6492, "July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)," May 22, 2009, finding "The term 'admission' is typically used to denote an inpatient admission and inpatient hospital services."

[5] 2014 IPPS Final Rule at 1797.

[6] *Id.* at 1899.

[7] *Id.* at 1788.

[8] In issuing the 2014 IPPS Final Rule, CMS relies on Section 1814 (a) (3) of the Social Security Act (42 U.S.C. §1395f), which requires the following, "[W]ith respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period..."

Federal regulations codified at 42 C.F.R. § 424.13 (a) require certifications of the need for inpatient care for *outlier cases* as follows:

Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the following:

- (1) The reasons for either—
 - (i) Continued hospitalization of the patient for 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).
- (2) The estimated time the patient will need to remain in the hospital.
- (3) The plans for posthospital care, if appropriate.

[9] 2014 IPPS Final Rule at 1782-1783.

[10] *Id.* at 1790.

[11] *Id.* at 1789.

[12] *Id.* at 1790.

[13] *Id.* at 1796-1797.

[14] *Id.* at 1791.

[15] *Id.* at 1789.

[16] *Id.* at 1840.

[17] *Id.* at 1816.

[18] See <http://www.mckesson.com/payers/decision-management/interqual-evidence-based-clinical-content/interqual-level-of-care-criteria/> (last accessed August 19, 2013) (emphasis added).

[19] In making these arguments, recovery auditors and qualified independent contractors often rely on language present in the Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.5.2, which provides the following guidance to medical reviewers conducting medical necessity reviews of inpatient claims:

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."

Emphasis added.

Similar language is present in the Medicare Quality Improvement Organization Manual (CMS Pub. 100-10), Ch. 4, § 4110 (emphasis added):

Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient 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.*

Of note, neither the Medicare Program Integrity Manual provision or Medicare Quality Improvement Organization Manual provision cited above is acknowledged by the 2014 IPPS Final Rule.

[20] See *e.g.*, *In the case of Providence Health Center*, Docket Number M-12-809 (decided June 29, 2012), finding, "There is no evidence that the beneficiary's medical needs were not fully being met in observation status, *nor has the appellant identified any additional necessary medical services that were not available in observation status that became available through an inpatient admission.*" Emphasis added.

See also *e.g.*, *In the case of Indiana University Health Methodist Hospital*, Docket Number M-12-872, (decided May 17, 2012), finding, "the beneficiary's condition was not so critical that an *acute level of inpatient care* was necessary." Emphasis added.

[21] 2014 IPPS Final Rule at 1824.

[22] *Id.* at 1820.

[23] *Id.* at 1830.

[24] *Id.* at 1830.

[25] *Id.* at 1837-1838 (emphasis added).

[26] *Id.* at 1814-1815. The 2014 IPPS Final Rule indicates that, "We... believe the rule, as finalized, provides for sufficient flexibility because of its basis in the physician's expectation of a 2-midnight stay. Such would include situations in which the beneficiary improves more rapidly than the physician's reasonable, documented expectation." However, note that, in most cases, it will be a registered nurse (rather than a physician) conducting the medical review and opining as to whether the physician's expectation of a 2-midnight stay was "reasonable."

[27] *Id.* at 1831.

[28] *Id.* at 1833.

[29] 78 Fed. Reg. 16614 (March 18, 2013).

[30] 78 Fed. Reg. 16632 (March 18, 2013).

[31] 2014 IPPS Final Rule at 1670.

[32] *Id.*

[33] *Id.*

[34] See *id.*, at 1674-1675.

[35] *Id.* at 1671 *et seq.*

[36] The requirements for Condition Code 44 are set forth in the Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 1, § 50.3, which permits a hospital to change a patient's

status from inpatient to outpatient, and submit an outpatient claim for the medically necessary Medicare Part B services provided, provided all of the following conditions are met:

- (1) The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- (2) The hospital has not submitted a claim to Medicare for the inpatient admission;
- (3) A physician concurs with the utilization review committee's decision;
- (4) The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

[37] 2014 IPPS Final Rule at 1675-1676.

[38] See *id.* at 1693 *et seq.*

[39] *Id.* at 1645.

[40] *Id.* at 1694.

[41] *Id.* at 1696-1697.

[42] 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.

[43] 2014 IPPS Final Rule at 1707.

[44] *Id.* at 1709.

[45] *Id.* at 1715, 1734. Issues raised by the commenters objecting to CMS' proposal included that it was unlawful and fundamentally unfair to apply the timely-filing limitation in situations where a Medicare contractor denied the Part A claim based on the finding that the care provided was reasonable and medically necessary, however the inpatient admission was not.

[46] *Id.* at 1721.

[47] *Id.* at 1739.

[48] *Id.* at 1743. Note however, that the 2014 IPPS Final Rule does not point to any statutory or regulatory authority that would prohibit adjudicators from issuing equitable remedies.

[49] 2014 IPPS Final Rule at 1728-1729. "[T]he Medicare claims processing systems changes that would be required in order to implement those types of adjustments... are impossible for Medicare's systems maintainers to implement and sustain..."

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