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Client Alert

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CMS Issues Ruling Allowing Hospitals to Bill for Part B Services Following Medical Necessity Denials of Inpatient Part A Stays: Proposed Rule Is Issued on Same Issue

I. INTRODUCTION

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) put on display on the Federal Register's website CMS Ruling 1455-R (the Ruling) and CMS Proposed Rule 1455-P (the Proposed Rule). Both the Ruling and Proposed Rule announce significant policy changes that will allow hospitals to rebill Medicare for Part B covered services in certain instances following the denial of a Part A inpatient admission for lack of medical necessity. This Ruling and Proposed Rule will be of great interest to hospitals dealing with Recovery Audit Contractor (RAC) denials of inpatient stays, and particularly "short stay" admission denials. To View the Ruling, click ***here***. To view the Proposed Rule, click ***here***.

CMS has historically taken the position that when a Part A claim for an inpatient admission is denied, a hospital can not be paid under Part B for therapeutic or observation services, even if those services were medically necessary and would have been paid if billed initially as outpatient services. CMS, however, has *partially* reversed this policy in its Ruling and Proposed Rule.

While on the one hand the Ruling and Proposed Rule offer relief from the stringent prior requirements governing billing for Part B services when a determination was made that an inpatient stay was medically unnecessary, these issuances also undermine the relief that hospitals have been receiving in challenges to inpatient denials before Administrative Law Judges (ALJs) and the Medicare Appeals Council.

It is also important to recognize that CMS maintains in both issuances that permitting providers to bill for an expanded set of Part B services after Part A payment is denied is contrary to established CMS policies. Moreover, as explained below, there are significant differences between the Part B rebilling policies outlined in the Ruling and

Proposed Rule. It appears that CMS's more liberal Part B rebilling policies included in the Ruling may be an attempt to alleviate the overburdened Medicare appeals system. Importantly, in both the Ruling and Proposed Rule, CMS attempts to modify the Medicare appeals framework by limiting a Medicare appeal adjudicator's scope of review.

In this Alert we outline several key provisions of the Ruling and Proposed Rule as well as important questions raised by CMS's approach to these provisions. It is important to recognize that the Ruling is viewed as an interim measure while CMS works to finalize its policy and CMS may change the proposed policies in any final rulemaking. We will delve into the Ruling and Proposed Rule in even greater detail during a Roundtable which King & Spalding will host on March 26, 2013.

II. BACKGROUND

Prior to the issuance of the Ruling and Proposed Rule, CMS has taken the position that, if a hospital's claim under Part A for an inpatient admission was denied for lack of medical necessity, the hospital was not permitted to bill Part B for any services that otherwise would be payable as outpatient services. This policy prohibited hospitals from billing for emergency room visits, clinics visits, scheduled outpatient surgeries and observation services that were acknowledged to be reasonable and necessary and actually provided to the patient but did not require an inpatient admission. As a result of the policy, RACs recovered 100 percent of the reimbursement for the Part A claim, and hospitals would receive no reimbursement for medically necessary services that were provided. To support such outcomes, CMS relied on the authority set forth below.

CMS has maintained a long-standing policy of allowing payment under Part B for a limited set of services provided to hospital inpatients with no Part A coverage. The list of services -- referred to as "Part B Inpatient" or "Part B Only" services -- for which hospitals could bill Part B, however, was very limited and included only a small set of diagnostic services and supplies such as laboratory tests and x-rays. *See* Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, ch. 6, § 10. Under prior policy, CMS would allow hospitals to submit Part B outpatient claims for an expanded set of services -- such as surgeries and observation services -- but only if the hospital met the stringent requirements for Condition Code 44. Under Condition Code 44, if a hospital determined upon internal utilization review that the services did not meet inpatient criteria, the hospital could submit an outpatient claim for Part B services, but only if the patient's status was formally changed pursuant to the utilization review process (granting the beneficiary notice of the proposed status change) prior to the patient's discharge and before a Part A claim was submitted. Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, ch.1 § 50.3.1. Because of these strict time limits and requirements, hospitals often have not been able to avail themselves of Condition Code 44, particularly after a RAC audit resulted in a denial of a previously paid inpatient stay that occurred months or years in the past. In addition to these policies, CMS also took the position that claims for Part B services submitted after the denial

of an inpatient claim were properly rejected if they were not submitted within the timely claim filing requirements set forth in 42 C.F.R. § 424.44.

In a series of decisions, the Medicare Appeals Council, however, held that CMS policies did not prohibit Medicare from reimbursing hospitals under Part B for medically necessary outpatient services provided to patients following the denial of an inpatient admission for lack of medical necessity. The Medicare Appeals Council, which is the final adjudicative decision-maker for the Secretary of Health and Human Services in Medicare claims appeals, cited other manual provisions and interpreted them so as to allow payment for all medically necessary services that were otherwise payable as outpatient services, including observation services. *See, e.g., In the case of O'Connor Hospital*, Medicare Appeals Council (Feb. 1, 2010); *In the case of UMDNJ - University Hospital*, Medicare Appeals Council (Mar. 14, 2005). Even though Medicare Appeals Council decisions are not binding on ALJs, ALJs began to routinely award Part B payment and remand cases for determinations of the amount that should be paid under Part B pursuant to the Council's decisions.

As a result of the number of ALJ decisions awarding Part B payment (including outpatient observation services), CMS issued a Technical Direction Letter (TDL) dated July 13, 2012 which instructed its claims processing contractors to make payment when ALJs awarded Part B payment. Specifically, the TDL notes that there have been "a number" of recent ALJ decisions that have upheld claims administration contractors' denials of inpatient services as not reasonable and necessary but that have required the contractors to "pay for the services on an outpatient basis and/or at an 'observation level of care.'" The TDL further explains CMS's view that these ALJ decisions conflict with certain CMS authority. Nonetheless, CMS instructed its contractors to make payment when there were ALJ decisions of this nature, based on the agency's recognition (confirmed in the Ruling) that, although the Medicare Appeals Council and ALJs do not establish Medicare payment policy, CMS is "bound to effectuate each individual decision." In both the Ruling and Proposed Rule, CMS explains that the issuances have been prompted, at least in part, because of the numerous appeal decisions awarding Part B payment which "have caused operational difficulties."

In November 2012, the American Hospital Association and several individual hospitals and health organizations that had appealed RAC denials of inpatient admissions sued CMS alleging that the policies described above were, among other issues, inconsistent with the Medicare statute. *American Hospital Association v. Sebelius*, 12-1770, (D.D.C. Nov. 1, 2012). The CMS Ruling may be an attempt to forestall the litigation by offering to provide some of the relief sought in the Association's lawsuit. However, if the Proposed Rule is finalized as written, the relief will be inadequate.

III. MARCH 13, 2013 CMS ISSUANCES

A. CMS Ruling 1455-R

At the outset, it is important to recognize that CMS has made clear that the Ruling is only an *interim* measure while CMS pursues formal rulemaking and contemplates its Part B rebilling policies. Moreover, based on the provisions included in the Proposed Rule, it does not appear that CMS intends to adopt the more liberal Part B rebilling policies set forth in its Ruling. Nonetheless, it is important for providers to understand the Ruling as it applies to currently pending matters and it may be several months before CMS issues any final rule.

The Ruling applies to any pending administrative appeals in which hospitals challenge the denial of an inpatient stay for lack of medical necessity and to recently denied claims that can still be timely appealed. The Ruling will also apply to all future inpatient admission denials for lack of medical necessity until such time as CMS finalizes the policy proposed in the companion Proposed Rule. Hospitals with such claims and appeals can submit Part B inpatient claims for Part B services that would have been payable to the hospital had the patient been treated as an outpatient rather than an inpatient (except for services that require "outpatient status" such as observation services). Hospitals may also submit Part B outpatient claims for services that were not otherwise separately billable because they fell within the three-day payment window prior to the inpatient admission. Under the Ruling, hospitals may elect to withdraw pending appeals to pursue Part B payment (or submit Part B claims for payment following a RAC denial). Alternatively, hospitals can continue to pursue their Part A appeals and, if the appeal is ultimately unfavorable, bill for Part B services within 180 days of a final unfavorable decision. The Ruling does not permit Part B rebilling policy for hospitals that self-identify medically unnecessary claims through self-audit or utilization review. The Ruling also terminates the Part A to Part B Rebilling demonstration.

1. Content of the CMS Ruling 1455-R

The Ruling is effective *immediately* and applies only to circumstances in which a Part A claim is denied by a Medicare contractor (e.g., a RAC) for lack of medical necessity for the inpatient admission. The Ruling does not apply in other circumstances in which Part A payment cannot be made, such as when a beneficiary's Part A hospital benefits are exhausted. The Ruling will remain in effect until the effective date of the regulations that finalize the policies proposed in the companion Proposed Rule.

As explained previously, the Ruling applies to pending administrative claims challenging the denial of an inpatient admission for lack of medical necessity as well as recent denials that are within the appeal time limit and future denials that occur before the effective date of any final rule on the topic. In such situations, the Ruling specifically provides covered hospitals with the following relief:

> "[T]he hospital may submit a Part B inpatient claim for more services than just those listed in MBPM, Chapter 6, Section 10" and "may submit a Part B inpatient claim for

> payment for the Part B services that would have been payable to the hospital had the beneficiary been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, for example, outpatient visits, emergency department visits and observations services." * * * Further . . . hospitals may continue to bill separately for the outpatient services furnished during the 3-day . . . payment window prior to the inpatient admission, including observation and other services that were furnished in accordance with Medicare's requirements."

CMS Ruling 1455-R at 16-17.

2. Procedures and Time Frames Set Forth in CMS Ruling 1455-R

The Ruling essentially allows hospitals to elect whether to pursue administrative appeals challenging the denial of the inpatient stay (paid under PPS based on DRG) or withdraw such appeals and submit claims for possible coverage of an expanded list of Part B services. Hospitals that elect to withdraw their appeals are required to submit a request for withdrawal of their claims to the appropriate adjudicator with whom the appeal is pending (except where the appeal has been remanded by an ALJ to a Qualified Independent Contractor (QIC)). Hospitals will have 180 days from the date of receipt of the adjudicator's dismissal notice to file their Part B claims (receipt is presumed to occur five days after the date of the notice).

Alternatively, hospitals can continue to pursue their appeals. In such cases, hospitals that are ultimately unsuccessful in reversing the Part A claim denial may still rebill under the policy announced in the Ruling and will have 180 days to do so from the date of their receipt of the final or binding unfavorable appeal decision (again, receipt is presumed to occur five days after the date of the decision).

When an ALJ has remanded an appealed claim to a QIC without ruling on the medical necessity for an inpatient admission, the Ruling requires QICs to return the claim to the ALJ "for adjudication of the Part A claim appeal consistent with the scope of review explained . . . in the Ruling." CMS Ruling 1455-R at 12. This is a reference to another holding in the Ruling under which CMS has dictated the appropriate "scope of review" for appeals that challenge the denial of an inpatient admission for lack of medical necessity.

The Ruling expressly rejects the authority of the Medicare Appeals Council decisions that ordered payment under Part B for medically necessary services provided during the course of a medically unnecessary inpatient stay and holds that "if such a determination is appealed, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and such adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination." CMS Ruling 1455-R at 15. Apparently, this holding means that for all claims currently on appeal, and which will be appealed before a final rule is issued, adjudicators may only address the underlying question of the necessity of the inpatient stay but may not order payment for Part B services which the hospital has not yet claimed. For hospitals that received an order remanding the case from an ALJ to a QIC for payment, their claims will be returned to the ALJ to make a ruling on the underlying necessity issue (or the hospital has the option to

withdraw the appeal at that stage and submit Part B claims for payment). In this respect, CMS has undermined the prior orders of its ALJs, forcing them to "re-adjudicate" their appeals on remand under the Ruling dictates.

B. Proposed Rule 1455-P

CMS proposes to adopt a similar rebilling policy in its Proposed Rule. However, there are two significant differences between the Proposed Rule and the Ruling. First, in the Proposed Rule, CMS is proposing to apply the existing claim filing deadline (one-year after date of service) to Part B rebilling following a medical necessity denial. Under the Ruling, CMS granted providers with existing appeals and claim denials an additional 180 days *after appeal rights were exhausted* to rebill for Part B services. The Proposed Rule provides far less relief, therefore. Second, the Proposed Rule would allow hospitals to rebill for Part B services if the hospital determines pursuant to 42 C.F.R. § 482.30(d) (utilization review for inpatient services) that an inpatient stay was unnecessary after the beneficiary has been discharged. In other words, if the Proposed Rule is finalized as now written, a hospital could bill Part B even if it did not give notice to the beneficiary prior to discharge that he would be treated as an outpatient (and thus subject to copays and deductibles), as long as the hospital submits a "no pay/provider liable" Part A claim acknowledging that the hospital, not the beneficiary, is financially liable for the cost and services on the Part A claim. Neither the Ruling nor the Proposed Rule appear to allow hospitals that identify unnecessary stays pursuant to post-claim audits and other similar reviews to rebill for Part B services.

1. Content of Proposed Rule 1455-P

The Proposed Rule issued in tandem with the Ruling proposes to adopt a similar Part B rebilling policy for all Part A claims for inpatient stays that are denied for lack of medical necessity after the effective date of a final rule. Specifically, the Proposed Rule proposes that rebilling will be allowed, following a denial, of an expanded set of "inpatient Part B" services to include "Part B services that would have been payable to the hospital had the beneficiary been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status" such as observation services. Like the Ruling, the Proposed Rule would allow hospitals to bill separately for outpatient services furnished during the 3-day payment window prior to the inpatient admission, including observation services. Finally, the Proposed Rule also proposes to adopt as a final rule the limited "scope of review" for administrative adjudicators that are reviewing challenges to the denial of a Part A inpatient admission: that is, the scope of review is limited to whether the claim was medically necessary and the adjudicator may not make a ruling about payment for items or services that have not yet been billed. As detailed below, however, much of the relief CMS provides to hospitals in the Ruling is eliminated in the Proposed Rule as a result of the Proposed Rule's adherence to the timely filing deadlines.

Additionally, unlike the Ruling, the Proposed Rule would allow hospitals to rebill for Part B services if the hospital determines pursuant to 42 C.F.R. § 482.30(d) (utilization review for inpatient services) after a beneficiary is discharged that an inpatient admission was unnecessary. Although the Proposed Rule would

eliminate the need to give notice to the beneficiary of a change from inpatient to outpatient status prior to discharge, it otherwise does not expressly eliminate the Condition Code 44 process. But neither the Ruling nor the Proposed Rule appear to allow hospitals to rebill for Part B services after identifying unnecessary stays pursuant to post-claim self audits and other such reviews.

2. Procedures and Time Frames Set Forth in CMS Proposed Rule 1455-P

The Ruling allows hospitals to continue to pursue appeals of the Part A denial in order to challenge the RAC's review of medical necessity and also allows hospitals to bill for necessary Part B services that were in fact provided if the appeal was ultimately disallowed. While the Ruling prohibits a hospital from *simultaneously* pursuing an appeal and submitting Part B claims, the Ruling grants hospitals an additional 180 days after the appeal is denied to submit Part B claims. That is not the case with the Proposed Rule.

Instead, CMS proposes to keep the timely filing deadline for Part B services in place so that Part B claims would have to be submitted within one year after the date of service rather than 180 days after the claim is denied or 180 days after appeal rights are exhausted. This restriction seems unnecessary and unwarranted and creates a giant game of chicken with the appeals process. CMS, in the Proposed Rule itself, recognizes that medical reviews that lead to denials of inpatient claims might occur more than a year after the date of service. Furthermore, generally speaking, claims may be reopened by contractors within four years of the date the claim is paid (RACs currently have a three year lookback period). But more practically, applying the one-year date of service time-limit for submitting Part B claims does not reflect hospitals' experience with RAC denials of inpatient admissions. A significant number of RAC inpatient denials are reversed on appeal by ALJs. Yet, the Proposed Rule would force hospitals to either abandon those appeals (because it would not be likely to receive an ALJ ruling within the one-year date of service filing deadline) or abandon any chance of receiving limited payment under Part B. This seems akin to the policy that was rejected by the Medicare Appeals Council. Moreover, CMS does not provide a rational explanation as to why it would depart from the more liberal policy that is now in place in the Ruling. In effect, the Proposed Rule establishes an "end run" around the deliberative decision making process that CMS's ALJ's and Medicare Appeals Council have engaged in over the past several years.

IV. Unanswered Questions

The claims appeal process has been bogged down with numerous appeals from hospitals that are challenging RAC denials of inpatient claims. CMS's prior policy of refusing to pay for Part B services provided during the inpatient stay until forced to do so by an ALJ or Medicare Appeals Council order is, in part, responsible for delays in the appeals process. CMS's Ruling appears to provide some welcome relief for many hospitals that are caught in this trap. However, the Ruling leaves several questions unanswered, and hospitals will need to receive more guidance about these questions before they consider how to move forward in light of the Ruling. Such questions include:

- CMS's explanation of the type of Part B services for which it will pay is unspecific. What precisely is included in the category of "Part B services that would have been payable to the hospital had the beneficiary been treated as an outpatient rather than admitted as an inpatient"?

- What must hospitals do to take advantage of the Ruling? The Ruling does not describe specifically how a hospital is to notify a claims adjudicator that it wishes to withdraw an appeal or how to submit "inpatient Part B" claims or "outpatient Part B" claims for services that were provided during an inpatient stay. Instead, the Ruling directs hospitals to look for further instructions from Medicare contractors and the Office of Medicare Hearings and Appeals.

- Will hospitals that have already received an ALJ or Medicare Appeals Council decision awarding Part B reimbursement, including observation services, be forced to abandon their claims for such services that are outside the scope of the Part B services approved under the Ruling (which specifically excludes observation services)?

- Are contractors prepared to receive such claims from hospitals and do they have the specifications in place for such claims to be paid appropriately? Will these claims be rejected because current systems will reject them as untimely submitted?

- Can hospitals that have had claims remanded by ALJs to QICs continue to work with QICs or MACs to receive Part B payment, including observation services to the extent so ordered?

- Several hospitals participated in the Part A to Part B Rebilling Demonstration under which they received only 90 percent of the reimbursement for Part B services. What are the exact terms under which the demonstration will be terminated?

- For providers with pending appeals, should the providers elect to file for Part B payment, will the providers be responsible for the interest that has been assessed on the alleged Part A overpayment? A related unanswered question is whether providers will be entitled to any interest if they elect to withdraw their pending appeals and accept Part B payment.

- The Ruling appears to preclude hospitals from making any claim for reimbursement associated with observation-like services that were provided following an inpatient stay, even though many RAC denials are premised on the notion that the patient only received observation care. To what extent are hospitals still being denied reasonable compensation for the necessary services they did provide in such cases?

V. NEXT STEPS

Although we recognize that the CMS's Part B payment policy outlined in the Proposed Rule may change in any final rule, the Proposed Rule and Ruling provide valuable insight into CMS's current thinking about Part B rebilling policies. Accordingly, providers may want to consider:

- Reviewing the Ruling and Proposed Rule carefully to identify questions, comments and problems;
- Submitting comments on the Proposed Rule;
- Contacting your Medicare Administrative Contractor to obtain more information on how Part B payment requests will be effectuated under the Ruling;
- Making your views known to state and national associations; and
- Registering for King & Spalding's March 26, 2013 Roundtable on the significant provisions included in the Ruling and Proposed Rule. (You will receive an invitation shortly.)