HDJN
The health law solution.

CLIENT ADVISORY

May 15, 2013

More Proposed Rules Targeting Short Stay Admissions: CMS Seeks to Define "Inpatient" in the Proposed FY 2014 IPPS Rules

On May 10, 2013, the Centers for Medicare & Medicaid Services (CMS) published its proposed fiscal year (FY) 2014 Inpatient Prospective Payment System (IPPS) rule. In recent years, CMS' recovery auditor contractors (RACs) have targeted short-stay inpatient hospital admissions. If the proposed rule is promulgated, the RACs and other Medicare auditors will continue to target short-stay inpatient hospital admissions, but will be armed with more objective criteria to support short-stay inpatient hospital admission claim denials.

I. Redefining "Hospital Inpatient"

Current CMS guidance explains that inpatient hospital admissions are appropriate for patients who are expected to need hospital care for 24 hours or more. All other patients are to be treated on an outpatient basis. The current guidelines are somewhat broad and subjective, explaining that the decision to admit a patient for an inpatient stay is a clinical decision based on the physician's professional judgment and expectations for the patient. In the FY 2014 IPPS proposed rule, CMS attempts to establish more objective criteria for billing an inpatient hospital stay. Specifically, the proposed rule creates a presumption that a hospital inpatient admission is reasonable and necessary when a beneficiary's inpatient stay lasts longer than one Medicare utilization day. CMS explains that this includes "encounters crossing between two (2) midnights." The proposed rule varies from the current, more subjective guidance (allowing expected time in the hospital to factor into the admission decision) by suggesting that an inpatient admission is appropriate only when inpatient hospital services span across a certain time period – i.e. "two midnights".

If the proposed rule is implemented, Medicare auditors may also presume that, if an inpatient stay did not exceed 24 hours, the inpatient stay was not medically necessary. Hospitals can overcome this presumption only if documentation shows that exceptional circumstances required the discharge or transfer of the patient within 24 hours of the inpatient admission. Though the proposed rule provides insight into CMS's expectations, the presumptions created by the proposed rule will create additional documentation burdens for hospitals while providing RACs with the regulatory authority needed to uphold inpatient admission claim denials.

II. Physician Order/Certification of Inpatient Admission Becomes a Condition of Payment

The Medicare Conditions of Participation ("CoP") for Hospitals already require a physician to order and certify the medical necessity of all inpatient hospital admissions. In the 2014 IPPS proposed rule, CMS proposes to make this CoP requirement a condition of Medicare payment as well. CMS explains "[w]hile the requirements for physician admission orders have long been clear in the CoPs, we are proposing to state explicitly in the payment regulations that admission pursuant to this order is the means whereby a beneficiary becomes a hospital inpatient and, therefore, is required for payment of hospital inpatient services under Medicare Part A."

III. New Quality Measures

The 2014 IPPS proposed rule also establishes additional hospital Inpatient Quality Reporting (IQR) measures. These measures are intended to reduce patient readmissions to hospitals following high risk episodes of care. CMS proposes to create a 30 day standardized episode of care window for patients who have COPD, stroke or myocardial infarction related hospital admissions. CMS hopes that by including these measures in the IQR program, hospitals with high rates of readmissions will experience lower payments for subsequent readmissions related to these conditions. Conversely, hospitals that have low occurrences of readmissions within the 30 day episode of care window will receive an increase in overall IPPS payments once DRGs are adjusted according to the risk standardization payment calculation.

IV. Implications for Long Term Care Hospitals (LTCHs)

Under the proposed rule, payments to LTCHs should increase by approximately $62 million or 1.1% in FY 2014. This increase is the result of several adjustments, including:

- a 1.8% adjustment for LTCHs that submit quality data;

- a "one-time" budget neutrality adjustment to standard federal rate of approximately -1.3% under the second year of a three-year phase-in; and
- projected increases in estimated high cost outlier payments as compared to FY 2013.

Additionally, a statutory moratorium on the application of the "25% rule" expires in FY 2013. In the proposed rule, CMS reminds LTCHs that in FY 2014, under the 25% patient threshold policy, if an LTCH admits more than 25% of its patients from a single acute care hospital, Medicare will pay the LTCH at a rate comparable to IPPS hospitals for those patients above the threshold.

HDJN encourages all hospitals to review the FY 2014 IPPS proposed rule very carefully to determine its potential impact on hospital operations. Comments on the proposed rule will be accepted until June 25, 2013. CMS expects to respond to comments in a final rule to be issued by August 1, 2013.

If you have questions or need assistance regarding Medicare reimbursement, including the Medicare IPPS rules for FY 2014, please contact Mary Malone (mmalone@hdjn.com), Emily Towey (etowey@hdjn.com) Michelle Calloway (mcalloway@hdjn.com) or Thomas Miller (tmiller@hdjn.com). They can be reached by phone at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C., is available on the firm's website at www.hdjn.com.