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CLIENT ADVISORY
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Rebilling and Two-Night Stays: CMS Releases 2014 Inpatient Prospective Payment System Final Rule

On August 2, 2013, the Centers for Medicare and Medicaid Services ("CMS") released the fiscal year 2014 hospital inpatient prospective payment system ("IPPS") final rule. In addition to establishing a 0.7% payment increase to PPS hospitals, CMS finalized its proposal to change the definition of an "inpatient" for payment purposes, as well as its proposal to give hospitals a limited opportunity to rebill denied Part A claims under Part B. Despite hundreds of comments urging CMS to adopt a more measured policy, the agency enacted its proposed rules as written, leaving hospitals at risk to receive more denials of inpatient admissions while at the same time limiting hospitals' ability to recoup partial reimbursement for denied payments.

The Rebilling Policy

In March, CMS published a proposed rule (CMS-1455-P) and a Ruling (CMS-1455-R) in response to an overwhelming number of appeals of Part A denials made by CMS' Recovery Audit Contractors ("RACs"). The RACs conduct after-the-fact reviews and routinely deny payment for inpatient admissions deemed not reasonable and necessary. Instead of recouping the difference between the Part A payment and the Part B payment that would be reasonable and necessary, the RACs' practice has been to deny the entire Part A payment and force hospitals to appeal to receive an offset award. Under CMS' Ruling, hospitals could choose to rebill denied Part A claims as Part B claims and receive partial payment in lieu of pursuing an appeal of the denial. CMS established a time limit for this rebilling procedure of 180 days after the denial or 180 days after the hospital withdraws a pending appeal of the Part A claim, but it waived its usual "timely filing" limit of 12 months from the date of service. In CMS' proposed rule, however, the agency proposed to formally establish the rebilling policy and impose the 12-month timely filing requirement, meaning that hospitals could only rebill a denied claim within 12 months of the original date of service. Industry stakeholders commented that this proposal rendered the rebilling policy essentially moot, as the RACs have the ability to audit and deny claims up to 3 years from the date of service, and in the majority of cases, the timely filing period has expired by the time the claims are audited and denied.

CMS finalized its Part A to Part B rebilling rule in the 2014 IPPS Final Rule, including the 12-month timely filing limit and the exclusion of certain "outpatient-only" services (including observation services). The rebilling policy will take effect on October 1, 2013, meaning that hospitals may take advantage of the more expanded rebilling policy from CMS' earlier ruling for claims if (1) the denial was one that already fell under the ruling or (2) the claim has a date of service prior to October 1, 2013 and is denied after September 30, 2013. Despite hospitals' insistence that it is cumbersome and confusing to rebill beneficiaries for resulting Part B copayments when rebilling claims under the Ruling, CMS refused to allow for an exception to its prohibition on waiver of beneficiary liability.

New Definition of "Inpatient"

In this rulemaking, CMS also finalized its proposed changes to the definition of an "inpatient" for Medicare payment purposes. CMS now considers an "inpatient" to be a patient who is admitted to the hospital with the expectation that the patient will need hospital care crossing "two midnights." Formerly, CMS considered a patient an "inpatient" if, upon admission, the admitting physician expected the patient to require hospital care for at least 24 hours. CMS and its contractors will now presume that if a patient receives care at a hospital for a time period that does not encompass "two midnights," the services are "generally inappropriate for payment under Medicare Part A." Faced with the threat of post-payment denials by RACs and other contractors, hospitals will be forced to bill more

patients' stays as outpatient stays, receiving lower reimbursement for what are usually the same services that are provided to an inpatient.

In this Final Rule, CMS also finalized a proposal to add regulatory language to make the presence of a physician's inpatient admission order an express condition of Medicare payment. Additionally, while CMS' regulations have previously required a physician "certification" of medical necessity for extended stays, CMS clarified that it expects hospitals to document a physician certification of medical necessity for all inpatient stays. The certification does not have to take any specific form, but must include a statement that (1) the services were provided in accordance with an inpatient admission order and (2) the reasons for the hospitalization or special or unusual services for cost outlier cases. The certification must be completed, signed, and documented in the medical record prior to a patient's discharge. Lack of a proper inpatient admission order or certification will be another basis on which RACs and other Medicare auditors will seek to deny payment.

If you have any questions about CMS' 2014 IPPS Final Rule or how these policy changes affect your hospital's compliance program and RAC appeals strategy, please contact a member of HDJN's Reimbursement team: Mary Malone (mmalone@hdjn.com), Emily Towey (etowey@hdjn.com), Michelle Calloway (mcalloway@hdjn.com), Colin McCarthy (cmccarthy@hdjn.com), Clay Landa (clanda@hdjn.com), or Tommy Miller (tmiller@hdjn.com). They are also available 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.

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