

CMS FINALIZES REBILLING AND INPATIENT ADMISSIONS CRITERIA POLICIES

AT A GLANCE

The Issue:

On Aug. 2, as part of its fiscal year 2014 hospital inpatient prospective payment system (PPS) [final rule](#), the Centers for Medicare & Medicaid Services (CMS) finalized its policy on rebilling Medicare Part A claims and its requirements for admission and medical review criteria for hospital inpatient services under Medicare Part A. These new policies are effective Oct. 1. The final rebilling policy allows hospitals to rebill under Part B for most services after a Part A claim has been denied because the admission was found not reasonable and necessary, although the Part B claim must be submitted within one year of the date of service. CMS also finalized its “two midnight” policy and will generally consider hospital inpatient admissions spanning two midnights as reasonable and necessary for payment under Part A. To educate providers about this new “two midnight” policy, CMS held a national Open Door Forum Aug. 6 and intends to hold additional forums, issue implementation instructions, and develop guidance and educational materials to ensure that hospitals, physicians and Medicare contractors will be able to apply the new policy on a consistent basis. See our separate *Regulatory Advisory* for further details on the other policies included in the inpatient PPS final rule.

Our Take:

The AHA is extremely disappointed that CMS’s final rule does not fundamentally reform its policy on rebilling and continues to deny hospitals reimbursement for all reasonable and necessary services they provide to their Medicare patients. The AHA plans to press ahead with the rebilling [litigation](#) we initiated last year. Further, while we appreciate CMS’s efforts to provide clarification and make modifications regarding when an inpatient admission is reasonable and necessary, we are concerned that the new “two-midnight” policy will not reduce the number of appeals of Part A claim denials – particularly if the guidance issued by CMS is not precisely written and enforced – and, more importantly, could be applied in a manner that undermines medical judgment. CMS is seeking provider input on this guidance to providers and Medicare contractors, which will be critical to implementing the final rule provisions in a fair and consistent manner. A number of statements in the final rule could be helpful to hospitals if incorporated appropriately in the guidance. The AHA intends to provide feedback to CMS to help shape its guidance and ensure consistent application of the new policies across providers and Medicare contractors. Further, the AHA continues to urge Congress to support changes included in the *Medicare Audit Improvement Act* (H.R. 1250/S. 1012).

What You Can Do:

- ✓ Share this advisory with your senior management team, including your chief financial officer and your director of billing.
- ✓ Identify whether your hospital has denials of claims as not reasonable and necessary under Part A that are still eligible for appeal, or appeals currently in process, that you may want to rebill under Part B.
- ✓ **Submit comments to CMS on the two midnight policy at IPPSAdmissions@cms.hhs.gov and participate in upcoming Open Door Forums (dates to be announced by CMS) to help shape subregulatory guidance and ensure the agency appropriately operationalizes the policy for providers and Medicare contractors.**
- ✓ Conduct training for physicians and staff on the rule’s documentation requirements regarding the two midnight policy.
- ✓ Look for additional communications from the AHA, including a member call on the two midnight policy.

Further Questions: For questions, contact Melissa Jackson, AHA senior associate director of policy, at (202) 626-2356 or mjackson@aha.org.

August 30, 2013

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BACKGROUND

On Aug. 2, the Centers for Medicare & Medicaid Services (CMS) finalized its policy on rebilling Medicare Part A claims as part of its fiscal year (FY) 2014 hospital inpatient prospective payment system (PPS) [final rule](#). CMS also finalized its requirements for admission and medical review criteria for hospital inpatient services under Medicare Part A as part of the same final rule. These policies are effective Oct. 1. See our separate *Regulatory Advisory* for further details on the other policies included in the inpatient PPS final rule.

The final rebilling policy allows hospitals to rebill under Part B for most services after a Part A claim has been denied because the admission was found not reasonable and necessary, although the Part B claim must be submitted within one year of the date of service. Historically, following an auditor's denial of a claim as not reasonable and necessary under Medicare Part A, hospitals were limited to rebilling under Part B for only certain ancillary services. The result was that hospitals were not fully reimbursed for reasonable and necessary services even though the only dispute was the setting in which the care should have been delivered.

In addition, CMS finalized its requirements for admission and medical review criteria, or "two-midnight" policy, to generally consider hospital inpatient admissions spanning two midnights as reasonable and necessary for payment under Part A. CMS states that the new "two-midnight" policy addresses the hospital community's concerns that Medicare's standards for hospital inpatient admission are not clear and that the medical review criteria for Part A hospital inpatient claims have been inappropriately applied. Further, CMS anticipates that its new requirements for admission and medical review criteria will result in a decrease in Part A claim denials based on inpatient admission and, therefore, in hospitals' reliance on the newly finalized Part B rebilling policy. CMS held a national Open Door Forum Aug. 6 and intends to hold additional forums, issue implementation instructions, and develop guidance and educational materials to ensure that hospitals, physicians and Medicare contractors will be able to apply the new policies on a consistent basis. Both policies are discussed in detail below.

PART B REBILLING POLICY

The final rule made few changes to CMS's March 13 proposed rebilling policy. The agency will permit hospitals to submit a new Part B claim when an inpatient admission is later denied as not reasonable and necessary. Hospitals will be permitted to rebill for an expanded set of services, but must do so within the one-year timely filing period.

The AHA is extremely disappointed that CMS's final rule did not fundamentally reform its policy on rebilling and continues to deny hospitals reimbursement for all reasonable and necessary services they provide to Medicare beneficiaries. The AHA plans to proceed with the [litigation](#) we initiated last year.

Eligible Claims

The final rule specified that the rebilling policy applies to general acute care hospitals, long-term care hospitals (LTCHs), inpatient psychiatric facilities, inpatient rehabilitation facilities (IRFs), critical access hospitals (CAHs), children's hospitals, cancer hospitals and Maryland waiver hospitals. Hospitals that are excluded from billing under the outpatient PPS, such as LTCHs and IRFs, would be eligible to rebill Part B inpatient services using their traditional Part B payment methodologies, such as the physician fee schedule.

In addition to claims denied by a Medicare auditor, a hospital may rebill under Part B if, during a self-audit, it identifies cases of inpatient care that should have been provided as outpatient care. This option applies only when patients have already been discharged.

Timely Filing Requirement

The rule finalized CMS's proposed application of the timely filing rules, which allows hospitals to rebill under Part B only within one year of the date of service. **This provision will significantly limit the number of Part A denials eligible for Part B payment, as Recovery Audit Contractors (RACs) have the authority to audit services provided during the previous *three* years, and often audit services after the one-year timely filing window has expired.**

CMS acknowledged that it has statutory authority to create exceptions to the one-year timely filing requirement. However, the agency did not believe an exception was appropriate in this case, since it asserts that hospitals have the ability to avoid being disadvantaged by the timely filing window if they initially bill correctly by following Medicare's guidelines for inpatient admissions.

Eligible Services

CMS finalized its proposal to expand the types of services that may be rebilled as a Part B inpatient claim when a Part A claim for the services was denied as not reasonable and necessary. Prior to the final rule, CMS allowed providers to rebill only for certain ancillary services. In the final rule, CMS declined to create a list of services that are eligible for rebilling. Instead, the agency states that a hospital may rebill for all services "that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient."

However, the final rule states that “such services that require an outpatient status” cannot be billed for the time period the beneficiary spent in the hospital as an inpatient and thus cannot be included on the Part B inpatient claim. Specifically, the final rule excludes from rebilling those services that, by statute, Medicare definition or standard Healthcare Common Procedure Coding System code, are defined as outpatient services. CMS states that, currently, the exclusion applies to outpatient visits, including emergency department visits; observation services; and outpatient diabetes self-management training services. **Although the proposed rule also excluded outpatient physical, speech-language and occupational therapies from rebilling, CMS acknowledged in the final rule that these services may be appropriately delivered as part of inpatient stay, and thus may be rebilled under the final rule.** The agency notes that it may identify additional services that require outpatient status and restrict rebilling of those services through future rulemaking.

Finally, the final rule expressly states that hospitals may rebill separately for outpatient services furnished during the three days prior to an inpatient admission. These services should be billed on a Part B outpatient claim and are subject to the one-year timely filing requirement.

Appeals Process Changes

In the final rule, CMS reiterates that a hospital that is dissatisfied with the decision of a Medicare contractor may either appeal its Part A denial or submit a Part B inpatient claim, but may not pursue both options at the same time. If a hospital simultaneously pursues both actions for the same claim, CMS will deny the Part B claim.

If, during a self-audit, a hospital identifies cases of inpatient care that should have been provided as outpatient care, the hospital must cancel its Part A claim by submitting a “no pay/provider liable” Part A claim, indicating that the provider is liable for the cost of the Part A service. The hospital could then submit a Part B inpatient claim for the services that would have been reasonable and necessary if the patient had been treated as an outpatient.

If a beneficiary has an active Part A appeal, then the hospital may not file a Part B claim until the beneficiary’s appeal is finalized, and then may do so only if the timely filing window has not expired. If a beneficiary does not have an active Part A appeal, the hospital’s filing of a Part B inpatient claim would not affect that beneficiary’s Part A appeals rights.

Finally, CMS finalized its proposed restriction of the scope of Administrative Law Judges (ALJs) adjudicating the third stage of the Medicare fee-for-service appeals process. Specifically, ALJs and other appeals adjudicators may decide only whether a Part A claim is reasonable and necessary under Part A, and may not decide whether the claim would be reasonable and necessary under Part B. CMS disagrees that this is a restriction in ALJ scope, arguing that adjudicators’ scope of review has always been limited to the initial determination made on the claim before them and that they may not order payment for items or services that have not yet been billed or received an initial determination. It is CMS’s position that a Part B claim submitted under the rebilling policy is a new claim rather than

an adjustment of the denied Part A claim; therefore, the Part B claim must receive a determination before an ALJ can act on it.

Beneficiary Financial Liability

The final rule states that a Medicare beneficiary would not be financially liable for denied Part A care unless he knew in advance of the provision of services that the services would not be covered under Part A. Therefore, hospitals must refund any amount paid by the beneficiary (such as a deductible or co-pays) for denied Part A services. However, beneficiaries would be liable for any applicable deductible or co-payment amounts under Part B, and the full cost of self-administered drugs, if the hospital submits a timely Part B inpatient claim. If the hospital fails to bill Part B in a timely manner, the hospital may not charge the beneficiary.

CMS plans to issue subregulatory guidance regarding how a hospital should handle a situation where a Medicare beneficiary is entitled to a refund of cost sharing under Part A, but owes a liability under Part B. Further, CMS plans to conduct an educational campaign to increase beneficiaries' awareness of Part B rebilling policies. For example, CMS will require that contractors include new messages on the Medicare Summary Notice for beneficiaries affected by a Part A claim denial that may be subject to Part B rebilling. The message will inform beneficiaries that the hospital may submit the claim under Part B and that different cost-sharing charges may apply.

Effect on Administrator's Ruling

CMS continues to apply its March 13 Administrator's Ruling to claims originally eligible for rebilling under that ruling (see the [AHA Regulatory Advisory](#) on this ruling for more information). It also finalized a policy to apply the Administrator's Ruling to claims for services provided before Oct. 1, 2013 that are denied after Sept. 30, 2013. Significantly, claims that are rebilled under the Administrator's Ruling are not subject to the one-year timely filing window.

ADMISSION AND MEDICAL REVIEW CRITERIA

In response to concerns expressed by AHA and others, CMS made several changes to the requirements for admission and medical review criteria under Medicare Part A in its final rule. CMS also provided clarity regarding the proposed two-midnight *benchmark* and the two-midnight *presumption* in its final rule. These changes and clarifications, which are discussed in further detail below, apply to all general acute care hospitals, CAHs and LTCHs, but do not apply to IRFs.

Physician Orders

CMS finalized, with some modifications, its proposed language clarifying the rules governing physician orders of hospital, including CAH, inpatient admissions. Specifically, the agency stated that an individual becomes an inpatient of a hospital if a physician (or other qualified practitioner, as provided in the regulations) orders an inpatient admission in accordance with the hospital conditions of participation (CoPs). CMS provides that the order must include the admitting practitioner's recommendation to admit "to inpatient," "as an inpatient,"

“for inpatient services,” or similar language specifying his or her recommendation for inpatient care.

CMS indicated that in order for Medicare to pay for that admission under Part A, the order must be furnished at or before the time of the inpatient admission and must be documented in the medical record – that is, the order must be supported by objective medical information, including physician admission and progress notes. CMS also reaffirmed the continuing need for physician certification and recertification of medical necessity of hospital inpatient services under the current regulations. CMS clearly noted that although an admission order and physician’s certification are required for Part A payment, they are not by themselves conclusive evidence that the inpatient admission and services were medically reasonable and necessary and would be considered together with other documentation in the medical record during any medical necessity reviews.

In its proposed rule, CMS indicated that the physician order must be furnished by a qualified and licensed practitioner “who is responsible for the inpatient care of the patient at the hospital.” However, in response to numerous comments regarding other practitioners (including emergency department physicians, hospitalists, physicians in group practices or residents) who could sign the inpatient admission order, CMS modified its proposed rule so that the order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital, as permitted by state law, and who is *knowledgeable about the patient’s hospital course, medical plan of care, and current condition*. Further, CMS stated that the practitioner may not delegate the order to another individual who does not meet these conditions.

Two-Midnight Benchmark

The two-midnight *benchmark* is guidance for admitting practitioners and reviewers to identify when an inpatient admission is generally appropriate for payment. CMS finalized its proposed two-midnight *benchmark*, with modifications. Specifically, CMS stated that physicians or other practitioners should admit a beneficiary if:

- They expect that the beneficiary will remain in the hospital for more than one Medicare utilization day, which CMS defines as an admission that crosses two midnights; or
- The beneficiary requires a procedure that is specified as inpatient-only.

Conversely, if the physician expects to keep the beneficiary in the hospital for a period of time that does not cross two midnights, and the procedure is not specified as inpatient-only, the services will generally be considered inappropriate for payment under Medicare Part A.

CMS initially proposed that the starting point for this time-based benchmark would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided. **However, at the AHA’s urging, the agency revised the starting point for this time-based policy to allow the ordering physician to consider time the beneficiary spends receiving outpatient services (including observation services, treatments in the emergency department, and procedures provided in the**

operating room or other treatment areas) when determining whether the two-midnight benchmark is expected to be met. The time a beneficiary spends as an outpatient before the inpatient admission order is written will not be considered inpatient time, but will count for the limited purpose of determining whether the two-midnight benchmark was met and, therefore, payment is appropriate under Part A.

In addition to this two-midnight benchmark, CMS also finalized its position that the judgment of the physician and the physician's order should be based on complex medical factors, such as patient history and co-morbidities; the severity of signs and symptoms; current medical needs; and the risk of an adverse event. As is currently required, the physician must clearly and completely document the clinical facts supporting the inpatient hospital admission. **CMS notes that it is this documentation that would justify the medical necessity of the admission, regardless of the actual duration of the hospital stay and whether it ultimately crosses two midnights.** In other words, if it was reasonable for the physician to expect the beneficiary to require a stay lasting two midnights, even though the patient did not actually stay that long, payment would be made under Medicare Part A if the documentation in the medical record reflected such complex medical factors (and the physician's order and certification requirements also are met).

CMS also acknowledges that there may be unforeseen circumstances that result in a shorter beneficiary stay than the physician's expectation of two midnights. Therefore, the agency created an exception to the two-midnight benchmark, if a beneficiary's death or transfer results in a shorter-than-expected stay. CMS indicated it will identify additional instances in which it expects the two-midnight benchmark will not apply in its manual guidance. In such cases, the patient may be considered to be appropriately treated on an inpatient basis and payment may be made under Part A.

Two-Midnight Presumption

CMS also finalized a two-midnight *presumption* for the purposes of medical review of hospital inpatient admissions. Specifically, CMS indicated that its external review contractors will presume that inpatient hospital claims with lengths of stay greater than two midnights after the formal physician order for admission are reasonable and necessary and generally appropriate for Part A payment. Further, these claims 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 two-midnight presumption. Patient status reviews for lengths of stay greater than two midnights would typically occur if CMS suspects that a provider is abusing the new benchmark by unduly delaying the provision of care.

Conversely, CMS finalized a requirement that contractors' medical review efforts focus on inpatient hospital admissions that cross fewer than two midnights. The agency notes that such claims account for the largest proportion of improper inpatient hospital payments under Medicare Part A. For such stays, Medicare review contractors will review the following when determining whether payment under Part A is appropriate:

- the physician order for inpatient admission to the hospital, along with the other required elements of the physician certification;
- the medical documentation supporting the expectation that care would span at least two midnights; and
- the medical documentation supporting a decision that it was reasonable and necessary to keep the patient at the hospital to receive such care.

In their review of the medical record, Medicare review contractors will consider complex medical factors that support a reasonable expectation that the duration of the stay will meet the two-midnight benchmark. CMS indicates that both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered. **In other words, regardless of whether a stay that crosses two midnights transpires, if it was reasonable for the physician to expect the beneficiary to require a stay lasting two midnights, and that expectation is documented in the medical record, inpatient admission is generally appropriate and payment may be made under Medicare Part A.**

Clear and Consistent Instructions and Guidance

CMS intends to hold national Open Door Forums, issue implementation instructions, and develop educational materials to ensure that hospitals, physicians and Medicare contractors will be able to apply the new requirements on a consistent basis. These instructions and materials will emphasize **that “the decision to admit should be based on and evaluated in respect to the information available to the admission practitioner at the time of admission.”** Therefore, as the AHA urged, CMS plans to restrict its auditors to consider in their reviews only the information available to the admitting physician at the time of admission.

Payment Adjustment

CMS estimates that its policy will increase inpatient PPS expenditures by \$220 million. Therefore, the agency finalized its proposed offset to this additional expenditure by permanently and prospectively reducing the operating PPS standardized amount, the capital standard federal payment rate, sole community hospitals’ hospital-specific rates (as well as Medicare-dependent hospitals’ rates if the program is extended), and the Puerto Rico-specific amount each by 0.2 percent.

While we appreciate CMS’s efforts to provide clarification and make modifications to its proposed rule regarding when an inpatient admission is reasonable and necessary, we are concerned that this policy will not reduce the number of appeals of Part A claim denials, particularly if the guidance issued by CMS is not precisely written and enforced. More importantly, we are concerned that the policy could be applied in a manner that undermines medical judgment. We also are very disappointed that, despite the hospital field’s objections, CMS chose to finalize its 0.2 percentage point cut to inpatient payments to offset the additional inpatient PPS expenditures it believes will be associated with this policy. The AHA

continues to urge Congress to support changes suggested in the *Medicare Audit Improvement Act of 2013* (H.R. 1250/S. 1012).

NEXT STEPS

CMS intends to hold national Open Door Forums, issue implementation instructions and develop educational materials to ensure that hospitals, physicians and Medicare contractors will be able to apply the new requirements on a consistent basis. The AHA will be providing comments to CMS on key considerations for the guidance. The AHA also encourages hospitals to provide additional suggestions and concerns directly to CMS. These may be sent to IPPSAdmissions@cms.hhs.gov.

FURTHER QUESTIONS

For questions, please contact Melissa Jackson, AHA senior associate director of policy, at (202) 626-2356 or mjackson@aha.org.