HLP CLIENT ALERT

CMS Publishes 2014 Inpatient Prospective Payment System ("IPPS") Final Rule:
CMS Payment Policies Related to Patient Status Revised

On August 2, 2013, the Centers for Medicare & Medicaid Services ("CMS") published its highly anticipated 2014 Inpatient Prospective Payment System ("IPPS") Final Rule (the "2014 IPPS Final Rule"). The 2014 IPPS Final Rule will be effective on October 1, 2013.[i] There are two main aspects of the 2014 IPPS Final Rule that will significantly affect the day-to-day operations of hospitals nationwide: First, the 2014 IPPS Final Rule finalizes CMS' proposal to allow billing of many services under Part B following a determination that a Part A inpatient claim will be denied as not medically necessary. Second, the IPPS Final Rule changes the criteria for coverage of Part A of inpatient hospital claims.

A. Payment of Part B Hospital Inpatient Services

On March 13, 2013, the Centers for Medicare & Medicaid Services ("CMS") concurrently issued Ruling CMS-1455-R (the "Ruling")[ii] and a proposed rule (the "Part B Inpatient Billing Proposed Rule")[iii] 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 as set forth below.

1. *Payable Part B Inpatient Services*

Following a Part A claim denial because an inpatient admission was deemed not reasonable and 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 ("DSMT"), and hospital outpatient visits (including ED visits).[iv] However, to the extent that such services are provided to outpatients in the 3-day (1-day for non-IPPS hospitals) payment window preceding inpatient admission, such services may be billed on a Part B outpatient claim.[v] Therapy services are not excluded from Part B inpatient billing in the 2014 IPPS Final Rule.[vi]

2. *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,[vii] even if this determination is made following a patient's discharge from the hospital (i.e., "self-audit").[viii] Although it would seem that this

provision of the 2014 IPPS Final Rule replaces the need for and use of "Condition Code 44," from an operational standpoint if a hospital determines prior to a patient's discharge that the patient's status ought to be that of outpatient rather than inpatient and uses Condition Code 44 to effectuate this change, then the hospital will receive more prompt reimbursement for services rendered. 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,[ix] operationally complicating the process and delaying payment.

3. 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,[x] 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 (rather than admitting beneficiaries as inpatients).[xi]

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., deducible 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.[xii] It is CMS' position that it "cannot… hold beneficiaries harmless for the financial responsibility related to Part B coinsurance and deductible for covered claims."[xiii] Based on comments made within the 2014 IPPS Final Rule[xiv] and recent conversations this office has had with the Office of Inspector General ("OIG"), it is our understanding that the OIG presently is drafting guidance regarding hospitals' obligations with respect to collection of beneficiaries' Part B financial responsibilities. Notably, beneficiary financial liability is often higher for Part B claims than for Part A claims.

Commenters raised concerns related to patients' financial liability in cases where a patient had a 3-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.[xv] However, 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…"[xvi]

4. Timely Filing Provisions

Over 300 commenters on the Part B Inpatient Billing Proposed rule objected to the proposal that claims for billed Part B inpatient services would be rejected as untimely if submitted later than 1 calendar year following the dates of service at issue. Just one commenter supported the proposal.[xvii] 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.[xviii]

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.

5. 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).[xix] The 2014 IPPS Final Rule again 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…"). 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."[xx] In addition, citing its "longstanding Medicare policy,"[xxi] 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.[xxii]

B. Criteria for Coverage of Part A Inpatient Hospital Claims

In addition to finalizing criteria for Part B Inpatient Billing, the 2014 IPPS Final Rule establishes new requirements for coverage of Part A inpatient hospital claims, in particular by creating new requirements for physician orders and certifications and by establishing new guidelines to establish the medical necessity of an inpatient hospital stay under Part A. Generally speaking, many of the proposals set forth in the 2014 IPPS Proposed Rule were finalized, as set forth in greater detail below.

1. Physician orders and certifications

In the 2014 IPPS Final Rule, CMS finalized its proposal to establish that, "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…" The physician order must be present in the medical record and supported by the admission notes and progress notes, in order for a Medicare Part A claim to be paid.[xxiii] Contrary to guidance previously published,[xxiv] the 2014 IPPS Final Rule clarifies that an admission order must expressly document the admitting physician's intent to order inpatient status for the beneficiary.[xxv] An admission order may be made verbally or in writing. CMS indicated its intent to provide additional guidance regarding its expectations of verbal orders by way of sub-regulatory guidance.[xxvi]

The 2014 IPPS Final Rule also creates a requirement for physician certification meeting the requirements of 42 C.F.R. § 424.14.[xxvii] Although 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 and regulations, CMS found these arguments unpersuasive.

With respect to orders, as finalized, 42 C.F.R. § 412.3(a) will read:

> 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…[xxviii]

With respect to certifications, as finalized, 42 C.F.R. § 424.13(a)(2) will require the following:

> (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).[xxix]

The physician order is a required component of the certification[xxx] and must be made at the time of a beneficiary's admission to the hospital.[xxxi] The certification must be signed and documented in the medical record prior to the hospital discharge.[xxxii]

CMS views the regulatory requirements as "clarifications,"[xxxiii] and specifically notes, "[W]e are not finalizing any new documentation requirements."[xxxiv] However, CMS is also requiring that the certification be documented via a separate signed statement within the medical record (except for delayed certifications),[xxxv] and payment for a Part A claim will be tied to physician documentation generally. Therefore, it is essential that admitting physicians and hospitalists are educated regarding CMS' "clarified" requirements, in order to ensure that hospitals receive payment for the medically necessary care provided.

2. Establishing the Medical Necessity of an Inpatient Admission

In the 2014 IPPS Final Rule, CMS finalized criteria to establish the medical necessity of an inpatient admission. In particular, under the 2014 IPPS Final Rule, 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 2 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.[xxxvi] Note that the 2014 IPPS Final Rule does not include exceptions to this standard based on the intensity of services rendered: "[O]ur 2-midnight benchmark policy is not contingent on the level of care required."[xxxvii]

a. Medical Review

With respect to medical review, the IPPS Final Rule establishes two distinct, but related, medical review policies: a 2-midnight *presumption* and a 2-midnight *benchmark*.

i. Presumption

"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."[xxxviii] Deviating from the 2014 IPPS Proposed Rule, the 2014 IPPS Final Rule states that the physician order initiates the inpatient admission.[xxxix]

Note, however, the 2014 IPPS Final Rule is clear that inpatient hospital claims satisfying the 2-midnight presumption will still be assessed by medical review contractors in the following circumstances: (1) To ensure the services provided were medically necessary; (2) to ensure that the 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.[xl] In other words, although the medical review contractors will not focus medical review efforts on claims satisfying the 2-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 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…"[xli]

ii. Benchmark

On the other hand, CMS' medical review contractors will direct focus on inpatient hospital admissions with lengths of stay crossing 1 midnight or less. With respect to the 2-midnight *benchmark* CMS states the following:

> 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 contactors 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…"[xlii]

With respect to the 2-midnight benchmark, the ordering physician may consider time a beneficiary spent receiving outpatient services (including observation services, treatment in the ED and outpatient procedures) when determining whether the 2-midnight benchmark will be met, justifying an inpatient admission.[xliii]

The 2014 IPPS Final Rule summarizes the application of the benchmark as follows:

> Medical reviewers will still consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary. For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital.[xliv]

Given the opportunity to bill inpatient services under Part B, if a hospital stay does not cross 2-midnights (including a patient's time spent receiving outpatient services), hospitals may

choose to either utilize Condition Code 44 to change the patient's status prior to discharge, *or* use the Part B billing option based on self-audit by the hospital's Utilization Review committee – given that the claim has a higher likelihood to be reviewed by a medical review entity and the inpatient admission will not be presumed to be medically necessary. The 2014 IPPS Final Rule 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."[xlv]

As noted by the regulatory language cited above, the 2-midnight benchmark places great emphasis on the physician's documentation regarding his or her expectations of length of stay. Therefore, it is essential that all hospital physicians are educated regarding the importance of documentation within the medical record.

For all of the reasons set forth above, the importance of physician documentation in the context of inpatient hospital claims cannot be overstated. Compliance with the 2014 IPPS Final Rule may involve the adoption of new forms (e.g., Admission Order / Certification forms), and must involve thorough documentation of the need for inpatient hospital services, the physician's expectations regarding length of stay, and rationale for the physician's opinion.

For further information related to claims for inpatient hospital services and appeals of claim denials, please contact The Health Law Partners, P.C., attorneys Jessica L. Gustafson, Esq. or Abby Pendleton, Esq. at (248) 996-8510.

[i] *See* 2014 IPPS Final Rule, *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html?DLPage=1&DLSort=0&DLSortDir=ascending (last accessed August 7, 2013).

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

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

[iv] 2014 IPPS Final Rule at p. 1670.

[v] *Id.*

[vi] *Id.*

[vii] *See id.,* at pp. 1674-1675.

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

[ix] *Id.* at 1675-1676.

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

[xi] *Id.* at 1645.

[xii] *Id.* at 1694.

[xiii] *Id.* at pp. 1696-1697.

[xiv] *Id.* at 1704.

[xv] *Id.* at 1707.

[xvi] *Id.* at 1709.

[xvii] *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.

[xviii] *Id.* at 1721.

[xix] *Id.* at 1739.

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

[xxi] Presumably, by this statement, the "longstanding Medicare policy" CMS relies upon is its longstanding policy to deny payment altogether when an inpatient hospital stay is denied for the reason that the "setting" in which the care provided was inappropriate. This policy was unlawful and has been abandoned by CMS by way of the Ruling and subsequent rulemaking.

[xxii] 2014 IPPS Final Rule at pp. 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…"

[xxiii] 2014 IPPS Final Rule at pp. 1782-1783.

[xxiv] *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."

[xxv] 2014 IPPS Final Rule at 1797.

[xxvi] *Id.* at 1793.

[xxvii] *Id.* at pp. 1782-1783.

[xxviii] *Id.* at 1788.

[xxix] *Id.* at 1789.

[xxx] *Id.* at 1790.

[xxxi] *Id.* at pp. 1796-1797.

[xxxii] *Id.* at 1791.

[xxxiii] *See e.g., id.* at 1789.

[xxxiv] *Id.* at 1789.

[xxxv] *Id.* at 1790.

[xxxvi] *Id.* at 1840.

[xxxvii] Id. at 1816.

[xxxviii] *Id.* at 1830 (emphasis added).

[xxxix] *Id.* at 1792.

[xl] *Id.* at 1830.

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

[xlii] *Id.* at 1831.

[xliii] *Id.* at 1833.

[xliv] *Id.* at pp. 1842-1843. Note the permissive language of this portion of the 2014 IPPS Final Rule: the medical reviewer "may apply" the 2-midnight benchmark.

[xlv] *Id.* at pp. 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. Particularly given the recovery auditors' financial incentive to deny, hospitals are well advised to closely monitor these short-stay cases.