RAC Medical Necessity Denials of Inpatient Services – Fair & Equitable Reimbursement

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As the RACs continue to focus on medical necessity issues in inpatient hospital admissions, hospitals are left with few good options to effectively address these issues. The Medicare definitions regarding the terms "inpatient" and "outpatient" are circuitous and do not give hospitals much guidance, if any, as to when patients should be kept in outpatient observation as opposed to being admitted as an inpatient. If these admissions are subsequently audited, a RAC's decision that the services were medically necessary but should have been performed in a different setting (outpatient) does not result in a reduction in payment from a higher Part A inpatient amount to a lower Part B outpatient amount. It results in the hospital receiving virtually no payment for medically necessary services that a RAC claims was merely performed in the wrong setting.

CMS published FAQ 9462 in November 2008 (and updated it only last month) taking the position that a hospital that receives a demand letter stating that services should have been performed in an outpatient setting can only rebill at the outpatient level for ancillary services and only if all the claim processing rules and claim timeliness rules are met. Unlike the demonstration program, there are no exceptions to these rules. Therefore, in most cases, hospitals are left which no choice but to appeal the RAC's decision in order to receive any level of payment for medically necessary observation and underlying services including but not limited to emergency department care, surgical procedures, recovery room and anesthesia.

While there are no statistics that we are aware of published on the rates of overturning medical necessity decisions in short stay cases, both from our experiences and anecdotally, it

seems that hospitals are having significant success in this arena. On appeal to the ALJs, hospitals have frequently sought to prove that the services were medically necessary and properly performed on an inpatient basis. However, as alternative relief in the event that the ALJ does not agree that the services were performed in the proper setting, hospitals have requested that the ALJ order CMS to pay for the services at the outpatient rate. In all the cases that we are aware of, either ALJs or the Medicare Appeals Council have agreed to pay at the outpatient rate when this was the appropriate setting for a medically necessary service.[1] However, absent appealing the RAC's decision to the ALJ (or the Council), hospitals have no method to receive full payment for the services provided.

This landscape has forced hospitals to appeal a RAC's decision even in cases when the hospital would otherwise just agree to accept payment at the outpatient rate as CMS has created no process for the hospitals to rebill at the outpatient rate. While reasons for this policy have been unclear, there are no legal impediments to a policy change which would eliminate the need for hospitals to appeal virtually every RAC inpatient medical necessity denial in order to secure some meaningful level of payment for medically necessary services provided to beneficiaries.

On March 29, Andrew Wachler along with the American Hospital Association, the Greater New York Hospital Association, representatives from three major healthcare systems and Don Romano met with representatives from CMS to discuss the issues of medical necessity denials in short stay cases. These hospital representatives advocated for reinstituting a method for resubmitting an adjusted bill, such as occurred during the RAC demonstration, to allow hospitals to resubmit claims when necessary services were provided in the wrong setting. CMS

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[1] For example, *UMDNJ – University Hospital v. Riverbend GBA* (March 14, 2005) and *O'Connor Hospital v. National Government Services* (February 1, 2010).

appeared sensitive to the hospitals concerns on this issue and continues to explore whether this concept could be reinstituted during the RAC permanent program.

The current system is neither equitable nor efficient. Even the Statement of Work for the Recovery Audit Contractor Program published by CMS states that the mission of the program "is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments." But even though proper payment is the stated goal, hospitals have been given no way to receive payment for services that even the RAC agrees were medically necessary (albeit in a different setting). This failing creates inefficiencies by forcing hospitals to incur the costs of appeal and increase the caseload for ALJs unnecessarily. While some short stay cases will clearly still be appealed even if hospitals are enabled to submit an adjustment bill, in a number of cases hospitals would choose to avoid the costs of appeal and simply accept payment at the outpatient rate. Additionally, any concerns about the possibility of beneficiary's received bills for larger Part B co-payments years after a procedure could be addressed through an understanding between CMS and hospitals that such collection efforts would be unreasonable in light of both the passage of time and the failure to notify beneficiaries in advance of the possibility that these services would later be rebilled under Part B.

In summary, it is time for CMS to fix this inequity of the RAC program and allow the submission of an adjustment bill when a RAC finds that services provided in an inpatient setting were medically necessary but provided in the improper setting. Fixing this would both be equitable in that it would pay the hospitals for medically necessary services provided and efficient as it would eliminate the need for hospitals to appeal virtually every short stay case. We will continue to update the RAC Monitor of developments as they occur.