Inpatient Denials and Part A and/or Part B Reimbursement

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I. Introduction

In today's audit landscape, hospitals' inpatient short-stay claims are receiving increased attention from the Centers for Medicare & Medicaid Services ("CMS"). On November 15, CMS announced two demonstration programs that directly impact hospitals, specifically their short-stay inpatient claims. The first demonstration program is voluntary and is called the Part A to Part B Rebilling Demonstration Program. The second program, the Recovery Auditor Pre-Payment Review Demonstration Program, however, is mandatory for providers in 11 states.[1] Hospitals included in the new demonstration programs, as well as hospitals in the 39 remaining states that are not voluntarily participating in the AB Rebilling Demo, must be aware of the most current audit developments which affect them and effective strategies to employ during the audit appeals process.

II. AB Rebilling Demonstration Program

The Part A to Part B Rebilling Demonstration Program traces CMS' goal to reduce improper payments from the Medicare program. It is a voluntary program which will involve the participation of up to 380 hospitals.[2] The program's participants, determined through a first-come first-served application process, will consist of 80 large hospitals (300+ beds), 120 moderate hospitals (100-299 beds) and 180 small hospitals (99 or less beds).[3] The program will run for three years, from January 1, 2012 to December 31, 2014. Enrollment for the program opened on December 12, 2011 at 2pm ET.

The AB Rebilling Demonstration Program involves the rebilling of only certain claims for Part B reimbursement. Specifically, short-stay inpatient claims, denied beginning January 1, 2012 by a Medicare Administrative Contractor, Zone Program Integrity Contractor, Recovery Auditor, or a Comprehensive Error Rate Testing (CERT) because the services were provided in the incorrect setting can be resubmitted as a new claim for the outpatient services provided. In addition, short-stay inpatient claims self-identified by a provider as being rendered in the incorrect setting, after the services were provided and billed, may be resubmitted as a new claim for the outpatient services.[4]

Once a hospital rebills a claim for Part B reimbursement, it will receive 90% of the total Part B payment, not including observation services, but still will be required to refund the difference of the beneficiary's co-pay and deductible due under Part A and Part B.[5] CMS expressed its rationale for the 90% during the November 30 Special Open Door Forum. CMS noted that it did not want to provide 100% of Part B reimbursement because it feared that full payment would encourage hospitals to "game" the system and did not want to incentivize inaccurate billing.

One of the most concerning aspects of the AB Rebilling Demonstration Program is the requirement that participants waive their right to appeal all inpatient short-stay claims denied for lack of medical necessity because the services were provided in an inappropriate setting.[6] The appeals prohibition highlights the inequity of a system where a provider must choose between either appealing the denial of an inpatient claim, but being

unable to rebill the claim for outpatient reimbursement or rebilling the claim for 90% reimbursement of the Part B outpatient claim, but waiving all due process rights.

III. Recovery Audit Pre-Payment Review Demonstration Program

On November 15 CMS also announced the Recovery Audit Pre-Payment Review Demonstration Program. Unlike the AB Rebilling Demonstration Program, this program is mandatory and will have a dramatic effect on providers in 11 states because it allows Recovery Auditors (RACs) to conduct pre-payment reviews on providers' Medicare claims in those states. Prior to the announcement of this demonstration program and in states outside of the demonstration program, RACs may only conduct post-payment reviews of providers' Medicare claims. However, on December 30, CMS announced that the implementation of the Recovery Audit Pre-Payment Review Demonstration Program was delayed until further notice. There has been no indication that this delay is indefinite, therefore it is still important for providers to understand the basics of the program.

The Recovery Audit Pre-Payment Review Demonstration Program will allow RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules.[7] CMS selected 11 states for the demonstration program: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri. In the current plan, CMS will roll-out the demonstration program with a focus on inpatient short-stay claims, focusing on MS-DRG 312 Syncope & Collapse as the only claim subject to review. However, as the program progresses, CMS will initiate pre-payment review of seven more DRGs. The DRGs will be in addition to the DRGs already in place. CMS will likely add more claims, including physician claims, as the demonstration program proceeds. Further, the demonstration program is in addition to and not in replacement of the current RAC Program. The limit on the number of medical records reviewed by the contractors are the same as those under the post-payment RAC program, therefore, it could be expected that the limits may be doubled for hospitals in the demonstration states.

Despite CMS' focus on the positives of the Recovery Audit Pre-Payment Review demonstration program, there are very serious implications for providers subject to the demonstration program. Specifically, the program reflects the ongoing difficulty to balance Medicare program integrity and the detrimental effects a pre-payment review has on Medicare providers. Pre-payment review is an aggressive method for contractors to audit providers and proactively prevent improper payments. However, pre-payment review threatens providers because it significantly impacts cash flow and there are no substantive criteria or procedures in place to determine placement on or removal from pre-payment review. For hospitals in the demonstration program, they will have no choice but to experience pre-payment review and the possible devastating impacts the review may have on their cash flow.

CMS' Recovery Audit Pre-Payment Review Demonstration Program indicates a pronounced shift in contractors' focus on pre-payment reviews. From a Medicare program integrity perspective a "prevent and detect" effort is effective to avoid improper payments, but pre-payment reviews can be unjustly devastating to providers. Specifically with regard to hospitals, pre-payment reviews may involve hospitals being forced to absorb the costs for expensive procedures and admissions while a contractor reviews and potentially denies a claim. In fact, if a hospital appeals a denied claim 30 days after each level of appeal, it could take at least a year before the claim reaches the ALJ level of appeal.[1]

[1] Interestingly, hospitals subject to the pre-payment review demonstration program that are also enrolled in the AB Rebilling demonstration program will not be able to appeal pre-payment review denials of inpatient short-stay claims, but will only be able to rebill them through the AB Rebilling demonstration program.

One possible result from the Recovery Audit Pre-Payment Review Demonstration Program will be hospitals choosing to bill services that the hospitals may view as inpatient, as outpatient. Although hospitals should determine whether to bill services based upon a clinical decision, the pre-payment review demonstration program places them in difficult position because of the uncertainty of payment for inpatient short-stay claims.

IV. The Rest of Us

Even providers that are not participating in the recently announced CMS demonstration programs are affected by the demonstration programs' implications on obtaining an order for Part B reimbursement for Part A denials for lack of medical necessity. Specifically, the demonstration programs reinforce the importance that hospitals appeal Part A denials and in the event that those claims continue to be denied, seek Part B reimbursement. In addition, the Recovery Audit Pre-Payment Review Demonstration Program highlights the importance that providers receive Part B reimbursement early in the process and not have to wait until they reach the ALJ stage of the appeals process. At this juncture, there is not an effective mechanism for providers that are not a part of the AB Rebilling Demonstration program to achieve Part B reimbursement in this context, despite the fact that they are entitled by law to it. Since the reimbursement mechanism is not in place, it is essential that hospitals continue to appeal Part A claims denied for medical necessity because the services were allegedly provided in the wrong setting and in the alternative seek Part B reimbursement. A consistent effort by the hospital industry will help to encourage CMS to implement a mechanism for Part B reimbursement that not only reaches beyond the AB Rebilling Demonstration Program, but also maintains hospitals' due process rights to appeal Part A inpatient denials.

The demonstration programs announced on November 15 reflect the current state of the Medicare program and the federal government's extensive efforts to curb improper payments to providers. They also reflect, however, the need for hospitals to individually and collectively seek Part B reimbursement in the context of Part A claims denied for medical necessity.

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[1] The Recovery Audit Pre-Payment Review Demonstration Program's implementation was delayed on December 30, 2011.

[2] Part A to Part B Rebilling Demonstration Program, Provider Outreach and Education PowerPoint presentation, November 28, 2011, available at: https://www.cms.gov/CERT/downloads/Rebilling_Demo_Outreach_1129.pdf (Last visited: Dec. 9, 2011).

[3] *Id*.

[4] *Supra*, Note 13. During the Special Open Door Forums, CMS clearly stated that conditional Code 44 still applies, where a hospital is precluded from changing the service from inpatient to outpatient once the patient has been discharged but the services have not been billed. This places hospitals in the Demonstration Program in a difficult position because in order to rebill the short-stay inpatient services as outpatient they must first submit a bill for the inpatient services.

[5] *Supra*, Note 9.

[6] *Supra*, Note 13.

[7] Centers for Medicare & Medicaid Services, Fact Sheet for the Recovery Audit Pre-Payment Review Demonstration Program, November 15, 2011, available at: https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170 (Last visited: Dec. 11, 2011).