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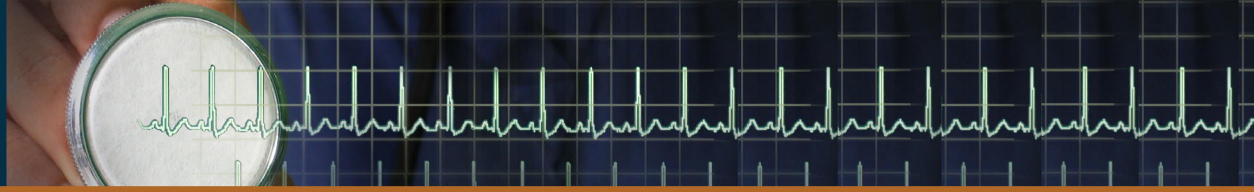

CMS Delays Post-Payment Reviews for "Short-Stay" Inpatient Admissions

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On August 19, 2013, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule (the "Final Rule") intended to provide more of a bright line test for hospitals and Medicare Administrative Contractors ("MACs") and Recovery Audit Contractors ("RACs") (collectively, "Contractors") to use in determining when it is appropriate to bill for a short-stay inpatient admission under Medicare Part A versus billing for outpatient services under Medicare. The Final Rule creates a presumption against post-payment reviews by Contractors if the beneficiary's inpatient admission "crosses 2 midnights". Instead of providing desired clarity on this issue, however, the Final Rule, effective October 1, 2013, generated a significant number of questions and uncertainty within the hospital industry. Industry experts, including the American Hospital Association ("AHA"), requested that CMS delay the effective date of the Final Rule given the numerous questions and the short amount of time between the publication of the Final Rule and the effective date of its provisions. In response to the stated concerns, CMS agreed to delay post-payment review for claims with dates of admission from October 1, 2013 through March 31, 2014. This alert provides a summary of the Final Rule and CMS's newly issued FAQs and supplemental guidance regarding the Final Rule and its provisions regarding the submission of Part B inpatient claims denied payment under Medicare Part A.

The Final Rule Regarding "Admissions" 42 C.F.R. §412.3

Pursuant to the Final Rule for "Admissions", the following elements must exist in order for a hospital to be presumed eligible to receive payment under Medicare Part A for an inpatient admission:

1. The patient must be formally admitted pursuant to a physician's or other qualified practitioner's order.[1] The admitting physician or other qualified practitioner must be knowledgeable about the patient's hospital course, medical plan of care and current medical condition.

2. The admitting order must be furnished at or before the time of the inpatient admission, and must be present in the medical record and supported by the physician's or other qualified practitioner's admission and progress notes.

1 It should be noted that the existence of a physician order will not be considered presumptive evidence of the medical necessity of the admission.

3. To constitute an appropriate inpatient admission, the physician or other qualified practitioner must expect to keep the patient in the hospital for a stay that "crosses at least 2 midnights" based upon the patient's history, comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event, all of which must be fully and completely documented in the medical record.

4. Stays that do not cross 2 midnights will be considered to be appropriately treated on an inpatient basis only if an unforeseen circumstance occurs, such as the patient recovers more quickly than expected, the patient dies, leaves against medical advice, or is transferred to another hospital.

If the stay does not cross 2 midnights, the presumption will be that such services should have been provided and billed on an outpatient basis under Medicare Part B. While CMS has indicated that it plans to take a flexible approach with respect to enforcing the 2-midnight rule and that 2 midnights would be presumptively valid for an inpatient admission, CMS has warned that it will instruct its Contractors to watch for evidence of hospitals "gaming the system." For example, if a hospital has a policy that requires patients with minimally invasive surgery to stay 2 midnights, Contractors would be justified in reviewing/auditing the claim.

CMS Attempts to Clarify the 2-Midnight Rule through FAQs

CMS has released FAQs in response to the confusion surrounding the 2-midnight rule. The following summarizes the information provided by CMS:

1. CMS will instruct Contractors that unless there is evidence that a hospital has tried to game the system, they are not to review claims that span 2 or more midnights for a determination relating to the appropriateness of the inpatient admission.

2. With respect to the medical necessity of a visit, Contractors are instructed to evaluate the physician's or other qualified practitioner's expectations based on the information available to the admitting physician or other qualified practitioner at the time of the inpatient admission.

3. During the period of October 1, 2013 through March 31, 2014, MACs will conduct "prepayment probe reviews." Such reviews will include ten to twenty-five claims and such reviews will continue and increase in size if there is evidence that the hospital has issues with its inpatient admission decisions. The MACs will share their findings by letter or individualized telephone calls. If Medicare Part A inpatient admissions are denied, the hospital can rebill under Medicare Part B.

4. CMS has stated that with the exception of inpatient only list admission, it is only in rare circumstances that an inpatient admission would be considered reasonable in the absence of an expectation of at least a 2-midnight stay.

5. With respect to calculating the 2-midnight benchmark, Contractors will be instructed to consider the time the beneficiary spent receiving outpatient services in the hospital,

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including observation status, treatment in the emergency department and procedures in the operating room, but excluding waiting room and triage time.

6. With respect to patients that satisfy the 2-midnight benchmark solely because there is a delay in the provision of care, CMS advises that Contractors may exclude time related to delays in the provision of medically necessary services from the 2-midnight benchmark.

7. Documentation regarding the decision to admit should reflect the complex medical factors such as history and comorbidities, the severity of the signs and symptoms, current medical needs, and the risk of an adverse event. Consideration can be given to the patient's age, disease processes, and the potential impact of sending the patient home. CMS has indicated that telemetry and an ICU stay do not alone justify an inpatient admission in the absence of a 2-midnight stay.

8. CMS stated that if the physician or other qualified practitioner is not sure about the inpatient admission, then he or she should admit the patient with observation status and reconsider providing an order for inpatient admission. CMS stated that it is not bound by commercial screening tools to help evaluate the inpatient admission decision.

9. CMS is currently exploring ways for providers to indicate on a claim the amount of time a patient spent as an outpatient before becoming an inpatient in order for the provider to satisfy the 2-midnight benchmark.

Finally, as an interim measure, until CMS can determine what its policy will be going forward, CMS has agreed that when a Medicare Part A claim for a hospital inpatient admission is denied because the inpatient admission was deemed not to be reasonable and necessary, the hospital may submit a subsequent claim for Medicare Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except where the services specifically require outpatient status (e.g., outpatient physical therapy).

For a copy of the entire Final Rule, please see http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

Questions?

Should you have any questions about this Alert or compliance with Medicare reimbursement in general, please contact any member of Shipman & Goodwin's Health Law Practice Group listed on the first page of this alert.

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