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healthcare financial management association

## **HFMA Fact Sheet: Medicare Part B Inpatient Billing in Hospitals**

CMS released a proposed rule, *Medicare Program; Part B Inpatient Billing in Hospitals*, which would revise the current billing policy under Medicare Part B following a denial of a Medicare Part A inpatient claim for services not reasonable and necessary. Specifically, the rule would allow payment for additional Part B inpatient services when a Medicare Part A claim is denied because the hospital inpatient admission was not reasonable and necessary, and would establish a permanent policy on a prospective basis once it is finalized.

### **Background**

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner may admit the beneficiary for inpatient care or treat the patient as an outpatient. In some cases, when the beneficiary is admitted and the hospital provides inpatient care, a Medicare claims review contractor subsequently determines that the inpatient admission was not reasonable and necessary, and therefore denies the associated Part A claim for payment. Under Medicare's longstanding policy, in these cases, hospitals may bill a subsequent Part B inpatient claim for only a limited set of medical and other health services, referred to as "Part B inpatient" or "Part B only" services, even if additional services furnished would have been medically necessary had the beneficiary been treated as an outpatient. Under current Medicare policy, these Part B inpatient claims are considered new and are subject to certain time limits for filing claims, rather than adjustments to the originally submitted Part A claim.

Hospitals have expressed concern that the policy allowing only limited billing for Part B inpatient services provides inadequate payment for resources that they expended to take care of beneficiaries in need of medically necessary hospital care, although not necessarily inpatient care. Hospitals have also indicated that they often do not have the necessary staff, including utilization review staff or case managers, available after normal business hours to confirm physicians' decisions to admit beneficiaries.

In light of concerns related to the financial impact of extended time as an outpatient on Medicare beneficiaries, and the impact of denials of inpatient claims on hospitals, CMS implemented the Part A to Part B (A/B) Rebilling Demonstration for hospitals. The demonstration, originally slated for three years, allows a limited number of hospitals to rebill for additional Part B inpatient services outside the usual timely filing requirement, when Part A inpatient short-stay claims are denied because the inpatient admissions were determined not reasonable and necessary. Under the demonstration, hospitals may be eligible to receive 90

percent of payment for all Part B services that would have been reasonable and necessary had the beneficiaries been treated as outpatients instead of inpatients.

CMS also solicited public comments in the CY13 OPPTS/ASC proposed rule on various policy clarifications or changes that have been suggested by stakeholders to address these issues, including revising its Part B inpatient billing policy.

### **Provisions of Proposed Rule**

When Part A payment cannot be made for an inpatient claim because the admission is determined not reasonable and necessary, CMS believes that Medicare should pay for all Part B services that would have been reasonable and necessary (except for services that require an outpatient status) had the hospital treated the beneficiary as an outpatient rather than an inpatient. Accordingly, CMS proposes to revise its current policy to allow payment for more Part B inpatient services than Medicare currently allows in these cases. CMS would continue applying the timely filing restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within 1 year from the date of service. The hospital could recode the reasonable and necessary services that were furnished as Part B services, and bill them on a Part B inpatient claim.

CMS would exclude services that are, by definition, provided to hospital outpatients and not inpatients. Specifically, CMS would exclude services that by statute, Medicare definition, or standard Healthcare Common Procedure Coding System code are defined as outpatient services, including:

- Outpatient diabetes self-management training services
- Outpatient physical therapy services
- Outpatient speech-language pathology services, and outpatient occupational therapy services
- Outpatient visits
- Emergency department visits
- Observation services

### *Three-Day Payment Window*

The proposals in the rule would not change the three-day payment window policy requiring payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the three calendar days (one calendar day for non-IPPS hospitals) prior to the date of an inpatient admission to be bundled with the payment for the beneficiary's inpatient admission. The Part B outpatient claims for the outpatient services provided in the three-day payment window would be subject to the usual timely filing restrictions and not be considered adjustment claims. Hospitals must furnish information necessary to determine the amounts due for the services billed on a Part B outpatient claim for services rendered in the three-day payment window prior to the inpatient admission.

### Applicable Hospitals

All hospitals billing Part A services would be eligible to bill the proposed Part B inpatient services, including short-term acute care hospitals paid under the IPPS, OPSS, long-term care hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, critical access hospitals, children's hospitals, cancer hospitals, and Maryland waiver hospitals. CMS proposes that hospitals paid under the OPSS would continue billing the OPSS for Part B inpatient services. Hospitals that are excluded from payment under the OPSS would be eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies.

### Beneficiary Liability

Since the proposal would allow billing for additional Part B inpatient services, it could create a unique liability issue for Medicare beneficiaries that did not previously exist. Beneficiary cost-sharing under Part A is different (and, in some cases, may be less) than under Part B. Part A coinsurance only applies after the 60<sup>th</sup> day in the hospital. A beneficiary would be entitled to refunds of any amounts he or she paid to the hospital for a Part A claim if the hospital is held financially responsible for denied services under section 1879 of the Act. However, under the proposed policy, beneficiaries would continue to be liable for their usual Part B financial liability, including Part B copayments for each hospital Part B outpatient or inpatient service, and for the full cost of self-administered drugs. Under the proposed Part B billing policy, some beneficiaries who are entitled to coverage under both Part A and Part B may have a greater financial liability for hospital services compared to current policy, as they would be liable for additional Part B services billed when the inpatient admission is determined not reasonable and necessary. Most supplemental insurers or benefit programs, including Medigap plans, employer retiree plans, Federal Employees Health Benefits Program, TRICARE, and Medicaid participate in Medicare's coordination of benefits or claims crossover process, and elect to receive Medicare crossover claims if there is cost-sharing. Additionally, most, if not all of these supplemental insurers elect to receive Medicare crossover claims if there is cost-sharing (that is, deductible or coinsurance amounts that remain for the beneficiary to pay).

### **Ruling on Billing for Additional Part B Inpatient Services**

In an increasing number of cases, hospitals that have appealed Part A inpatient claims that were denied because the inpatient admission was not reasonable and necessary have received partially favorable decisions from the Medicare Appeals Council or Administrative Law Judges (ALJs). While upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, the Medicare Appeals Council and ALJ decisions have ordered payment of the services as if they were rendered at an outpatient or "observation level" of care.

Thus, these decisions effectively require Medicare to issue payment for all Part B services that would have been payable had the beneficiary originally been treated as an outpatient (rather than an inpatient) instead of the limited set of Part B inpatient services that are designated in the Medicare Benefit Policy Manual (MBPM). These decisions have also required such payment regardless of whether the subsequent hospital claim for payment under Part B is submitted within the applicable time limit for filing Part B claims. Paying for all reasonable and necessary Part B services under these circumstances is contrary to CMS's longstanding policies that permit billing for only a limited list of Part B inpatient services, and require that these services be billed within

the usual timely filing restrictions. Further, the increasing number of these types of decisions has created numerous operational difficulties.

After reviewing the public comments received in response to the CY13 OPPTS/ASC proposed rule, considering the most efficient way to effectuate the Medicare Appeals Council and ALJ decisions, and further assessing the Part B inpatient payment policy, CMS issued an administrative ruling concurrently with the proposed rule. The ruling establishes a standard process for effectuating these decisions and handling claims and appeals while CMS considers how to best address this issue going forward. The ruling provides that when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary, the hospital may submit a subsequent Part B inpatient claim for more services than just those listed in section 10, Chapter 6 of the MBPM, to the extent the services furnished were reasonable and necessary. The hospital may submit a Part B inpatient claim for payment for the 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 when those services specifically require an outpatient status. The ruling only applies to denials of claims for inpatient admissions that were not reasonable and necessary; it does not apply to any other circumstances in which there is no payment under Part A, such as when a beneficiary exhausts Part A benefits for hospital services or is not entitled to Part A.

### **Treatment of Pending Appeals and Appeal Rights**

There are currently thousands of appeals pending that are subject to the ruling. In determining the least burdensome approach for both hospitals and itself, CMS published the notice to inform hospitals of their right to withdraw pending appeals of Part A claim denials that are subject to this ruling, and instead submit Part B claims for payment. If the hospital elects to withdraw its Part A appeal and submit a Part B claim, the hospital will have 180 days from the date of receipt of the appeal dismissal notice to submit the claim. If the appeal of the Part A claim remains pending, the hospital may submit a Part B claim if the Part A appeal is later withdrawn, or an unfavorable Part A appeal decision becomes final or binding. In these cases, the hospital will have 180 days from the date of receipt of the final or binding decision, or the date of receipt of the dismissal notice, to submit the Part B claim. The ruling is effective as of its issuance date, and addresses the treatment of claims and associated appeals only until the related proposed rule is finalized.

As an interim measure until a final rule can be issued, CMS is adopting the decisions of the ALJs and the Medicare Appeals Council that subsequent Part B rebilling by a hospital in situations covered by the ruling is supported by concepts of adjustment billing. Under this approach, Part B inpatient and outpatient claims that are filed later than one calendar year after the date of service must not be rejected as untimely by Medicare's claims processing system as long as the corresponding denied Part A inpatient claim was filed timely.

### **Other Information**

Comments on the proposed rule are due May 17, 2013.

Read the proposed rule in the March 18, 2013, *Federal Register*.  
<http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf>

Read the ruling notice, effective March 13, published in the March 18, 2013, *Federal Register*, <http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06159.pdf>