PUBLICATION

CMS Adopts Final Rules for Inpatient Admissions and Inpatient Part B Billing [Ober|Kaler]

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In its final IPPS rule for FY 2014 CMS adopts its earlier proposals regarding its two-midnight policy related to inpatient admissions and hospital billing under Part B following a denial of an inpatient stay. CMS discusses its position on pages 50906-50954 of the final rule.

Two-Midnight Policy for Inpatient Admissions

As discussed in our previous article, CMS proposed to revise the standards for determining what constitutes a proper inpatient admission. CMS is adopting its proposed revisions, which shift the criteria from an expectation of a single overnight or 24-hour stay to an expectation of a stay crossing two midnights. Under this new policy, there will be a presumption that a hospital inpatient admission for a beneficiary who requires a stay that includes at least two midnights is an appropriate inpatient admission. There will also be a presumption that a beneficiary with an inpatient stay that includes less than two midnights is not a proper inpatient admission, and should be treated as an outpatient, unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required services over at least two midnights. There is an exception to the two-midnight rule for services deemed inpatient only by CMS. CMS also instructs its contractors to disregard the presumptions if they believe a provider is systematically prolonging the provision of care in order to cross two midnights.

The rule allows for an exception: an inpatient admission would still be appropriate even if less than two midnights are spanned in “unforeseen circumstances.” However, the examples in the rule appear to limit such unforeseen circumstances to extreme situations: a beneficiary's death or transfer. In a recent CMS Open Door Forum conference call, CMS also included a patient leaving against medical advice as another situation where an inpatient admission without a two –midnight stay might be appropriate.

As discussed in the preamble to the final rule and during the Open Door Forum, the determination of the two midnight threshold should be based on the cumulative time the beneficiary spends in the hospital, beginning with any initial outpatient services, including time in observation, the emergency room or other outpatient departments. However, the hospital is not permitted to bill for the inpatient services until a physician orders those services.

Inpatient Part B Billing

CMS also adopted its recently proposed rule for inpatient Part B billing, which we discussed in an earlier publication. The final rule provides that when a Medicare contractor denies an inpatient stay on medical necessity grounds or a hospital determines after discharge that a hospital inpatient admission was not reasonable and necessary, the hospital may rebill under Part B an expanded scope of services that would have been considered reasonable and necessary had the patient been treated as an outpatient. There are, however, limitations that are significant. First, the expanded scope of services excludes those that require an outpatient status, such as observation services and hospital outpatient visits. It also limits the ability to bill to

one year from the date of service, which will likely make most of such services unbillable when the services are denied by a Medicare contractor, as the denial will likely fall outside of the one year window. In addition, if a provider chooses to rebill under Part B, it is prohibited from appealing the Part A denial. On the positive side, however, the hospital in that situation may be paid for hospital outpatient services furnished prior to the inpatient order.

When CMS issued its proposed Part B billing rule, it also issued CMS Ruling 1455-R. That Ruling allowed hospitals to rebill denied Part A inpatient stays under Part B: (1) within 180 days after the revised determination denying the inpatient stay or (2) if the denial was appealed, within 180 days of the final appeal determination denying the inpatient stay. The Ruling was to expire when the final Part B billing rule went into effect, i.e., by October 1, 2013. The final rule, however, establishes that providers may follow the rebilling rules in the Ruling provided: (1) the Part A claim denial was one to which the Ruling originally applied, or (2) the Part A inpatient claim has an admission date before October , 2013,1 and is denied after September 30, 2013, on the basis that although the medical care was reasonable and necessary, the inpatient admission was not.

Comments

Although CMS has stated that one of the primary reasons for the new rules is to clarify when an inpatient admission is appropriate, the new rules actually do little toward that end. The standard is not clearer, just different. The expectation of the physician with regard to the anticipated length of stay, according to the new rules, must still be based on “such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event.” When asked during the Open Door Forum what role InterQual, Milliman or other outside tools developed to judge the appropriate standard of care would play in future determinations of inpatient admissions, CMS representatives stated that it would answer the question later in guidance. However, it would not state when that guidance would be forthcoming, despite the fact that the new rules go into effect on October 1 of this year. CMS representatives also stated that guidance addressing whether residents would be permitted to write inpatient orders would also be forthcoming. Providers are urged to send questions and further comments to CMS via its inpatient mailbox at ippsadmissions@cms.hhs.gov.