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Client Alert

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Recent CMS Memorandum Affirms ALJ Decisions Ordering Hospital Payment for Part B and Observation Services

Under current Centers for Medicare & Medicaid Services (CMS) rules, hospitals stand to lose most (if not all) payment when a CMS contractor denies an inpatient claim on grounds that the services could have been provided on an outpatient or "observation" basis. Although it would seem logical such a denial should result in Part B reimbursement for the outpatient services rendered, current CMS manual provisions allow for only a fraction of the reimbursement the hospital would have received if it had initially billed the claim under Part B. Recent administrative law judge (ALJ) decisions have attempted to override this outcome by ordering CMS contractors to make full Part B payment for outpatient care.[1] It was unclear, until recently, whether or how CMS contactors would comply with such ALJ decisions, which are contrary to CMS manuals that prohibit Part B payment for patients that have been admitted as inpatients.[2]

A July 13, 2012 CMS memorandum alleviates certain concerns by confirming that contractors must comply with such ALJ decisions and specifying exactly how contractors will implement payment. Additionally, the memorandum allows hospitals to obtain payment for observation services, even in the absence of a physician order, if the ALJ decision mandates payment at the observation level. CMS makes clear that the memorandum does not change its underlying manual provisions, and these special exceptions to CMS policy apply only where a hospital has obtained the requisite ALJ order for payment. Despite these limitations, the memorandum is a significant development for hospitals that are able to appeal such denials to the ALJ level. Typically, a hospital's primary objective on appeal is to overturn the inpatient denial entirely, but these ALJ decisions and the recent CMS memorandum give hospitals additional traction on a secondary argument – that the hospital is entitled to full Part B payment, including payment for observation services, if the inpatient denial is upheld.

1 For an example of one such decision issued at the DAB-MAC level, see In the Case of O'Connor Hospital, issued February 1, 2010. This firm discussed the O'Connor Hospital decision in detail in a prior article, available here.

2 See Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 1, Section 50.3.1 (defining an "outpatient" as a "person who has not been admitted as an inpatient"); see also CMS Memorandum to All FIs, Carriers, and MACs, July 13, 2012 ("Payment may only be made under the OPPS for patients that are outpatients - that is, a patient that has not been admitted as an inpatient.").

Current CMS Rules and Reimbursement Outcomes

The current dilemma stems from a relatively simple question – whether an individual is an inpatient or outpatient in the hospital. The line between these two patient statuses and their corresponding Medicare reimbursement systems is clouded by several factors, not least of which is "observation" care – a gray area that technically falls under Part B outpatient care, but looks and feels to the casual observer like Part A inpatient care.[3] Increasingly, hospitals have received denials for inpatient claims on the rationale that the care given could have been provided on an outpatient basis. Short hospital stays are particularly prone to this type of denial, with CMS contractors arguing that the hospital could have held the patient under observation to determine whether admission was necessary.

These denials have placed pressure on hospitals to scrutinize inpatient admission decisions and, in certain instances, to hold borderline patients in outpatient observation rather than admit them. The maze of reimbursement rules only further complicates the matter. Once a patient is admitted as an inpatient, the hospital's reimbursement for the legitimate care and services provided is in jeopardy if a CMS contractor subsequently denies the claim on grounds that it should have been billed under Part B.

CMS rules acknowledge that payment may be made for certain Part B services provided to inpatients when a Part A claim is denied, but the list of such reimbursable services is limited and amounts to only a fraction of the full reimbursement that would have been available if the claim were initially submitted under Part B.[4] Additionally, CMS does not allow hospitals to bill for observation care without a physician order for such services.[5] Where a hospital had admitted an individual as an inpatient, the record will most likely not include an observation order, because observation is technically an outpatient service. If a contractor subsequently denies the claim on grounds that it would be more appropriately billed as an outpatient observation case, the hospital has no practical means to obtain payment, even though the care provided is as intensive, if not more so, than observation care.

CMS has created a special billing code, known as Condition Code 44, that enables hospitals to switch a patient's status from inpatient to outpatient and bill under Part B, but this option is only available if the switch is made prior to the submission of a claim and while the patient is still in the hospital.[6] In most cases, especially where a short stay is concerned, it is almost impossible to obtain the necessary utilization review and physician sign-off to make the switch while the patient is still in the hospital. Thus, Condition Code 44 becomes useless for many hospitals in the very cases where a meaningful mechanism for changing the patient's status is most needed.

3 CMS defines observation care as a set of "specific, clinically-appropriate services, which include ongoing short-term treatment, assessment, and re-assessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients . . . ." Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 6, Section 20.6.

4 See id., Ch.6, Section 10 (listing Part B services payable when payment cannot be made under Part A due to a medical necessity denial).

5 Medicare Claims Processing Manual, CMS Pub. 100-04, Section 50.3.2.

6 Id.

Perhaps in response to national scrutiny of these issues, from hospitals and patients alike, CMS recently initiated a demonstration project allowing participating hospitals that receive Part A denials to resubmit bills under Part B. The demonstration project indicates that CMS is reconsidering some of these problematic reimbursement issues, but it has also triggered heavy criticism, because hospitals will receive only 90 percent of the allowable Medicare payment for the Part B services and, in return, must forgo rights to appeal the inpatient denial.

The Recent CMS Memorandum

Some hospitals have attempted to address these issues through the claims appeals process by arguing at the ALJ level that, if the Part A denial is upheld, the court should order the CMS contractor to make payment under Part B. A number of ALJ decisions have granted this request and ordered Part B payment, in spite of CMS guidance to the contrary. In its recent memorandum, CMS affirms its position that such ALJ decisions conflict with current Medicare manual guidance, but states that CMS contractors must nonetheless comply with these decisions.

While the memorandum does not discuss the applicable ALJ rulings at length, it highlights language from a representative decision, in which the ALJ states that the hospital is entitled to payment on an outpatient basis or "'at an observation level of care.'" CMS interprets such decisions to "require the claims administration contractor to pay for all services that would be separately payable under the OPPS had the hospital initially billed Medicare for outpatient services on a 31x or 85x type of claim." Based on this interpretation, the memorandum outlines a step-by-step process that contractors must follow to implement an ALJ order for payment.

Within 30 days of receipt of the effectuation notice regarding the ALJ decision, the contractor must contact the hospital to request a new replacement claim for the services at issue. The memorandum notes that the new claim may not include a line item for observation, unless there is an order for observation in the record; however, the memorandum also notes an important exception to this rule. In cases where the ALJ ruling explicitly states that payment should be made at the "'observation level of care'" or "'including observation care,'" the hospital may include observation in the new bill, even in the absence of a physician order. CMS interprets such ALJ rulings to "specifically substitut[e] the order to admit for the order for observation." Hospitals will have a 180-day timeframe to submit new claims after receiving an initial request from the contractor. The memorandum instructs contractors to close the case if the new bill is not submitted within this time period.

Although acknowledging inconsistency with CMS policy and the necessity to effectuate specific ALJ orders, CMS makes clear at the end of the memorandum that it is not backing off current policy. In fact, CMS explicitly limits the memorandum's application "to the very specific ALJ decisions described" therein, and concludes by stating that: "[t]his instruction should not be construed or interpreted as a change in policy outlined in these manual sections. Contractors should continue to follow existing policy and practices in

all situations where there is not a conflicting ALJ order." Thus, the tension remains for hospitals that do not receive an ALJ order for Part B or observation payment.

Conclusion

For hospitals wrestling with these issues and appealing inpatient denials to the ALJ level, this memorandum is of significant importance. Hospitals now have a defined process to resubmit for Part B payment, if the requisite ALJ ruling is obtained. And, where the ALJ ruling includes observation care, hospitals may include such care on the new bill, even in the absence of a physician order, allowing hospitals to claim much greater share of payment for legitimate services.

Hospitals should take the CMS memorandum into account when drafting ALJ appeals, and should consider crafting any arguments for Part B payment in a way that will elicit an ALJ ruling that includes observation. Additionally, hospitals that obtain ALJ decisions ordering such payment must be aware of the deadlines involved to ensure that the contractor request for a replacement claim and the hospital response are made in a timely manner.