Compliance Advisory:

Medicare Part A Appeals

MEADE ROACH & ANNULIS
HEALTH CARE ATTORNEYS

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CMS Issues Interim Ruling and Proposed Rule Affecting Part A Appeals

On March 13, 2013, the Centers for Medicare and Medicaid Services simultaneously issued CMS Ruling 1455-R (the "Interim Ruling") and CMS Proposed Rule CMS-1455-P (the "Proposed Rule") which impact appeals of decisions under the Recovery Audit Contractor ("RAC") Program involving denials of Part A claims on the basis that services were not medically reasonable and necessary. On March 22, 2013, CMS issued Transmittal 1203 (Change Request 8185) (the "Transmittal") intended to implement the Interim Ruling. However, the implementation date for the instructions set forth in the Transmittal is July 1, 2013.

Summary of the Interim Ruling

The Interim Ruling became effective as of its date of publication on March 13, 2013. The Interim Ruling applies to Part A hospital inpatient claims that were denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary. The Interim Ruling applies as long as the denial was made: (1) while the Interim Ruling is in effect; (2) prior to the effective date of the Interim Ruling, but for which the timeframe to file an appeal has not expired; or (3) prior to the effective date of the Interim Ruling, but for which an appeal is pending.

Partial Reversal In the Case of O'Connor Hospital

The Interim Ruling effectively reverses, in part, the Medicare Appeals Council's (MAC's) decision, In the Case of O'Connor Hospital ("O'Connor"). In O'Connor, the MAC determined that it had the authority under CMS' rules to order payments for outpatient observation level of care under Part B of the Medicare Program, when a provider appealed a Medicare contractor's decision to deny a Part A inpatient claim. In contrast, CMS is taking the position under the Interim Ruling that if a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim; thereby precluding all contractors, including administrative law judges ("ALJ's"), from addressing any issue regarding any potential Part B claim the provider has not yet filed. However, in deference to O'Connor, CMS has decided to provide interim relief permitting hospitals to submit Part B claims for services that were provided under the claims denied under Part A.

Options for Hospitals Under the Interim Ruling

The Interim Ruling provides the following instructions for hospitals when a Part A inpatient claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary until such time CMS finalizes the Proposed Rule:

1. If the hospital admitted the patient as an inpatient, the hospital may submit a Part B inpatient claim for more services than just those listed in the Medicare Benefit Policy Manual ('MBPM"), Chapter 6, Section 10, to the extent additional reasonable and necessary services were furnished. In this case, 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.

Transmittal Instructions

Under circumstances in which the patient has been admitted as an inpatient and is discharged as an inpatient, the Transmittal provides that the hospital may submit a Part B inpatient 12X TOB and an 11X inpatient Provider Liable TOB. On the 12X TOB, the hospital must recode the services that were furnished as Part B services, and must, when available, provide the Healthcare Common Procedure Coding System (HCPCS) code(s), Current Procedure Terminology (CPT) code(s) and revenue code(s) that describe the medically necessary services that were ordered and rendered in accordance with Medicare rules and regulations, and that are documented in the medical record. Please note that because the beneficiary's patient status remains inpatient, rebilling under the Ruling does not impact skilled nursing facility (SNF) eligibility.

Hospitals submitting Part B inpatient claims subject to this interim policy shall include condition code "W2" on the claim. By using the "W2" condition code on the Part B claim(s), the hospital acknowledges that the Part B claim is a duplicate of the previously denied Part A claim, that no payment shall be made with respect to the items or services included on the Part A claim, and that any amounts collected from the beneficiary with respect to the Part A claim will be refunded to the beneficiary. By using the "W2" condition code, the hospital attests that there is no pending appeal with respect to a previously submitted Part A claim, and that any previous appeal of the Part A claim is final or binding or has been dismissed, and that no further appeals shall be filed on the Part A claim. Contractors shall reject as unprocessable any Part B claims subject to this interim policy that do not contain the "W2" condition code.

Please note: Billing for a Part B inpatient claim is not available when the services provided require billing for outpatient services, including outpatient visits, emergency department visits, and observation services. However, if the hospital also provides outpatient services in the emergency department or observation services it may bill for outpatient services as outlined below.

2. If the hospital provided "the outpatient services furnished during the 3-day payment window prior to the inpatient admission (including outpatient visits, emergency department visits, and observation services), the hospitals may bill for these services on a Part B outpatient claim. For example, if a hospital is able to meet the documentation requirements for billing observation services (including a physician order for outpatient observation), then it will be in a position to bill for observation services on an outpatient claim.

   CMS has indicated that during the time in which the Interim Ruling is in effect, claims filed under the options set forth above, will not be subject to the usual timely filing restrictions which require Part B inpatient and Part B outpatient claims to be filed no later than 1-calendar year after the date of service as long as the corresponding denied Part A inpatient claim was timely filed.

3. The hospital may withdraw pending appeals of Part A claim denials, and instead submit Part B claims for payment. Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending, except where the appeal has been remanded from an ALJ to a the Qualified Independent Contractor ("QIC"). Appeals of Part A claim denials that were remanded from the ALJ level to the QIC level will be returned to the ALJ level for adjudication of the Part A claim appeal consistent with the scope of review explained later in this Ruling.

   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.

In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service. If a hospital submits a Part B claim for payment without withdrawing its appeal request, the Part B

claim for payment may be denied as a duplicate. Once the hospital submits a Part B claim, parties will no longer be able to appeal the Part A claim.

Termination of Demonstration Project

The Part A to Part B Rebilling Demonstration is being terminated. We will communicate to hospitals and contractors the details regarding termination of this Demonstration.

Proposed Rule

Summary of the Proposed Rule

Under the Proposed Rule, hospitals will be required to file Part B claims no later than 1 calendar year after the date of service. If the Proposed Rule is finalized as proposed, billed Part B inpatient claims would be rejected as untimely when those Part B claims are filed later than 1-calendar year after the date of service. **This would effectively preclude hospitals from obtaining Part B reimbursement subsequent to any unsuccessful appeal for Part A reimbursement that takes longer than 1-clalendar year after the date of service.** (Including those reviews in which the contractor has taken more than 1-calendar year after the date of service for a determination).

The Proposed Rule also adopts the policy outlined in the Interim Ruling with respect to prohibiting duplicate billing or simultaneous requests for Part A or Part B payment. Additionally, the Proposed Rule emphasizes that if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot utilize the Part B billing process proposed in this rule to extinguish a beneficiary's appeal rights. Therefore, the hospital's submission of a Part B claim would not affect a beneficiary's pending appeal or right to appeal the Part A claim. If a beneficiary has a pending Part A appeal for an inpatient admission denial, then any claims rebilled under Part B by the hospital would be denied as duplicates by the Medicare contractor.

The Proposed Rule also adopts the Interim Rulings limitation on the adjudicator's scope of review of Part A Appeals prohibiting the RAC, QIC or ALJ to address any issue involving any potential Part B claim the hospital has not yet filed.

For a discussion of next steps hospitals should be taking to preserve their rights to Part A and Part B reimbursement under the Interim Rule, we invite you to join Aegis Compliance & Ethics Center for its Compliance Round-Up on April 9th 2013 at noon CST. Please email Kara Murray at kmurray@meaderoach.com for more information.

If you have any questions about this Compliance Advisory, please contact:

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