PUBLICATION

AHA and Hospitals Sue HHS Over Claims Denials Involving Patient Status [Ober|Kaler]

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In a suit recently filed in the United States District Court for the District of Columbia, the American Hospital Association (AHA) and several hospitals, assert that the Medicare Program improperly denied payment to hospitals for reasonable and necessary services provided to hospital patients who Medicare contractors found were improperly admitted as hospital inpatients. The plaintiffs claim that these Medicare denials issued by Recovery Audit Contractors (RACs) are both procedurally and substantively flawed.

From a procedural standpoint, the plaintiffs assert that although Medicare requires that the complex medical decision on whether to admit a patient be made by a physician, RACs rarely use physician reviewers to overturn the physician's admission. In addition, RACS receive financial incentives (a percentage of funds recovered by the Medicare program for the denials) that provide improper motives for the RAC denials.

Substantively, the plaintiffs assert that the payment denials result in inadequate payment for the services rendered. The RAC denials are determinations that the patients should have been treated as outpatients rather than inpatients. The hospitals in this situation must return the entire Part A (inpatient) payment. They are then entitled to receive payment under Part B. However, Medicare policy prohibits payment for most items and services that were billed under Part A when it is determined the patient should have been treated on an outpatient basis. The policy allows hospitals to receive payment for only a few ancillary items, like splints and cast, that typically amount to a small percentage of the total care of cost. The hospitals argue that since the RACs have not found the care to be unreasonable or unnecessary, it is inappropriate not to pay the hospitals fully for the care as an outpatient service, i.e., the same amount the hospital would have received if it had deemed the patient an outpatient rather than an inpatient at admission.

The complaint alleges this payment policy by Medicare violates the Administrative Procedure Act and asks the court to declare the policy invalid and order Medicare to pay hospitals the full Part B reimbursement at issue.

On the same day this suit was filed, November 1, 2012, CMS issued its Outpatient PPS Final Rule, discussing some aspects of the problem. In its proposed Outpatient PPS rule, CMS had requested comments on this issue of inpatient versus outpatient status. In the final rule CMS summarized the comments it received, which addressed the Part A to Part B Rebilling Demonstration Project, the need to clarify Medicare admission criteria, the role of hospital utilization review, prior authorization alternatives, time-based criteria for inpatient admissions, and payment alignment for equivalent outpatient and short inpatient hospital stays. CMS, however, declined to provide any response to the public comments, stating that it would take the comments into consideration as it moves forward to determine future actions to provide more clarity and consensus regarding patient status for purposes of Medicare payment.

Comments

This is an issue that has been brewing for years, with stakeholders in the provider community repeatedly trying to get CMS to revise its payment rules. Providers are between a proverbial rock and a hard place. Determining

whether to admit a patient as an inpatient or treat them as an outpatient is a complex medical decision. It is not clear cut. There is no conservative, safe course that hospitals can choose. If they bill the grey area cases as outpatients, the hospitals likely will have increased observation outlier cases, which may subject them to scrutiny for improperly outpatient billing. In addition, outpatients are subjected to higher copayments and may not qualify for subsequent skilled nursing stays. On the other hand, if hospitals bill the grey area cases as inpatients, they likely will have increased inpatient short stays and come under scrutiny for billing the higher inpatient amount. Until greater clarity is provided by CMS, hospital billing departments should work closely with their compliance departments to ensure the hospitals are doing all they can to monitor the situation and comply to the best of their ability with the Medicare guidance as it currently stands.