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Final Rebilling Rule With One-Year Deadline Will Drive Internal Audits

CMS finalized its Part A/B rebilling rule with the one-year timely filing requirement, and in the process elevated the role of internal auditing and utilization review.

According to the final 2014 inpatient prospective payment system (IPPS) regulation unveiled Aug. 2, hospitals may resubmit claims to Part B when they realize admissions are not medically necessary in Medicare's eyes or they are denied by auditors. While hospitals decry the requirement that they rebill Part B within a year of the date the Part A services were provided, there is one bright spot for beneficiaries: They won't lose credit toward a three-day qualifying stay in a skilled nursing facility (SNF) when hospitals rebill the claim, as long as the hospitalization was medically necessary.

The final rule replaces a March 13 ruling (CMS-1455-R) that allowed Part A/B rebilling without a timely filing deadline *(RMC 3/25/13, p. 1, 6/24/13, p.1)*. "If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under §482.30(d) of this chapter or §485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services," CMS says.

It Helps to Get It Right the First Time

The one-year timely filing requirement puts the onus on hospitals to get the status right during the stay, says Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa. "While recovery auditors have, in the past, reviewed cases within one year of payment, which would allow for rebilling, it is unlikely under this new paradigm that they would choose to do so. It is more likely that we will see increased denial activity by the Medicare administrative contractors, but these denials will allow for rebilling under the final rule," he says. That means hospitals have to redouble internal audits so they can identify medically unnecessary admissions and rebill in time. CMS is "holding their feet to the fire more," but has also been "fairly descriptive in terms of the key items they want to see," including physician orders and documentation that supports the standard of care and patient's expected length of stay.

The IPPS regulation spares hospitals from the shackles of the one-year timely filing requirement for a little longer. Hospitals can rebill older cases when the Part A claim was submitted on or before Sept. 30, 2013, even if they're denied after the rule takes effect on Oct. 1. And cases already in the pipeline are not subject to the one-year deadline. "The line of demarcation is October 1," George Mills, director of the CMS Provider Compliance Group, said at an Aug. 6 open-door forum.

CMS gave several reasons for sticking to the one-year timely filing deadline. "We disagree that it is unlawful and fundamentally unfair to apply the 1-calendar year time limit to file claims for Part B services, because hospitals are responsible for determining whether the submission of a Part A or Part B claim is appropriate within the applicable timeframe," CMS says. Anyway, the volume of Part A denials and the resulting need to rebill should decline in light of the new two-midnight standard, CMS contends (see story, p. 1).

Rebilling gives hospitals an alternative to condition code 44, which is a vehicle for reclassifying Medicare Part A stays as Part B services, but it isn't that useful because the change must be made before discharge with the approval of the treating physician and utilization review committee. "It makes condition code 44 less important," another CMS official said at the open-door forum. "If the patient status is not changed before discharge, the hospital can bill all of the same services they would have been able to bill if the patient was not admitted." However, the advantage to condition code 44 is hospitals file one Medicare claim and are paid promptly rather than having to submit an adjusted claim after a denial or internal audit. CMS specifically describes rebilling in terms of submitting new claims, and not adjusted claims.

To rebill Part A claims, the 2014 regulation, like the ruling, invites hospitals to submit two kinds of claims if they want to capture reimbursement for all Part B services:

◆ ***Part B inpatient claims for post-admission services,*** including services reimbursed under the outpatient prospective payment system unless they require an

outpatient order, ambulance services, prosthetic and orthotic devices and services provided incident to a physician's professional services. They would be billed on a Part B inpatient (12x) claim.

◆ ***Part B outpatient claims for services provided before an admission and other services that used to fall under the DRG window payment policy,*** including observation and emergency room visits. "These hospital outpatient services could be billed on a Part B outpatient (13x) claim, but would not be payable if furnished to inpatients and billed on a Part B inpatient (12x) claim," the rule says.

For outpatient therapy, CMS changed course in the final rule, agreeing to cover it under Part B even when provided during the inpatient admission. That wasn't the case in the proposed rule (CMS-1455-P). But physical, speech and occupational rehab is subject to the annual, per-beneficiary cap and medical-review process for claims that exceed the cap, including the hours it was provided while the patient was classified an inpatient.

Rebilling shouldn't replace a utilization-review (UR) program that focuses on patients while they are still in the hospital, Wuebker says. Think of rebilling as a back-up plan, to be used sparingly only if the UR process doesn't detect a medically unnecessary admission, he says. "The main point is getting the status correct while the patient is still in the hospital, but now you have to have an order, and [auditors] will be looking at physician documentation much closer," he says.

Don't count on advance beneficiary notices (ABNs) and the hospital-issued notice of noncoverage (HINN) to warn beneficiaries that their copays may rise when Part A stays are rebilled under Part B, CMS says. ABNs and HINNs must be presented to beneficiaries in advance, and rebilling is an after-the-fact sort of thing. But CMS plans an education campaign to raise beneficiary awareness of potential changes in their liability. Also, beneficiaries in need of SNF care after discharge won't be undermined by rebilling. Medicare doesn't pay for SNF admissions unless they are preceded by three-day, medically necessary "qualifying" inpatient stays. However, the final rule notes that beneficiaries only have to meet a broad definition of "medical necessity" and that the beneficiary's status doesn't change from inpatient to outpatient under the rebilling policy. "The beneficiary would still be considered a hospital inpatient for the duration of the stay," CMS says.

Contact Wuebker at rwuebker@ehrdocs.com. View the final rule, which will be published in the Aug. 19 *Federal Register*, at http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1. ✧