



# VCU Medical Center

## Office of Health Innovation

### Proposed Rule: Medicare Program; Part B Inpatient Billing in Hospitals

**Description:** This proposed rule would revise Medicare Part B billing policies when a Part A claim for a hospital inpatient admission is denied as not medically reasonable and necessary. When Part A payment cannot be made for a hospital inpatient claim because the inpatient admission is determined not reasonable and necessary, CMS proposes that Medicare should pay for all the Part B services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient.

### Major Provisions

#### **Part B Hospital Inpatient Billing**

When a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was deemed not to be reasonable and necessary, or when a hospital determines after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, the hospital may be paid for all the Part B services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient, if the beneficiary is enrolled in Medicare Part B.

CMS would exclude services that by statute, Medicare definition, or standard Healthcare Common Procedure Coding System (HCPCS) code are defined as outpatient services, including:

- Outpatient diabetes self-management training services (DSMT),
- Outpatient physical therapy services,
- Outpatient speech-language pathology services,
- Outpatient occupational therapy services ,
- Outpatient visits,
- Emergency department visits, and
- Observation services.

This proposed policy would only apply to denials of claims for inpatient admissions that are not reasonable and necessary, and would not apply to any other circumstances in which there is no payment under Part A, such as when a beneficiary exhausts Part A benefits for hospital services or is not entitled to Part A.

To ensure the accuracy and appropriateness of payment under Part A, CMS proposes that this policy would apply when CMS or a Medicare review contractor determines that the hospital inpatient admission was not reasonable and necessary, and also when a hospital determines under Medicare's

utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, but the beneficiary has already been discharged from the hospital.

### **Billing for Part B Outpatient Services in the Three-Day Payment Window**

The proposals in this proposed rule would not change the 3-day payment window policy, which requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a hospital that is not paid under the Inpatient Prospective Payment System) prior to the date of an inpatient admission to be bundled (that is, included) with the payment for the beneficiary's inpatient admission, if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital.

### **Applicability**

CMS proposes that all hospitals billing Part A services be eligible to bill the proposed Part B inpatient services, including short-term acute care hospitals paid under the IPPS, hospitals paid under the OPSS, long-term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), CAHs, children's hospitals, cancer hospitals, and Maryland waiver hospitals. We propose that hospitals paid under the OPSS would continue billing the OPSS for Part B inpatient services. Hospitals that are excluded from payment under the OPSS would be eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies.

### **Time Limits for Filing Claims**

The proposed rule would require that claims for billed Part B inpatient services be rejected as untimely when those Part B claims are filed later than one calendar year after the date of service. This proposal treats these Part B claims as new claims subject to the timely filing requirements, instead of as adjustment claims.

Because it is the responsibility of providers to correctly submit claims to Medicare by coding services appropriately, it is important to note that the exception which extends the time for filing a claim if failure to meet the deadline was caused by error or misrepresentation of an employee, contractor or agent of HHS (commonly referred to as the "administrative error" exception), would not apply in situations where a provider bills the originally submitted Part A claim incorrectly.

### **Appeals Procedures**

If a hospital is dissatisfied with an initial or revised determination by a Medicare contractor to deny a Part A claim for an inpatient admission as not reasonable and necessary, the hospital may either submit Part B inpatient or outpatient claims or file a request for appeal of the denied Part A claim.

In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment for the same services provided to a single beneficiary on the same dates of service. This includes requests for payment under both Part A and Part B. Thus, if a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, the hospital cannot also maintain its request for payment for the same services on the Part A claim.