In Fiscal Year 2014, the Centers for Medicare & Medicaid Services (CMS) changed its rules regarding the circumstances under which Medicare will make payment under Medicare Part A for inpatient admissions. These changes are significant. Whereas before, Medicare’s guidance instructed physicians to exercise their “complex medical judgment” as to whether to admit a patient after considering numerous clinical factors, under the new Two Midnight benchmark finalized in the FY 2014 Inpatient Prospective Payment System (IPPS) Final Rule, Medicare rules now state that inpatient admission and Part A payment are generally appropriate only if at the time of admission the physician has a reasonable expectation that the patient’s stay will cross two midnights or require services on Medicare’s inpatient only list. Unlike the prior standard, this benchmark applies regardless of the patient's severity of illness or the intensity of the care required and provided by the hospital.

For example, prior to this rule change, it was generally understood that patients who require intensive care in an ICU experience clinical conditions that require a certain level of care that can only be provided safely in an inpatient setting. Therefore, inpatient admission (and Part A payment) would be medically necessary and appropriate. But under the Two Midnight rule, the level of service provided, and the patient’s need for such services, are no longer relevant factors. The only relevant factor for Part A coverage, according to CMS, is whether it was reasonable for the admitting professional to believe that the patient would require a length of stay that spanned two midnights. Even so, CMS has recently stated in guidance that there may be “rare and unusual” circumstances that require inpatient admission (and, therefore, for which Part A payment is appropriate) even though there is no expectation that the beneficiary’s stay would last more than two midnights.

The Two Midnight rule change will have financial consequences for both hospitals and beneficiaries. CMS has predicted that when hospitals implement the Two Midnight rule, they will in the aggregate increase the number of patient encounters that will be claimed as inpatient and thereby increase IPPS expenditures. Medicare claims data demonstrates that exactly the opposite phenomenon will occur. For example, in the FY 2014 final rule, CMS predicted that the Two Midnight rule will result in 360,000 short inpatient stays per year converting to outpatient status. But Medicare claims data for 2011 shows that there were nearly 1.5 million

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1 78 Fed. Reg. at 50946; CMS, Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013 (Updated March 12, 2014).

2 78 Fed. Reg. at 27649-27650. In the 2014 IPPS final rule, CMS finalized a .2% payment reduction in the IPPS standardized rate to account for a supposed increase in IPPS payments resulting from adoption of the “two midnight” rule. CMS asserted that its “two midnight presumption” would move a substantial number of encounters (400,000) that are currently being paid under OPPS – that is, paid as observation services – into IPPS payment. This figure would not be entirely offset, according to CMS, by the number of encounters (360,000) that would be paid under OPPS as observation services because they are less than two day encounters. According to CMS, this increase in IPPS encounters would lead to a $220 million per year increase in IPPS payments, requiring a .2% reduction of the standardized rate. Many commenters opposed the .2% rate cut.
short stay cases. Even reducing that number for patient death (90,000), patient transfer (87,000), patients who are discharged against medical advice (40,000) and discharges to SNFs (50,000), CMS’s prediction of 360,000 fewer inpatient cases per year widely misses the mark. Thus, there will be far more inpatient stays of less than two days in duration that will be billed as outpatient encounters than there will be extended observation encounters that will be billed as inpatient stays. For most PPS hospitals, this will mean a decrease in revenue and greater difficulty in covering their costs of patient care; the DRG payment received for an admission goes farther toward covering the resources needed to provide services to the patient as compared to outpatient reimbursement.

For beneficiaries, being treated on an outpatient basis for a severe condition, including complications arising after outpatient surgery, could have significant financial consequences: Medicare Part B does not cover self-administered drugs, for example, and beneficiaries are subject to increased liability for copayments and coinsurance related to stays that do not cross the two midnight benchmark and consequently are billed under Part B instead of Part A.

Finally, the implementation of the Two Midnight rule, and the related requirements for written inpatient orders and physician certifications, have been difficult to implement. As a result, CMS has announced a one-year Probe & Educate implementation period for the Two Midnight rule. During fiscal year 2014, Medicare Administrative Contractors will conduct probe sample reviews of inpatient claims on a pre-pay basis to provide hospitals guidance as to the degree to which they are appropriately applying the Two Midnight rule, written order requirement and physician certification requirement. Recovery Audit Contractors will not be permitted to review fiscal year 2014 inpatient claims for application of these rules. This implementation transition will be over in September 2014 and, unless the Two Midnight rule is reversed, hospitals will be audited in the future as to how well they apply these rules. The time is now, therefore, to fully understand these rules and their implications.

This outline is organized to provide the legal background to understand the many legal and operational concerns related to the Two Midnight rule. This outline will cover:

1. Medicare’s guidance regarding inpatient status and admission criteria under the new Two Midnight rule adopted in the FY 2014 IPPS final rule; and

I. Medicare Guidance On Inpatient Admission Standards

In the FY 2014 IPPS final rule (CMS 1599-R), CMS finalized several changes to Medicare’s inpatient admission rules, adopting the Two Midnight standard.\(^3\) Medicare’s previous published guidance for inpatient admission directed physicians to exercise their “complex medical judgment” and it did not provide specific guidance as to how to make an admission decision on a case by case basis. But in contrast with this apparent deference to physician judgment, CMS’s guidance also directed contractor medical reviewers to use “screening tools” while at the same time exercise their own judgment as to whether inpatient admission was medically necessary. This outline first discusses Medicare coverage criteria for payment of inpatient claims under Part A prior to the FY 2014 rule change and then moves to a discussion of the FY 2014 IPPS final rule and the new requirements.

A. Inpatient Admission Criteria Before the Two Midnight Rule

Before FY 2014, Medicare inpatient coverage policy was exclusively contained in Medicare manuals. Medicare’s Benefit Policy Manual stated that the decision to admit a patient is a “complex medical judgment which can be made only after the physician has considered a number of factors . . . .”\(^4\) Physicians were directed to use a 24-hour period as a benchmark for exercising their judgment: “they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.”\(^5\)

These manual provisions directed physicians to look at “the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting.”\(^6\) CMS further provided that other factors the physician should consider when making the decision to admit included:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies that appropriately are outpatient services; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.\(^7\)

\(^4\) BPM (CMS Pub. 100-02), ch. 1, § 10 (2012).
\(^5\) Id.
\(^6\) Id.
\(^7\) Id.
B. Contractor Criteria Used to Review Admission Decisions Before the Two Midnight Rule

1. CMS’s Program Integrity Manual instructed contract medical reviewers that “[i]npatient care rather than outpatient care is required only if the beneficiary’s medical condition, or health would be significantly and directly threatened if care was provided in a less intensive setting.”

“"The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.”

2. CMS’s Benefits Policy Manual stated that medical reviewers were to only consider the medical evidence that was available to the physician at the time he or she made the admission decision. They were instructed not to take into account other information, such as test results, that were not available to the admitting physician unless it would support the admission decision. CMS required that its contractors use a “screening tool” as part of their medical necessity reviews of inpatient hospital claims, though CMS did not mandate that any particular criteria be used. According to CMS, “in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on documentation in the medical record.”

3. Commonly used “screening” criteria include InterQual Clinical Decision Support (published by the McKesson Corporation) and the Milliman Care Guidelines (published by Milliman, Inc.). Literature associated with screening instruments, like InterQual, state that they are to be used for screening purposes only, and are not intended to be used to make final clinical or payment determinations.

4. In a 2009 Medicare Appeals Council (MAC) decision, InterQual was described as “widely used” among acute care hospitals and certain CMS contractors. The MAC gave “substantial deference” to a decision to admit that passed InterQual screening criteria.

C. FY 2014 Changes to Inpatient Admission Guidance and Medical Review Criteria – The Two Midnight Rule

In finalizing changes to Medicare’s inpatient admission guidance, CMS stated that it was acting to bring greater clarity to the decision to admit a patient and acknowledged that

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8 Program Integrity Manual (PIM), (CMS Pub. 100-08), ch. 6, § 6.5.2.A (2012) (emphasis added).
9 Id. at 6.5.2 (emphasis added).
10 BPM (CMS 100-02), ch. 1, § 10 (2012).
11 PIM (CMS 100-08), ch. 6, § 6.5.1 (2012) (“The reviewer shall use a screening tool as part of their medical review of acute IPPS.”) (emphasis added).
12 In the Case of Sacred Heart Hospital, Medicare Appeals Council Decision at 8 (Nov. 10, 2009).
there was a wide variation in interpretation of its prior guidance. CMS finalized the following changes in the FY 2014 IPPS final rule (CMS 1599-R).

1. **The Two Midnight Standard:** CMS adopted an inpatient admission guideline commonly called the Two Midnight rule. Under the two midnight rule, other than for procedures that appear on the Medicare “inpatient only” list codified at 42 C.F.R. § 419.22(n), surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient payment under Part A only “when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based on that expectation.” Conversely, if the physician does not expect the patient to stay across two midnights, then inpatient care would generally be inappropriate under Part A. This coverage standard has been codified in regulations at 42 C.F.R. § 412.3(e).

   a. In making a decision as to whether a patient is expected to required a stay that crosses two midnights, physicians are to look at factors such as:

      - Patient history and comorbidities
      - Severity of signs and symptoms
      - Current medical needs and risk of adverse event

   b. The Two Midnight Rule applies to all hospitals except IRFs.

2. **Exception One: Unforeseen Circumstances:** If an unforeseen circumstance, such as beneficiary death or transfer, or the beneficiary is discharged against medical advice results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and the hospital inpatient payment may be made under Medicare Part A. This exception is codified in regulations at 42 C.F.R. § 412.3(e)(2).

3. **Exception Two: “Rare and Unusual Circumstances”:** Since adoption of the two midnight rule, CMS has stated in guidance that there may be “rare and unusual” circumstances in which an inpatient admission for a service not on the inpatient only list may be reasonable and necessary in the absence of an expectation of a two midnight stay. The rationale for such an exception is not stated, but the presumption is that certain “rare and unusual” cases may be severe enough to warrant the need for the type of medical care and services that can only be furnished safely and effectively on an inpatient basis regardless of how long those inpatient services are required. CMS says this exception is only for rare and unusual circumstances, and it has to date provided just one example of

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14 Review Hospital Claims for Patient Status: Admissions on or After October 1, 2013 (updated 3/12/14).
such a case and two examples that do not constitute such rare and unusual circumstances:

a. Example to Exception Two: Newly Initiated Mechanical Ventilation.\textsuperscript{15}

b. Examples that are not “rare and unusual” exceptions to the two midnight rule: admissions for telemetry and admissions to the ICU.\textsuperscript{16}

c. CMS states that it will work with the hospital industry to identify additional exceptions. The fact that CMS acknowledges that such exceptions do exist lends support to the argument that hospitals may submit claims for Part A payment in cases in which there was no reasonable expectation of a two day hospital stay on the reasonable belief that such cases are “rare and unusual” exceptions.

4. **Calculation of time for physician’s expectation of two-midnight stay:**
The starting point in time for application of the two midnight rule is when a beneficiary begins receiving medically necessary hospital services whether provided on an inpatient or outpatient basis. Thus, hospital care provided in another treatment area of the hospital such as the emergency room (ER), operating room, or observation services provided on an outpatient basis may count toward the benchmark and should be taken into consideration when the physician makes his or her determination as to whether the patient will require hospital care crossing two midnights. CMS will not count wait times before the initiation of care, including triaging activities, and inpatient admissions to prevent inconvenience to the patient, family, physician or hospital.\textsuperscript{17}

For example, if patient has been in observation past one midnight, the benchmark is met if the physician expects the patient to require an additional midnight of care.

5. **Evidence supporting the reasonable expectation of the two midnight stay must be documented in the medical record.** All services counted toward the two midnight benchmark must be medically necessary which must be supported by documentation in the medical record. For purposes of medical review, contractors will evaluate the medical record to determine whether the “expected length of stay and the determination of need for medical or surgical care are supported by complex medical factors such as history and comorbidities, the severity of signs and

\textsuperscript{15} Id.
\textsuperscript{16} Id.
\textsuperscript{17} 2 Midnight Admission Guidance & Patient Status Reviews for Admissions on or After Oct. 1, 2013, CMS Frequently Asked Questions.
symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care.”18

6. **Two Midnight Medicare Review Criteria: The Two Midnight “Presumption”:** In the FY 2014 IPPS rule, CMS adopted a requirement that medical review contractors would presume that hospital inpatient status is reasonable and necessary for beneficiaries who “require more than 1 Medicare utilization day (defined as encounters crossing 2 midnights) after admission.” In other words, inpatient stays that cross two midnights after formal inpatient admission will be presumed to be reasonable and necessary and appropriate for Part A payment. Medical review efforts for formal inpatient admission greater than 2 midnights will focus on undue delays in provision of care in order to meet the two midnight presumption.19 CMS has subsequently stated that contractors will look for evidence of an interruption or delay in care as evidence of gaming the two midnight presumption.20

7. **Two Midnight Medicare Review Criteria: The Two Midnight “Benchmark”:** For stays that last less than two midnights after formal inpatient admission, Medicare contractors will not presume that inpatient status was reasonable and necessary for Part A payment. Instead, review contractors will evaluate such claims pursuant to the two-midnight benchmark. Reviewers will look to see if complex medical factors such as patient history, comorbidities, severity of symptoms, risk of adverse events support the expectation of a two-day stay and the need to keep the patient in the hospital. In conducting such reviews, contractors will consider time spent receiving hospital services as an outpatient before the formal admit order for purposes of determining whether two-midnight expectation was met.21

D. **FY 2014 Changes to Conditions of Payment for Inpatient Admissions: Written Orders and Physician Certifications**

In FY 2014, CMS proposed and finalized two significant regulatory requirements as conditions of Part A payment for inpatient admissions. While the Medicare conditions of participation for acute care hospitals include a requirement for a physician, or other licensed practitioner, “recommendation” for admission, a written admission order was never, until FY 2014, codified in regulations as a Medicare condition of payment. Similarly, while CMS takes the position that physicians have long been required to certify to the medical necessity of an inpatient stay prior to submitting a claim for Medicare payment, such a requirement was never clear in the regulations. In the FY

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18 *Id.*
2014 IPPS rule, CMS adopted changes to the physician certification regulations to make this requirement clear.

The written order and certification requirements can be confusing and they have been difficult for hospitals to implement. But it is important for providers to master these rules; failure to comply provides Medicare medical review contractors an easy target for a technical claims denial, thereby jeopardizing DRG reimbursement for an otherwise medically necessary inpatient stay.

1. **Requiring a physician’s order as a condition of payment.** Before the two midnight rule, there was no regulation or other written guidance that clearly stated that a physician’s order for admission is required as a condition of Medicare payment. In past practice, the lack of an order could be overcome in the claims review process by other documentation in the medical record which indicated that the physician intended the patient to be admitted and treated as an inpatient. Since October 1, 2013, the regulations at 42 C.F.R. § 412.2 now require that the order be properly documented in the medical record as a condition of Part A payment.22

2. **Who must write the order?** The order to admit can be furnished by a physician or other qualified practitioner who is a) licensed by the State to admit inpatients to hospitals, b) granted privileges by the hospital to admit inpatients to that specific facility, and c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission.23

3. **The role of medical residents:** CMS has clarified that a medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act by proxy for the ordering practitioner provided they are authorized under state law to admit patients and meet certain specified requirements. As long as a resident or non-physician practitioner is authorized to admit inpatients in the state where the hospital is located and is permitted to do so under the hospital's bylaws or policies, he or she may write inpatient admission orders on behalf of the ordering practitioner (e.g., the attending), if the ordering practitioner allows it and accepts responsibility for the admission decision by countersigning the order before the patient is discharged.24

4. **Orders are entitled to no presumptive weight:** CMS has codified CMS Ruling 93-1 which rejects application of the “treating physician rule” to Medicare inpatient stays. In FY 2014, CMS adopted a regulation which states that “[n]o presumptive weight shall be assigned to the physician’s

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22 Hospital Inpatient Admission Order and Certification, CMS (Jan. 30, 2014).
23 Id.
24 Id.
order . . . in determining the medical necessity of inpatient hospital services. . . .”25 The rule is codified at 42 C.F.R. § 412.46(b).

5. **Possible exception to the written order requirement and the ability to submit claims with missing or defective orders:** Despite this regulatory requirement, CMS has stated in guidance published in January 2014 that it will allow its contractors to consider the written order requirement to be fulfilled in the case of defective or missing written orders where it is clear in the medical record that the physician intended to admit the beneficiary as an inpatient.26 Hospitals with missing or defective written orders, therefore, should evaluate the circumstances of the affected inpatient admission to determine whether a claim for Part A reimbursement may still be submitted.

6. **Physician Certification of Medical Necessity:** CMS also adopted a physician certification requirement in the 2014 IPPS final rule (CMS 1599-R). Along with the medical record documentation, the physician certification provides evidence to support that the hospital services furnished were reasonable and necessary. Although no particular form is required, the physician certification is comprised of the following requirements which can be verified as described below:

   a. **Authentication of the practitioner order** (certifying that the hospital inpatient services were reasonable and necessary). This requirement can be fulfilled by signing or countersigning the admission order;

   b. **An articulation of the reason for inpatient services.** This requirement can be fulfilled by evidence of the patient’s diagnosis as contained in the medical record.

   c. **A statement as to the estimated time the beneficiary is required to spend in the hospital or the actual time in the hospital.** The expected or actual length of stay may be documented in any of four ways: in the order, on a separate certification or decertification form, in the progress notes assessment, or as an aspect of routine discharge planning;

   d. **The certification must be signed, dated and documented in the medical record before the patient is discharged.** Critical Access Hospitals must also certify that there is a reasonable expectation that the beneficiary will be discharged or transferred within 96 hours after admission.27

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25 78 Fed. Reg. at 27647
26 Hospital Inpatient Admission Order and Certification, CMS (Jan. 30, 2014).
27 Id.
e. If all the required information described above is included in progress notes, hospitals can meet the certification requirement by having the physician sign a statement which indicates that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.\(^{28}\)

7. **Who can sign the certification?** Only physicians are permitted to sign the certification: a doctor of medicine or osteopathy, dentist (in circumstances specified in 42 CFR 424.13 (d)), or a doctor of podiatric medicine (as provided by state law). The certification or recertification must be signed by the physician responsible for the case or another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.\(^{29}\)

8. According to Medicare, the only physicians with sufficient knowledge of the case to serve as the certifying physician include the attending/admitting physician or a physician on call for the attending or a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for her. A physician member of the hospital staff who has reviewed the case and who also enters into the record a complete certification statement can serve as the certifying physician where there is a non-physician admitting practitioner who is licensed by the state and has been granted privileges by the facility. **The admitting physician of record also may be an emergency department physician or hospitalist.** Medicare does not require the certifying physician to have inpatient admission privileges at the hospital.\(^{30}\)

9. As stated above, CMS does not require a specific procedure or form for the certification and recertification statements. As long as the method the provider adopts permits verifications, certification and recertification, statements may be entered on forms, notes or records that an authorized individual signs, or they may be made on a special separate form. It is appropriate for the certifying physician to write a statement indicating that the patient's medical record contains the information required (if all the information is included in progress notes) and that the hospital inpatient services are or continue to be medically necessary. Attestation statements indicating that the beneficiary's hospital stay is “expected to span 2 or more midnights” are not required under the inpatient admissions policy and they are not adequate by themselves to support the expectation of a 2 midnight stay. Rather, the expectation must be supported by the entirety of the medical record.\(^{31}\)

\(^{28}\) *Id.*  
\(^{29}\) *Id.*  
\(^{30}\) *Id.*  
\(^{31}\) *Id.*
II. MEDICARE’S PART A TO PART B REBILLING POLICIES

In recent years, Medicare medical review contractors have denied Part A reimbursement for inpatient stays of short duration on the basis that the inpatient stay itself was not medically necessary because the services could have been provided in a less intense setting, such as on an outpatient basis in observation. Contractor focus on short stays, and the lack of clarity of the standards that contractors were applying to such claims for reimbursement, led CMS to adopt the Two Midnight Rule. But these actions also focused attention on CMS’s “Part B inpatient” rebilling policy. Even though the inpatient stay was not medically necessary, the underlying services that were provided, such as surgical procedures, were. But until recently, CMS had a policy that allowed hospitals to bill for only a small range of services provided on an inpatient basis when an inpatient stay was later denied as medically unnecessary. CMS reversed course on this policy in 2013, and adopted final changes to the so-called Part A to Part B rebilling policy in the FY 2014 IPPS final rule. The hospital industry has generally been unhappy with this new policy; while it allows for more expanded rebilling of services provided on an inpatient basis, it has been difficult and cumbersome to follow. In addition, the policy is not generous because it does not allow for Part B rebilling more than one year after the original date of the inpatient service.

A. CMS Ruling 1455-R

1. On March 13, 2013, CMS issued Ruling 1455-R which purported to acquiesce in Medicare Appeals Council decisions and ALJ decisions that ordered CMS to make payment under Part B for all services provided during a Part A inpatient stay denied for lack of medical necessity and which would have been payable if the services had been provided on an outpatient basis rather than an inpatient basis.32

2. CMS Ruling 1455-R applies to all Part A claims denied by a Medicare contractor on the basis that the inpatient stay was not reasonable or necessary and which fit into one of the following categories:

   - the claim was denied before March 13, 2013 and an appeal was pending as of March 13, 2013;
   
   - the claim was denied before March 13, 2013 and the time to appeal the denial had not expired as of March 13, 2013; or
   
   - the claim is denied after March 13, 2013 and before the effective date of any rule finalized following the promulgation of CMS Proposed Rule 1455-P33

3. For all claims covered by the Ruling, CMS grants the providers an option to pursue appeal of the Part A denial or bypass appeal and submit Part B

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33 78 Fed. Reg. at 16616.
claims for payment. Providers cannot simultaneously pursue appeal and payment under Part B.

4. **Deadlines:** For claims that are covered by the Ruling, CMS has instructed its contractors to ignore timely filing deadlines which CMS otherwise would argue apply to “new” Part B claims. Instead, the following deadlines apply:

- **Appeal withdrawn:** If a provider elects to withdraw its Part A appeal, it must request dismissal from the claims adjudicator at the level at which its appeal is pending. The provider has 180 days from the date of receipt of notice that the appeal has been dismissed to submit Part B claims for services provided immediately before and during the inpatient stay.

- **Appeal continued:** If a provider continues with its Part A appeal and it receives an unfavorable ruling, it has 180 days from the date of receipt of notice of the “final or binding” unfavorable decision to submit Part B claims. Note: an unfavorable decision becomes “binding” if the time to appeal it to the next level expires. In such a case the 180 days still runs from the date of the unfavorable decision.

- **Denials that are not yet appealed:** The Ruling covers claims that are denied after March 13, 2013 or which were denied before March 13, 2013 and which could still be timely appealed. Providers may pursue appeal and follow the deadlines in the previous two bullets. Providers can also elect to not appeal in which case they must file Part B claims within 180 days of the date of the receipt of the denial.

5. CMS Ruling 1455-R permits providers to file two types of Part B claims for services rendered during and immediately before the inpatient stay:

- **Part B Outpatient Claims:** Providers can bill separately for the outpatient services furnished during the 3-day (or 1-day for non-PPS hospitals) payment window prior to the inpatient admission. These can be billed as outpatient services on a 13X Part B outpatient TOB. This can include claims for observation services provided prior to the point of admission.

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34 Id.
35 Id.
36 Id.
37 Id.
38 78 Fed. Reg. at 16615; see also Transmittal 1203 (Change Request 8185, March 22, 2013).
- **Part B Inpatient Claims:** Providers can bill separately for all services that were provided during the inpatient stay (after the point of admission) which would otherwise be payable if the services had been provided on an outpatient basis rather than an inpatient basis. These services can be billed as outpatient services on a 12X Part B inpatient TOB.³⁹
  
  o the list of services provided during the inpatient stay that are billable is “more than” the list of services that are listed in MBPM, Chapter 6, Section 10.⁴⁰
  
  o any services that “specifically require an outpatient status” such as outpatient visits, ER visits and observation services cannot be billed.⁴¹
  
  o providers must also submit a 11X inpatient Provider Liable TOB to address the inpatient Part A claim.⁴²

6. CMS Ruling 1455-R also purports to limit a Medicare claims adjudicator’s scope of review of a Part A inpatient claim denied for lack of medical necessity. According to CMS Ruling 1455-R, the adjudicator’s scope of review is “limited to the claim(s) that are before them (sic) on appeal, and such adjudicators may not order payment for items or services that have not yet been billed or have not yet received initial determinations.”⁴³ This restriction is designed to prevent ALJs from ordering Part B payment during the course of an adjudication of a Part A claim denial.


1. Published in the Federal Register on August 19, 2013.⁴⁴

2. Finalizes a new Part A to Part B rebilling policy that would apply to Part A inpatient claims denied on the basis that the admission was not reasonable and necessary. The Part A to Part B rebilling policy adopted in the final rule is in large part identical to the rebilling policy that CMS permitted in CMS Ruling 1455-R. An important exception, however, is the one year timely filing requirement discussed below.

3. The new policy is effective for claims with date of admission after 10/1/2013.

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³⁹ *Id.*
⁴⁰ *Id.*
⁴¹ *Id.*
4. Like CMS Ruling 1455-R, providers would be permitted to submit two types of Part B claims for services rendered during and immediately before the inpatient stay (see supra at II.A.5).

- Part B outpatient claims would include all outpatient services furnished during the payment window:

- Part B inpatient claims would include all services provided during the inpatient stay that would be payable if they were provided on an outpatient basis:
  - includes all services payable under OPPS (except services requiring “outpatient status” which include observation services and ER services)
  - ambulance services
  - prosthetic and orthotic devices
  - some DME and lab services

5. **Hospital Self-Audits**: The Part A to Part B rebilling policy applies to inpatient Part A claims denied for lack of medical necessity by medical review contractors. But the new policy finalized in the 2014 IPPS rule also allows hospitals to rebill under Part B for claims identified by “self-audit after the beneficiary has been discharged.”45 The self-audit option is a significant improvement over CMS’s prior policy which required the hospital to change the patient’s status from inpatient to outpatient before discharge in order to bill Part B following a self-disallowed inpatient stay. The self-audit policy adopted by CMS does have limitations, however. The new policy:

- Still requires UR committee involvement, physician concurrence, **beneficiary notification**, and other aspects related to continuation of an inpatient stay set for in Medicare Conditions of Participation. But this involvement can take place after discharge.

- Requires the hospital to submit a “no pay/provider liable” Part A claim before submitting Part B claims.

- Hospital is required to refund beneficiary Part A deductible and bill beneficiary for Part B co-pays. In some circumstances, this could increase beneficiary liability, making the self-audit option less attractive.

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• Beneficiary retains “inpatient” status because no status change has been made. The inpatient days still count toward the beneficiary’s 3 day medically necessary inpatient stay requirement for SNF benefits.

6. Unlike CMS Ruling 1455-R, the new Part A to Part B rebilling policy requires hospitals to submit these Part B inpatient and Part B outpatient claims within one year of the date of the inpatient service, making the new policy inapplicable to claims that are denied by medical review contractors more than a year after the date of service.\footnote{Codified at 42 C.F.R. § 414.5(b)} This is a significant limitation of the new Part A to Part B rebilling policy and is widely opposed by Medicare hospitals.