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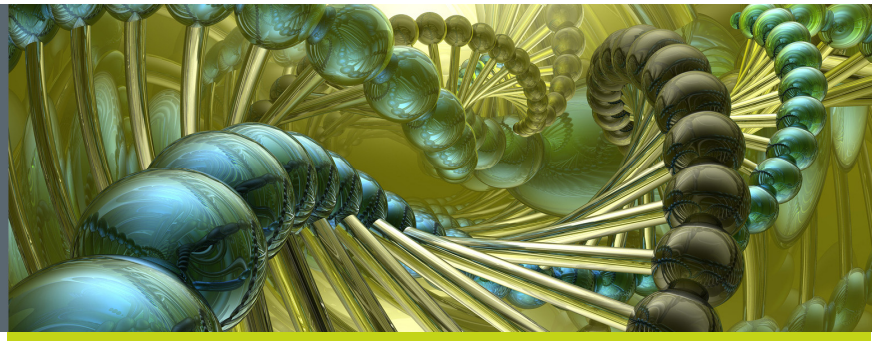

September 2013

FY 2014 IPPS/LTCH PPS Final Rule Goes into Effect October 1, 2013

In this Issue:

On August 19, 2013, the Centers for Medicare and Medicaid Services (CMS) published the fiscal year (FY) 2014 Hospital Inpatient Prospective Payment Systems (IPPS)/Long-term Care Hospital Prospective Payment Systems (LTCH PPS) final rule. Many changes implemented under the final rule will apply to discharges occurring on or after October 1, 2013, with the exception of the 2-midnight rule discussed below.

While CMS made several updates to payment systems and policies for acute care hospitals and long-term care hospitals (LTCHs), this e-Alert outlines a few new developments.

What Providers Should Know

- Inpatient Admissions. Although CMS delayed enforcement of the 2-midnight rule (as described further below) until January 1,2014, hospitals should have policies and procedures in place to ensure that any inpatient admissions reimbursed under Medicare Part A occur only pursuant to a physician order that is based on an anticipated inpatient stay that spans two midnights and for which the hospital has appropriate physician certifications/recertifications. To prepare for the January 1, 2014 enforcement start date of the 2-midnight rule, hospitals may want to consider changing documentation forms to ensure that the required orders occur prior to admission and that the appropriate certifications/ recertifications occur before discharge.

- Part B Rebilling. Although the ability to rebill denied Part A claims under Part B is certainly good news for hospitals, some limitations apply, and hospitals should not rely heavily on their ability to submit Part B inpatient claims for services denied under Part A. Given the one year time limit to re-bill for denied Part A claims and the other requirements, many denied claims may not be eligible for resubmission.

- HAC Reduction Program. Reducing the incidence of HACs is more important now than ever. As of October 1, 2014, hospitals will be subject to an additional one percent reduction in their DRG rates if they have a score in the top 25% of hospitals in the occurrence of HACs.

- LTCH payment limitations. The 25% limit on admissions to a LTCH from a single hospital is now fully applicable, and LTCHs should be aware of the percentage of patients admitted from individual acute care hospitals. Failure to conform to the 25% threshold will result in decreased reimbursement payments. LTCHs should also monitor CMS's proposal to limit LTCH payments to individuals that meet the CCI/MC criteria.

Requirements for Inpatient Admissions and Payment Under Medicare Part A

Historically, there has been a lack of consensus among providers, Medicare, and other stakeholders as to when a Medicare beneficiary is appropriately admitted to a hospital as an inpatient. There has also been a widespread belief among hospitals that Medicare's standards for inpatient admission are unclear and result in an inappropriate application of Medicare's medical review criteria for Part A hospital inpatient claims.

Responding to these concerns, CMS used the 2014 IPPS final rule as an opportunity to clarify its guidelines for appropriate inpatient admissions in several ways. First, CMS clarified that a physician order for inpatient admission is required as a condition of Medicare Part A payment. The physician order must be included in the medical record and must be supported by objective medical information contained in the physician's admission and progress notes. CMS also made it clear that the physician order is intended to complement, not replace, the existing statutory requirement for physician certification and recertification for hospital stays. Under new regulations, the order is a required component of the certification. But in contrast to the order, which must be furnished at or before the time of the inpatient admission, the certification may be completed any time prior to discharge. In addition, in an effort to help providers and CMS auditors identify appropriate inpatient admissions and to minimize short-stay hospital inpatient claims, CMS clarified its former policy that an inpatient admission must span at least twenty-four hours to mean that the patient's stay must cross two midnights. Thus, CMS has now established a two-part "2-midnight rule," as follows:

1. 2-midnight benchmark. Unless designated by CMS as inpatient only, surgical procedures, diagnostic tests, and other treatments will be appropriate for payment under Medicare Part A as an inpatient stay only when the physician expects the beneficiary to require a stay that spans at least two midnights and admits the beneficiary based on that expectation. The admitting physician should consider all time

spent at the hospital, including time spent as an outpatient in observation, when estimating the beneficiary's total expected length of stay.

2. 2-midnight presumption. For inpatient hospital claims with lengths of stay longer than two midnights after a formal admission, CMS will presume that such claims are generally appropriate for Part A payment, although medical necessity requirements still apply.

Enforcement of the 2-midnight rule will not begin October 1, 2013. After considerable pressure from hospital associations, CMS recently announced on September 26, 2013 that it will not permit Medicare Administrative Contractors or Recovery Auditors to review inpatient admissions of one midnight or less until January 1, 2014.

In the final rule, CMS also explained that the required physician orders for inpatient admission under the final rule applies to all inpatient hospital admissions, including inpatient rehabilitation facilities (IRFs). However, separate regulations govern the timing of an IRF admission and the determination of whether the admission was reasonable and necessary, and therefore IRFs are excluded from the 2-midnight admission guidelines provided in the final rule.

New Rules Permitting Re-billing Under Medicare Part B for Denied Admissions

CMS finalized its proposal to allow hospitals to receive Part B inpatient payments if an inpatient admission is determined to be not reasonable and necessary after discharge. Hospitals can rebill and receive Part B payment for most services, including those outpatient services furnished during the 3-day payment window, with the exception of certain services specifically requiring an outpatient status, such as observation services, outpatient diabetes self-management training, and hospital outpatient services. Contrary to its original proposal, CMS will not exclude therapy services rendered during a denied inpatient admission from Part B inpatient payment.

To obtain payment under Part B for denied inpatient admissions, the final rule outlined the following requirements:

1. The beneficiary must be enrolled in Medicare Part B.

2. The Medicare Part A claim for inpatient hospital services was denied because, following discharge, the admission was determined not to be reasonable and necessary by either the Medicare contractor or the hospital itself through its formal utilization review procedures under the Conditions of Participation The Part B rebilling process is not available for errors discovered as part of other internal reviews that do not conform with the requirements for utilization reviews under the Conditions.

3. The Part B inpatient claim is allowed only if the services would have been reasonable and necessary if the beneficiary was treated as an outpatient instead of an inpatient.

4. Providers must submit the Part B inpatient claim within one year of the date of service. CMS declined to create an exception to this time limit, despite the reality that Part A claims found to be improper by Recovery Audit Contractors (RACs) likely could be older than one year. Instead, CMS argued that hospitals now have an

increased ability to bill correctly from the outset given the final rule's new guidelines for inpatient admissions.

New HAC Reduction Program

CMS finalized the framework for the new Hospital Acquired Conditions (HAC) Reduction Program mandated by the Affordable Care Act. This new program, which will start October 1, 2014, imposes on hospitals with a high occurrence of HACs a one percent reduction in DRG payments in addition to the current payment reductions that apply when HACs that were not present on admission occur.

Under the new HAC Reduction Program, hospitals ranking in the top 25%, relative to the national average, of HAC measures will receive another 1% reduction in all DRG payments. CMS will make the reduction in addition to any adjustments pursuant to the Hospital Readmissions Program or the Value Based Purchasing Program.

In the final rule, CMS finalized HAC measures for FY 2015, several of which are already part of the Hospital Inpatient Quality Reporting Program. While both the HAC Reduction Program and the current HAC payment reductions focus on high-volume or high-cost conditions that are deemed preventable by following evidence-based guidelines, the HAC Reduction Program's measures are separate from the eleven categories of HACs subject to current payment reductions.

For the HAC Reduction Program, CMS determined to measure HAC occurrence rates by focusing on two Domains. For Domain 1, CMS adopted the AHRQ PSI-90 composite measure, which is comprised of eleven indicators. For Domain 2, CMS adopted the CDC measures related to Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Blood Stream Infection (CLABSI). The collection period for data on measures for FY 2015 is July 1, 2011 to June 30, 2013 for Domain 1 and January 1, 2012 to December 31, 2013 for Domain 2.

CMS finalized that it will calculate a hospital's Total HAC Score by:

1. Calculating individual measure scores. For Domain 1, PSI-90 indicators are risk and reliability adjusted and the PSI-90 composite measure is based on a weighted average of each indicator's rate. For Domain 2 measures, the measure result is based on the Standard Infection Ratio (SIR). Depending on each measure's results relative to other hospitals, CMS will divide hospitals into deciles based on relative performance (with the highest points assessed to the worst performance) and assign between one and ten points to each measure.

2. Calculating a domain score based on the performance score from each measure. For Domain 2, the score will be an average of the measure scores.

3. Weighting the domain score at 35% for Domain 1 and 65% for Domain 2.

4. Combining the weighted domain scores to determine the Total HAC Score.

To fulfill the ACA requirement to publicly report HAC rates for hospitals by FY 2015 as well, CMS will publish hospitals' measure-specific, domain-specific, and Total HAC scores on the Hospital Compare Website.

Hospitals are allowed to review and correct certain information prior to it being made available to the public.

Limitations on LTCH Payments

For many years, CMS has extended a moratorium on the full implementation of the 25% patient threshold payment adjustment policy for LTCHs. This policy eliminated full LTCH payment for any admission to a LTCH from an acute care hospital if that hospital accounted for more than 25% of all LTCH admissions for the applicable fiscal year. However, as expected in the final rule, CMS declined to further extend the statutory moratorium. Thus, for all discharges after October 1, 2013, if a LTCH admits more than 25% of its patients from a single acute care hospital, Medicare will no longer pay for the excess admissions using full LTCH rates; instead, the LTCH rates comparable to those under the IPPS will apply for admissions above the 25% threshold.

CMS also discussed a possible policy change to limit payments under the LTCH PPS to only certain patients meeting specific criteria. Namely, CMS suggested that only certain patients who are chronically critically ill and medically complex (CCI/MC) should be candidates to receive treatment in LTCHs and be paid for using the higher LTCH Medicare reimbursement. Under this proposal, LTCH PPS would be paid to LTCHs only for those patients that meet the CCI/MC profile at the point of transfer from an acute care hospital; all other patients would be paid at IPPS rates. A patient would satisfy the CCI/MC requirements if the patient (1) had a stay of at least eight days in an intensive care or critical care unit at an IPPS hospital, and (2) exhibited one or more of the following clinical factors: Prolonged Mechanical Ventilation (PMV), Tracheotomy, Multiple Organ Failure/ Stroke/Intercerebral Hemorrhage/TBI, Sepsis and Other Severe Infection, or Severe Wounds.

This policy change would severely reduce payments to LTCHs in the future, as LTCH payment would be made only for those patients with certain qualifying conditions. The American Hospital Association has estimated that this policy change would eliminate full LTCH payment for approximately 65% of LTCH patients. CMS intends to propose this change in the FY 2015 IPPS/LTCH PPS proposed rule in spring of 2014, to be implemented in FY 2015.

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