

CHALLENGING THE DENIAL OF SHORT STAY INPATIENT HOSPITAL CLAIMS

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During the CMS Recovery Audit Contractor (“RAC”) demonstration program, “wrong setting” denials, where an inpatient claim is denied for the reason that the services should have been billed as “observation” services, proved to be a lucrative target in the recovery of Medicare funds. According to a recent American Hospital Association (“AHA”) RACTrac survey, medical necessity denials are the top reason RACs have denied claims and the majority of those denials continue to be short stay inpatient claims where care was found to be in the wrong setting. As CMS continues to focus on medical necessity issues in inpatient admissions, hospitals must develop an effective appeals strategy.

To complicate matters, RACs that have denied inpatient claims found to be in the wrong setting have failed to credit payment for the medically necessary services at the outpatient rate for outpatient surgery or observation services and underlying care. As a result, hospitals have been forced to appeal all denials, including those they agree are justified, in order to retain even outpatient reimbursement. Fortunately, hospitals are experiencing success overturning denials in short-stay cases and reviewers consistently find that a hospital should at least be paid at the outpatient level.

Before advancing clinical arguments, a hospital should address CMS’ failure to provide sufficient guidance to determine whether a patient should be admitted as an inpatient. CMS’ MLN Matters article “Guidance on Hospital Inpatient Admission Decisions,” refers hospitals to the Medicare Benefit Policy Manual (“MBPM”) and the Medicare Program Integrity Manual (“MPIM”). The MBPM discusses factors to be considered by physicians when making the decision to admit while the MPIM describes similar factors that contractors are to consider when reviewing the medical necessity of an inpatient admission.

According to Chapter 1, Section 10 of the MBPM, “the physician responsible for a patient’s care at the hospital is also responsible for deciding whether the patient will be admitted as an inpatient” and “they should order admission for patients who are expected to need hospital care for 24 hours or more.” The decision to admit is a complex and forward looking medical judgment based only on the information available at that time. Factors to be considered when making the decision to admit include the severity of the symptoms, the medical predictability of an adverse outcome, and the need and availability of diagnostic studies.

According to Chapter 6, Section 6.5.2 of the MPIM, contractors are to consider factors similar to those in the MBPM when reviewing the medical necessity of an inpatient admission. The MPIM directs contractor’s to consider, “any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.” The MPIM clarifies this instruction by stating:

Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Instead, inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

Recently, Medicare contractors have used the language "inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting," as a standard of review. However, a hospital may argue that this language should more properly be considered an instruction to reviewing contractors that without any related medical conditions or the potential for adverse affects on the patient's health, any "extenuating circumstances" or factors that would only cause the patient or family inconvenience in terms of time and money, do not justify a inpatient admission. Moreover, CMS' guidance on inpatient admissions should be interpreted consistently across different CMS publications. As such, a hospital should challenge any interpretation of CMS inpatient criteria that allows RACs to apply different standards than hospitals for evaluating the medical necessity of an inpatient admission.

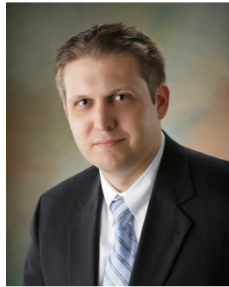
Although CMS' fails to provide sufficient guidance, a hospital should still challenge wrong setting denials by establishing that the services were properly performed on an inpatient basis. In addition to highlighting pertinent portions of the medical record; other sources may be helpful in developing a clinical defense. A hospital should submit medical literature supporting inpatient admission, documentation from a screening tool that admission was appropriate, or the opinion of a medical expert that the services at issue were medically necessary. A hospital should also reference any similarly situated cases that have been reviewed and approved by a Medicare contractor or other third party payor.

In addition to establishing an appeal based on the medical necessity of the inpatient admission, certain legal defenses are available. A hospital may assert that they are entitled to payment under the Waiver of Liability and Provider without Fault provisions of the Social Security Act, or that they are entitled to payment for medically necessary services at the outpatient rate for outpatient surgery or observation services and underlying care.

Hospitals should make efforts to evaluate their compliance with CMS' criteria. In addition to the exposure to audit denials, when making patient status determinations the billing of legitimate inpatient claims as outpatient observation claims can result in a significant loss of revenue for hospital. However, even with appropriate compliance programs in place, CMS' failure to provide meaningful guidance on inpatient admission allows Medicare contractors to review claims on a case-by-case basis and deny reimbursement to hospitals that have acted in good faith but simply guessed wrong. Hospitals that have been audited are advised to seek qualified assistance in the appeals process to ensure that all possible defenses are considered.



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