FOLEY & LARDNER LLP

07 DECEMBER 2012

Legal News: Health Care

Medicare Issues Final Rules for Hospital Outpatient and Ambulatory Surgery Center Payment Systems

On November 15, 2012, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* final rules that would, among other things, update payment policies and rates under the Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgery Center (ASC) Payment System for Calendar Year (CY) 2013. The rulemaking notice also includes new regulations, and amendments to current regulations, applicable to Quality Improvement Organizations (QIOs), and revises the Quality Reporting Program for Inpatient Rehabilitation Facilities.

Among the highlights of the rules are the following:

Increased Payments for Hospital Outpatient Services and Ambulatory Surgery Centers

In its press release, CMS stated that the rule will increase the OPPS rates by 1.8 percent. This increase is based on the projected hospital market basket increase of 2.6 percent, minus 0.8 percent in statutory reductions. The ASC payment rates will increase by 0.6 percent, which reflects the projected rate of inflation of 1.4 percent minus an 0.8 percent productivity adjustment required by statute.

Quality Improvement Organizations

Under the Medicare program, QIOs are charged with, among other duties, determining whether the services provided to Medicare beneficiaries are reasonable and necessary,

meet professionally recognized standards, and whether services that were provided on an inpatient basis could have been provided on an outpatient basis. In addition, QIOs review payment determinations and respond to complaints regarding the quality of services provided. In the final rule, CMS amended some existing regulations and promulgated some new regulations (42 C.F.R. §§ 476.110 to 476.170) to improve QIO operations. One change was to include in the regulations the changes to beneficiary complaint reviews and quality of care reviews that CMS issued in the QIO manual in May 2012. CMS stated in the rulemaking preamble that while the May 2012 manual revisions were necessary, it believed regulatory changes were needed to improve QIO operations. Thus, CMS appeared to acknowledge that enforcement of these changes required that they be issued as regulations through the notice and comment rulemaking process.

Pursuant to the new regulations, beneficiaries will be able to utilize an oral complaint process called “immediate advocacy.” CMS believes this new process will not only improve the ability of beneficiaries to file complaints, but also will reduce the burden on health care providers by avoiding the formality of the traditional peer review process in appropriate situations. CMS also instituted a new process governing QIO processing of written complaints by beneficiaries, including setting forth timeframes for reviews, responses, and the process for reconsideration of QIO determinations.

Additionally, CMS amended the regulation at 42 C.F.R. § 476.78 to clarify that the responsibilities and ramifications for not timely submitting records following a QIO request are equally applicable to practitioners and providers. Section 476.78 also was amended to require both practitioners and providers to deliver all medical information requested in response to a Medicare beneficiary complaint within 14 calendar days of the request. A QIO is authorized to require the receipt of the medical information sooner if the QIO makes a preliminary determination that the complaint involves a potential gross and flagrant or substantial quality of care concern, and that circumstances warrant earlier receipt of the medical information. Under the regulations, the failure by a practitioner or provider to timely submit requested records may result in the denial of payments, as well as the QIO reporting the matter to the Office of the Inspector General.

Part A to Part B Rebilling

In the rulemaking preamble, CMS discussed its policy regarding situations in which a Medicare contractor determines that an inpatient hospital stay was not medically necessary, and therefore denies payment under Part A for the inpatient stay. In such cases, hospitals frequently attempt to rebill Medicare Part B for certain services or supplies provided to the patient during the hospital stay. In the CY 2013 OPPS proposed rule, CMS solicited comments on what, if any, changes it should make in its rebilling policy. In the final rule, CMS stated that it received approximately 350 comments in response to its solicitation, including comments from hospitals, hospital associations, physician associations, rehabilitative and long-term care facilities, beneficiaries, beneficiary advocacy organizations, QIOs, organizations specializing in medical necessity review, and other interested parties. CMS stated that the majority of the commenters

requested that CMS not implement a comprehensive solution or set of solutions regarding this issue in the final rule.

CMS did not make any policy changes regarding Part A to Part B rebilling in the final rule. However, it did discuss what it stated is its “longstanding policy” that, following the denial of a claim for a short inpatient stay, hospitals may not rebill under Part B for all of the services furnished, but rather may submit claims for only a limited set of Part B services, which it referred to as “Inpatient Part B” or “Part B Only” services. Under this CMS policy, hospitals are only permitted to receive payment for the ancillary services listed in the Benefit Policy Manual, Chapter 6, Section 10, and are not eligible to receive payment for other services such as surgeries or observation services. CMS stated that the limited scope of allowed rebilling for “Inpatient Part B” services under its policy protects Medicare beneficiaries and provides disincentives for hospitals to admit patients inappropriately.

Hospitals have expressed concern that CMS’s policy provides inadequate payment for the resources that they have expended to take care of Medicare beneficiaries in need of medically necessary inpatient or outpatient hospital care. In fact, although not noted in the final rule, hospitals and hospital associations have complained repeatedly about CMS’s policy, and the American Hospital Association has recently brought suit on the issue. Also not noted in the final rule, CMS recently issued policy guidance that, while reaffirming the prohibition on rebilling under Part B, also instructs its contractors to process Administrative Law Judge (ALJ) decisions that give hospitals the right to full Part B payment when a short stay inpatient claim is denied for not being reasonable and necessary. ALJ decisions and decisions of the Departmental Appeals Board have uniformly upheld hospitals’ right to receive the full Part B payment in these situations. In light of the challenges to CMS’s policy, further revisions to this policy are possible.

Quality Reporting Programs

CMS has implemented quality reporting measures for multiple settings of care. These measures are intended to promote higher-quality and more efficient health care. The measures are reported on the CMS Hospital Compare Web site. Providers that do not submit the required quality information by the applicable deadlines are subject to a two percent reduction in their Medicare payment rates. In response to requests from commenters that CMS align the data submission deadlines and encounter/discharge data among the various quality reporting programs, CMS stated that it is working on more fully integrating the Hospital Outpatient Quality Reporting (Hospital OQR) program, the Hospital Inpatient Quality Reporting (IQR) program, and the Hospital Value-Based Purchasing (VBP) program.

Hospital Outpatient Quality Reporting Program

The rule makes several changes to the Hospital OQR program. CMS did not add any new measures to the 22 measures finalized for the CY 2014 payment determination, but it did confirm the removal of one measure (administration of Troponin in emergency

departments for chest pain and acute myocardial infarction), deferred data collection for another measure (cardiac rehabilitation patient referral from an outpatient setting), and confirmed the suspension of data collection for a third measure (transition record with specified elements received by discharged emergency department patients).

Ambulatory Surgery Center Quality Reporting Program

CMS did not make any changes to the quality measures for the Ambulatory Surgical Center (ASC) Quality Reporting program. The reporting requirements under the ASC Quality Reporting program began in CY 2012, and ASCs will be subject to a two percent reduction beginning in CY 2014 if they fail to timely submit the quality data.

Inpatient Rehabilitation Facility Quality Reporting Program

CMS added a measure on catheter-associated urinary tract infections (CAUTI), and made several other changes, to the Inpatient Rehabilitation Facility Quality Reporting program. The OPPS rule affects hospital outpatient departments in more than 4,000 hospitals, and the ASC rule affects approximately 5,000 Medicare-participating ASCs.

CMS invited comments on certain aspects of the final rules. The deadline for submission of comments is December 31, 2012.

The rule can be downloaded from the *Federal Register* here.

Legal News Alert is part of our ongoing commitment to providing up-to-the-minute information about pressing concerns or industry issues affecting our health care clients and colleagues. If you have any questions about this Alert or would like to discuss this topic further, please contact your Foley attorney or any of the following individuals:

Jeffrey R. Bates
Los Angeles, California
213.972.4682
jbates@foley.com

Maria E. Gonzalez Knavel
Milwaukee, Wisconsin
414.297.5649
mgonzalezknavel@foley.com

Judith A. Waltz
San Francisco, California
415.438.6412
jwaltz@foley.com

Donald H. Romano
Washington, D.C.
202.945.6119
dromano@foley.com

READ LESS

Related Intelligence

VIEW ALL RELATED INTELLIGENCE

Office of Civil Rights Releases Guidance on De-Identification of PHI Under HIPAA Privacy Rule

Legal News Alert: Health Care

California's Medi-Cal Program Implements Affordable Care Act Fraud, Waste, and Abuse Provisions

Legal News Alert: Health Care

OIG Issues 2013 Work Plan

Legal News Alert: Health Care

CMS Releases Final Stage 2 "Meaningful Use" Regulations for the Medicare and Medicaid Electronic Health Records Incentive Programs

Legal News Alert: Health Care

© 2012 FOLEY & LARDNER LLP

Attorney Advertisement