RAC MONITOR

CMS Demonstration Programs for Part A to Part B Rebilling, Pre-Payment Review Come with Significant Implications for Hospitals and Other Providers Undergoing RAC Audits

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On November 15, 2011, CMS announced a demonstration program that may provide some relief to hospitals whose inpatient claims are being denied as not medically necessary because the care was not provided in the appropriate setting. At the same time CMS has announced a demonstration program that allows Recovery Audit Contractors (RACs) to conduct prepayment review on certain types of claims in eleven states - a program that could have significant consequences for many providers.

The Part A to Part B Rebilling Demonstration Program will allow participating providers to receive 90 percent of the Part B payment for Part A inpatient claims where the inpatient admission is denied as not reasonable and necessary. Currently, if a Part A inpatient claim is submitted and denied on the basis that it could have been provided in an outpatient setting under Medicare Part B, the claim is denied in full and hospitals are not permitted to rebill for Part B payments. At present, hospital providers are forced to engage in costly and time consuming appeals processes in order to obtain an order for full Part B reimbursement for inpatient short stay claims denied under Medicare Part A.

Under the Part B Rebilling Demonstration Program, providers will be able to obtain 90 percent of the payable Part B amount, but will not be permitted to charge beneficiaries for any additional co-pay or out-of-pocket costs. Hospitals in the demonstration project will be able to resubmit claims for outpatient payments when claims are denied during the audit process or when improper payments are self-identified. Hospitals participating in the demonstration project will agree to waive their appeal rights to claims rebilled for Part B reimbursement.

The demonstration program will accept 380 volunteer participants on a first-come, first-serve basis. In its recent notice regarding two upcoming Special Open Door Forums, CMS indicated that the pool of hospital participants will be stratified by size into three categories: “small hospitals”, which will include hospitals with less than 100 beds; “moderate hospitals”, which will include hospitals with 100-299 beds; and “large hospitals”, which will include hospitals will 300 or more beds. CMS has not yet indicated the number of hospitals that will be allotted to each category. CMS’s Q & A regarding the Rebilling Demonstration indicated that enrollment for the program is set to begin on December 12, 2011 at 2:00 pm EST. CMS has specified that it will provide more information regarding enrollment in the program in the two identical Special Open Door Forums currently scheduled for November 30 and December 8 at 2:00 pm EST. Hospital providers can listen to the Special Open Door Forums by calling 1-866-501-5502 (Reference Conference ID# 28779067).

The limited information available about the Rebilling Demonstration has left many unanswered questions. First, it is unclear why CMS has limited the demonstration to only 380 hospitals or even how that number was determined. Moreover, CMS has not indicated how it will balance the allotment of demonstration participants between small, medium and large or urban and rural hospitals. It is unclear at this time whether any additional hospital allotments will be added during the three year

demonstration program or if hospitals not included in the rebilling demonstration will be forced to wait the full three years, utilizing only the Medicare appeals process to obtain orders for outpatient reimbursement.

One of the biggest questions that remain unanswered is at what level a participating hospital is required to waive its appeal rights. Does a hospital agree to waive all appeals of Part A claims that are denied based on the care being provided in an appropriate setting when it agrees to participate in the demonstration or does a participating hospital have the opportunity to choose which claims to resubmit for the 90 percent payment under Part B? Further, can this choice be made at any stage of the appeals process? While the demonstration is set to take effect on January 1, 2012, it is also unclear whether participating hospitals will be able to waive further appeal on claims currently pending in the appeals process in order to re-bill or if the program will only apply to claims identified after the start of the demonstration.

CMS has indicated that it believes the demonstration program will lower appeal rates because participating hospitals will be able to resubmit a claim for 90 percent of the Part B payment, whereas hospitals currently have to appeal these claims through the Medicare appeals process in order to obtain an order for Part B reimbursement. Hospitals that are not part of the demonstration program will have to continue to utilize the appeals process to obtain an order for full Part B reimbursement.

In addition to the Rebilling program, CMS also announced the Recovery Audit Pre-Payment Review Demonstration Program. This program will allow RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. These pre-payment reviews are focused on seven states with high instances of fraud and error-prone providers, including Florida, California, Michigan, Texas, New York, Louisiana and Illinois, as well as four states with high inpatient hospital stays, including Pennsylvania, Ohio, North Carolina and Missouri. The Demonstration Program will build on the RACs' existing infrastructure to review claims and will initially focus on inpatient hospital claims, specifically short stays. CMS will choose more specific claim types of reviews as the Demonstration Program continues and RACs will review the claims selected.

This program could create significant problems for providers. Pre-payment review allows the RAC auditors to deny payment upfront and force providers to go through the Medicare appeals process to obtain any payment, which can be a significant challenge in terms of restricted cash flow for many providers. Pre-payment review is an aggressive audit method; there is no substantive criteria for initiating a pre-payment review nor is there a procedural process in place for providers to seek removal from this form of review. The Pre-Payment Review RAC Demonstration Program reflects the ongoing challenge to balance the importance of the Medicare program integrity initiative and the effect a pre-payment review has on Medicare providers.

The practical impact of these demonstration programs has yet to be seen, but the current audit climate suggests that providers must be prepared. It is imperative for hospitals to stay current on the emerging developments related to both the Part B Rebilling Demonstration and the RAC Pre-Payment Review Demonstration as they implicate key reimbursement considerations.

LINK 1: (FACT SHEET)
https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

LINK 2: (Special Open Door Forums)

http://admin.wachler2.lawoffice.com/CM/Custom/2011.11.22.Open%20Door%20Forums.jlc.pdf

LINK 3: (AB Rebilling Demonstration)

https://www.cms.gov/CERT/downloads/AB_Rebilling_11_18.pdf