Review of Claims Affected by Temporary Suspension of BFCC-QIO Short Stay Reviews

Q&As

INTRODUCTION

On May 4, 2016, the Centers for Medicare & Medicaid Services (CMS) temporarily paused the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations’ (QIOs) performance of initial patient status reviews to determine the appropriateness of Part A payment for short stay inpatient hospital claims. CMS took this action in an effort to promote consistent application of the medical review of patient status for short hospital stays and to allow time to improve standardization in the BFCC-QIOs’ review process.

On June 6, 2016, CMS required the BFCC-QIOs to re-review all short stay patient status claims that were denied under the QIO medical review process since the BFCC-QIOs began conducting these reviews on October 1, 2015.

The temporary suspension remains effective, and the BFCC-QIO short stay claim reviews will resume after the BFCC-QIOs have completed retraining on the two-midnight policy, completed the re-review of previously denied claims, performed any needed provider outreach and education, and CMS validates the accuracy of the BFCC-QIOs’ performance of these activities. Many of these improvement steps have begun and are nearly complete. CMS believes that BFCC-QIOs reviews will resume within 90-120 days. CMS will advise stakeholders when the suspension is lifted.

Q: What is CMS announcing today?
A: Today, CMS is announcing it has clarified the instructions for medical review of claims affected by the temporary suspension of the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations’ (QIOs) performance of initial patient status reviews of acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. Specifically, CMS is announcing that these reviews will be limited to a six-month look-back period from the date of admission and announcing that Medicare Fee-For-Service (FFS) claims that:

1. Are outside their respective six-month look-back period or were not formally denied (as defined below) by the BFCC-QIO are being removed from the provider sample for re-review and will be paid under Part A.

2. Claims that are not formally denied and that are within the six month window will be reviewed when we resume QIO reviews as per our sub-regulatory guidance at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.
3. Were within the six-month look back period and were formally denied are being re-reviewed by the BFCC-QIO to determine whether the initial review decision was consistent with the two-midnight policy in effect at the time of the hospital admission.

For purposes of these instructions, “formally denied” is defined as meeting the following three criteria:

1. The provider was sent an initial results letter by the BFCC-QIO; and
2. The BFCC-QIO conducted and completed provider specific education on claims in question; and
3. The BFCC-QIO sent the provider a final results letter and the denial was sent to the MAC for effectuation.

Q: Why is CMS announcing a clarification to these instructions and limiting BFCC-QIO re-review to a six-month look-back period for claims impacted by the temporary suspension of the Beneficiary and Family Centered Care (BFCC) reviews?

A: Generally, when a Medicare Part A claim is denied by the BFCC-QIO, the provider has the opportunity to rebill under Medicare Part B within one calendar year after the date of service. The imposition of a six-month look-back period for claims impacted by the temporary suspension of the BFCC reviews is being implemented to help ensure that providers receiving denials for Part A claims have sufficient time to rebill under Medicare Part B.

BACKGROUND

Q3: When did QIOs begin reviewing short stay inpatient claims?

A3: On October 1, 2015, BFCC-QIOs began conducting initial patient status reviews to determine the appropriateness of Part A payment for short stay inpatient hospital claims. Claims with dates of admission between May 1, 2015 through December 31, 2015 are being reviewed in accordance with the FY 2014 Hospital IPPS Final Rule CMS-1599-F, which provided two distinct, although related, medical review policies: a two-midnight presumption and a two-midnight benchmark. Under the two-midnight presumption, inpatient hospital claims with lengths of stay two midnights or greater after the formal admission following the order are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two-midnight presumption. Under the two-midnight benchmark, inpatient claims are generally appropriate for Medicare Part A payment if the medical record supports the admitting physician’s reasonable expectation that the beneficiary will require medically-necessary hospital care that spans at least two midnights, including both pre- and post-admission care.

CMS adopted refinements to the two-midnight policy in the CY 2016 OPPS Final Rule, CMS-1633-F, effective for dates of admission on or after January 1, 2016. Under these refinements to the two-midnight policy, if the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case
basis if the documentation in the medical record supports the physician’s determination that inpatient care is necessary despite not meeting the two-midnight benchmark. Claims with dates of admission on or after January 1, 2016 are being reviewed in accordance with the CY 2016 OPPS Final Rule, CMS-1633-F.

Q4: How has CMS been monitoring the effectiveness of the BFCC-QIOs reviews during the initial phase of program implementation?
A4: CMS continuously engages in quality improvement efforts. To date, CMS has been closely monitoring and observing the BFCC-QIOs’ review and education processes and will continue monitoring the effectiveness of BFCC-QIO reviews through the use of a CMS accuracy review team. Through this oversight, CMS discovered that there were inconsistencies in the BFCC-QIOs’ application of the inpatient admission policy for short hospital stays and deemed it inappropriate to refer providers to the Recovery Auditors because of these known inconsistencies.

Q5: How does CMS plan to work with the BFCC-QIOs throughout this temporary suspension of short stay reviews?
A5: The quality improvement actions CMS is taking include BFCC-QIO educational sessions comprised of practical application of the two-midnight policy on a number of example claims to ensure the BFCC-QIOs accurately apply the two-midnight policy when performing medical reviews of patient status for short hospital stays. CMS developed a Short Stay Patient Status medical review (two-midnight) graphic (attachment) to provide greater transparency and consistency surrounding the FY 2014 Hospital IPPS Final Rule CMS-1599-F, and (when applicable) the CY 2016 OPPS Final Rule, CMS-1633-F that became effective January 1, 2016. Providers can also look forward to educational presentations on the topic being led by the BFCC-QIOs.

After the temporary suspension, CMS will continue its oversight efforts by routinely re-reviewing a subset of BFCC-QIO completed claim reviews, monitoring provider education calls, and responding to individual provider inquiries and concerns.

Q6: What should providers know and do about BFCC-QIO denied claims?
A6: As of June 6, 2016, the BFCC-QIOs are re-reviewing all patient status claims that were denied under the QIO medical review process that was initiated on October 1, 2015 to ensure that each medical review decision and subsequent provider education is consistent with the appropriate policy for the date of admission. Therefore, prior to submitting an appeal request, CMS urges providers to work with their BFCC-QIOs to determine if a denied claim has undergone a final determination (meaning that the claim has been re-reviewed after CMS’ clarified guidance). Providers with a denied claim will receive a letter from the BFCC-QIO indicating the claim is under re-review. If an appeal has already been submitted, then the BFCC-QIO will share its re-review findings with the appeals adjudicators to be taken into consideration during the appeal process. If upon re-review it is determined that the claim was incorrectly denied, the appeals adjudicators will issue revised determinations as necessary.

Q7: Have the BFCC-QIOs begun referring any providers to the Recovery Auditors?
A7: Since taking over patient status medical review activities on October 1, 2015 from the Medicare Administrative Contractors (MACs), the BFCC-QIOs have **not** referred any provider to the Recovery Auditors.

Q8: When a provider’s Part A claim is being re-reviewed by the QIOs, should the provider wait to rebill Part B claims until the re-review has concluded?
A8: No. If the claim for Part A payment was submitted by the provider and denied by the BFCC-QIO, then the provider should rebill under Part B prior to expiration of the one calendar year time limit for filing claims. If under re-review, the BFCC-QIO’s denial decision is reversed, then the Part A payment will be reinstated. In either scenario, providers are encouraged to rebill for Part B payment prior to expiration of the one calendar year time limit for filing claims to avoid the risk of receiving no payment if a Part A denial stands.

Q9: What is the timely filing requirement for Medicare FFS Claims?
A9: The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations at 42 CFR Section 424.44. The timely filing requirement, which is the maximum time period for submission of most Medicare FFS claims, is generally one calendar year after the date of service.

Q10: Will CMS/its contractors be able to identify and match these Part A claims with a provider’s rebilled Part B claims?
A10: In situations where a Part A claim was denied by the BFCC-QIO and the provider rebilled under Part B and received Part B payment, and the denial of the Part A claim is reversed by the BFCC-QIO, the appeals adjudicators will cancel the Part B payment and authorize the Part A payment without provider intervention.

Q11: Who initiated this pause/suspension?
A11: CMS initiated the temporary suspension on May 4, 2016 after receiving provider concerns, participating in several BFCC-QIO provider education sessions, and becoming aware of inconsistencies in the education given to providers. This action is consistent with processes that CMS has previously used to ensure effectiveness of other Medical Review contractors.

Q12: What concerns have hospitals brought to CMS about the inpatient admission review process under BFCC-QIOs?
A12: The most common concerns providers raised were that the BFCC-QIOs were misinterpreting the two-midnight benchmark and were inappropriately issuing denials for lack of medical necessity. There were also concerns that the second round of claim reviews were beginning before the first educational sessions had been completed, which does not give the provider sufficient time to make meaningful corrective actions.

Q13: How long will the pause last/when will two-midnight reviews by QIOs resume?
A13: The suspension is temporary, and the claim reviews will resume after the BFCC-QIOs have completed retraining on the two-midnight policy, completed the re-review of previously denied claims, and performed any needed provider outreach and education. Many of these improvement steps have begun and are nearly complete. CMS believes that BFCC-QIOs
reviews will resume within 90-120 days. CMS will advise stakeholders when the suspension is lifted.

**Q14: What is a BFCC-QIO? How are they related to QIOs?**

A14: In 2014 changes to the QIO Program were made to ensure that Medicare beneficiary needs are better met by designating a special type of organization, a BFCC-QIO, to address all beneficiary concerns and appeals, quality of care reviews, cases of suspected “patient dumping” covered by the Emergency Medical Treatment and Labor Act (EMTALA), and other types of case review such as short stay inpatient hospital claims. More information can be found at: [http://www.qioprogram.org/about/what-are-qios](http://www.qioprogram.org/about/what-are-qios).

**Q15: Was the two-midnight suspension written into this year’s IPPS proposed rule?**

A15: No, the temporary suspension was the result of CMS monitoring and oversight of the program, and is occurring to ensure greater accuracy.

**Q16: What sort of qualities/measures/benchmarks must happen in order for the two-midnight reviews to resume?**

A16: The BFCC-QIOs must demonstrate consistent and accurate application of the two-midnight policy for short stay reviews, to be determined by CMS oversight efforts.

**Q17: Will the two-midnight reviews be suspended under any further notices of proposed rulemaking?**

A17: This suspension is temporary and the result of CMS monitoring and oversight of BFCC-QIO’s short stay reviews.

**Q18: Does this mean the Two-Midnights Policy has been changed?**

A18: No. This suspension is only a temporary suspension of Short Stay Reviews. The Two-Midnights Policy as refined in the 2016 OPPS Final Rule is still in effect and is not impacted by this temporary suspension of reviews.

**Q19: How did CMS communicate this pause to the BFCC-QIOs?**

A19: On May 4, 2016, CMS issued a memorandum to the BFCC-QIOs to temporarily suspend Short Stay Reviews effective immediately.

**Q20: As the BFCC-QIOs are your contractors, what consequences will they face due to this poor performance?**

A20: This issue is being addressed as a quality improvement action designed to promote greater clarity, standardization and transparency. BFCC QIOs performance is assessed and evaluated on the entire BFCC-QIO scope of work that is inclusive of beneficiary concerns and appeals, quality of care reviews, cases of suspected “patient dumping” covered by the Emergency Medical Treatment and Labor Act (EMTALA), and other types of case and claims review.

**Q21: What are you doing to reduce the burden on hospitals that now must check to see if their claims are being re-reviewed? There is a cost to hospitals for those activities.**
A21: Providers will receive a letter indicating their claim is under review and a second letter indicating the re-review outcome as per Q5. There should be limited additional burden on providers as the BFCC-QIOs have the needed medical records to complete the re-reviews.

Q22: How will the temporary suspensions of two-midnight reviews affect the beneficiaries? In other words, will the beneficiaries feel the effects of the temporary suspensions?
A22: We do not expect this temporary suspension to have any negative impact on service delivery or beneficiary cost sharing.

Q23: What will be providers’ response to this update?
A23: We anticipate that providers will be generally receptive to the announcement as it removes ambiguity about reimbursement for claims affected by the temporary suspension of BFCC-QIO reviews.

Q24: Will this pause mean that improper payments to providers will not be recovered? If so, what does CMS estimate this will cost?
A24: The temporary pause in BFCC-QIO reviews does not mean improper payments will not be recovered from providers. CMS has a robust Medicare Claims Review Program inclusive of Medicare Administrative Contractors (MACs) Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)* Supplemental Medical Review Contractor (SMRC) Comprehensive Error Rate Testing (CERT) Contractors and Medicare FFS Recovery Auditors that process and review claims according to Medicare rules and regulations.