Inpatient Billing for Services that Should have Been Billed as Outpatient

As the above title implies, a violation of the FCA that occurs far too often is that time and time again hospitals have simply billed inpatient services that should have been billed as outpatient services in a variety of contexts. This sometimes is accomplished by admitting Medicare patients for unnecessary inpatient treatment and up-coding claims by falsifying information about patient diagnoses. This results in Medicare being overcharged for short-stay, inpatient procedures that should have been billed on a less costly outpatient basis. Medicare has extensive regulations on what should be billed for "observation" outpatient care instead of inpatient care.

The Use of Condition Code 44

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital's admission criteria. The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs. The definition of Condition Code 44 is as follows:

> Condition Code 44 Inpatient Admission changed to Outpatient:
>
> For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

CMS issued Transmittal 299 (Change Request 3444) on September 10, 2004, to implement new section 50.3 in Chapter 1 f the *Medicare Claims Processing Manual.* Section 50.3 describes when and how a hospital may change a patient's status from inpatient to outpatient as well as the appropriate use of Condition Code 44. In cases where a beneficiary's status is changed from inpatient to outpatient subsequent to UR determination that the inpatient admission does not meet the hospital's inpatient criteria, the hospital may submit an outpatient claim (Type of Bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

> The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
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> The hospital has not submitted a claim to Medicare for the inpatient admission;

A physician concurs with the utilization review committee's decision; and

The physician's concurrence is documented in the patient's medical record.

Blow the Whistle on Hospitals Billing for Inpatient Services when they should have been Billed as Outpatient Services

Individuals with knowledge of fraud committed by hospitals that bill for inpatient services when they should have been billed as outpatient services may be able to blow the whistle on this kind of fraud using the FCA, the TMFPA and other whistleblower reward programs. Whistleblowers play a critical role in bringing this type of fraud to light and holding wrongdoers accountable when they try to cheat the system.

To talk with me about your fraud case, call my Dallas law offices at 214-505-0097 or contact me online. Consultations with a Dallas County Qui Tam attorney are free and confidential. I handle these types of cases on a contingent fee basis, meaning you owe me no legal fees or expenses unless I obtain a recovery for you.

An example of a Substantial Whistleblower Award When Billing Inpatient Procedures When they should have been billed as Outpatient is as follows:

Two **whistleblowers** received a **Relator fee** of **$15 million** and **$12.4 million** of the recovery from an over **$260 million settlement** in September of 2018, in which a Florida-based hospital chain agreed to resolve criminal and civil charges for allegedly billing for inpatient services that should have been billed as outpatient services, remunerating physicians for referrals, and inflating claims for emergency department fees. *See* Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Hospital Chain Will Pay Over $260 Million to Resolve False Billing and Kickback Allegations; One Subsidiary Agrees to Plead Guilty (Sept. 25, 2018), https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one.