

CMS Policy: What is “Inherent Reasonableness” Policy?

Congress mandated the inherent reasonableness concept in the Balanced Budget Act of 1997 based on their finding that the HHS Secretary lacked adequate authority to make adjustments to ensure that Medicare payments were reasonable and equitable.

When existing Medicare payments for Medicare Part B services, including laboratory services, are determined to be "inherently unreasonable," that is, either excessively high or low, the Center of Medicare and Medicaid Services (CMS) has the authority to adjust such payments. Inherent reasonableness policy describes the process that CMS may use to establish a realistic and equitable payment for Part B services. This process does NOT apply to hospital inpatient services, home health services, or physician services.

The Final "Inherent Reasonableness" Rule

CMS published the final rule for applying "inherent reasonableness" payment policy in the December 13, 2005 Federal Register with an effective February 13, 2006.

Under this rule, adjustments to Medicare payments are limited by law to a 15% increase or decrease in a given year. A payment will not be considered grossly excessive or deficient if overall payment adjustment is less than 15%. Before adjusting payments, CMS must publish a proposed rule with comment in the Federal Register detailing the factors and data that contributed to the decision to adjust payment. Only after CMS reviews the comments and responds to them in a final rule, can the payment amount be changed. The factors considered when making inherent reasonableness determinations, include:

- Price markup;
- Differences in charges to Medicare and non-Medicare patients;
- Costs required to provide the service;
- Unit costs based on efficient use; and
- Payment amounts in differing localities.

In addition, if inherent reasonableness results in a total adjustment of more than 15% (remember only a 15% adjustment may be made each year), CMS must consider the potential impact on quality, beneficiary liability, assignment rates, beneficiary access, and participation of suppliers. CMS must also consult with suppliers likely to be affected by the change. The rule also permits Medicare carriers and fiscal intermediaries to use this authority, but they must follow a similar public disclosure and fact-gathering process at the local level and obtain CMS approval before implementing any payment changes. Whereas CMS payment determinations are binding on all Medicare contractors, local decisions will only affect the specific carriers or intermediaries involved and their respective geographic jurisdictions.

According to a reputable source.....”In theory, this new rule allows CMS to reduce payments for selected laboratory services, it is not expected that CMS will use it to that end because of the complex process involved. On the positive side, health care providers and other stakeholders may use this rule to petition CMS for increased payments using the same criteria.”