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The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Suite 120F
Washington, D.C. 20201

Re: Hospital Rebilling Under Medicare Part B

Dear Secretary Sebelius:

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) abandoned what we have called the "Payment Denial Policy"—a policy largely forbidding hospitals from rebilling under Medicare Part B after a contractor denies a Part A claim on the ground that though the care was reasonable and necessary, the inpatient admission was not. CMS stated in its March 13 Ruling that hospitals can rebill such claims under Part B going forward, at least until CMS finalizes a new rule on the subject. CMS also stated that hospitals can rebill under Part B for claims from the very recent past—those rejected under Part A and still live on appeal, or for which the time to appeal has not elapsed. But, CMS wrote, hospitals *cannot* rebill under Part B in the tens of thousands of cases where a contractor denied Part A payment and the time to appeal has expired.

That limitation in the March 13 Ruling is both unlawful and fundamentally unfair. Hospitals nationwide long refrained from rebilling these claims based on CMS's representations that rebilling would be futile. CMS now admits that its representations did not comport with the law. And yet in the same breath, it states that hospitals that relied on those representations have forfeited their right to be paid for reasonable and necessary services they provided. The Administrative Procedure Act and fundamental principles of equity and fair play do not permit that result. On behalf of our more than 5,000 member hospitals, health systems and other health care organizations—including Missouri Baptist Sullivan Hospital, Munson Medical Center, Lancaster General Hospital, Trinity Health Corporation, and Dignity Health, our co-plaintiffs in pending litigation over the Payment Denial Policy—and our 42,000 individual members, the American Hospital Association respectfully requests that CMS revisit this aspect of its March 13 Ruling. CMS should permit hospitals that submitted and were paid for a claim for inpatient services under Medicare Part A, which claim subsequently was denied by a Medicare review

contractor on the ground that the inpatient admission was not reasonable and necessary, to rebill for full Part B payment *in all cases where the original Part A claim was timely submitted*.

1. In a growing number of cases in recent years, Medicare review contractors have denied Part A claims that the contractors earlier had paid on the basis that, even though the care provided to the beneficiary was reasonable and necessary, the treating physician's decision to admit that beneficiary as an inpatient was not. In such cases, the Medicare contractor's denial effectively amounts to a conclusion that the hospital could, and should, have provided the care on an outpatient basis and billed for it under Part B. And yet CMS's Payment Denial Policy long prohibited hospitals from billing Medicare Part B in such circumstances for all but a small subset of the services provided.

That policy was unlawful for at least three reasons: (1) it was contrary to the Medicare statute, (2) it was arbitrary and capricious, and (3) it was invalid for lack of notice and comment rulemaking. And in fact, the Department of Health and Human Services' Departmental Appeals Board Medicare Appeals Council (DAB) declined to apply the policy in every case in which it considered the issue (at least 16 since 2005). The DAB found in each case that the hospital was entitled to Part B payment for reasonable and necessary services provided. Despite these decisions, CMS stuck to its policy. Because they believed the policy unlawful—and because the harm the policy caused to hospitals and patients grew tremendously due to the dramatic increase in scrutiny of hospitals' short-stay inpatient admissions under the Recovery Audit Contractor (RAC) program—the AHA and the five hospitals and health systems listed above filed a lawsuit last fall seeking, among other relief, a declaration that the policy was invalid.

2. CMS subsequently repudiated the Payment Denial Policy in its March 13, 2013 Ruling, denominated Ruling 1455-R, and a proposed rule issued the same day. In the proposed rule, CMS acknowledged that the Medicare statute and regulations require CMS to pay hospitals under Medicare Part B for reasonable and necessary services furnished to beneficiaries—in other words, that the Payment Denial Policy was unlawful:

> Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy, we believe that, under section 1832 of the [Social Security] Act, Medicare should pay all Part B services that would have been reasonable and necessary (except for services that require an outpatient status) if the hospital had treated the beneficiary as a hospital outpatient rather than treating the beneficiary as an inpatient[.]

Medicare Program; Part B Inpatient Billing in Hospitals, 78 Fed. Reg. 16,632, 16,636 (Mar. 18, 2013). In keeping with that acknowledgement, CMS stated in Ruling 1455-R that—for now—it would allow hospitals to rebill for the reasonable and necessary services furnished to a Medicare

patient after a Part A denial.[1] But it made clear that it would do so only for two subsets of cases: (i) those in which the contractor's Part A denial issues while the proposed rule is pending, and (ii) those in which the Part A denial already issued but the claim is still live on appeal or the time to appeal has not run. Ruling 1455-R at 7-8. By contrast, the Ruling made clear that CMS will *not* pay hospitals for the reasonable and necessary services they provided in many thousands of RAC-denial cases that are no longer live. In those latter cases, CMS apparently will apply the usual one-year time limit for filing Part B claims—the very claims that CMS long said were not cognizable—and deem as untimely any attempt to rebill.

The limited relief afforded by the Ruling covers only a fraction of the cases in which the unlawful Payment Denial Policy deprived hospitals of payments to which they were entitled. It does nothing to help the thousands of hospitals—including Missouri Baptist Sullivan, Munson, Lancaster General, Trinity Health, and Dignity Health—that lost many millions of dollars to RAC denials over the last several years and whose claims are no longer live. CMS repeatedly told those hospitals that almost all Part B payment was unavailable after RAC denials, and the hospitals took CMS at its word and never sought such payment. CMS now admits that it should have been paying all along. And yet it appears CMS will refuse to pay. In the weeks since Ruling 1455-R issued, the five hospitals and health systems identified above have tried to submit new claims for payment under Part B for services that were originally billed under Part A and were subsequently denied by a RAC, and that are not still live on appeal. We expect, given the approach CMS adopted in Ruling 1455-R, that contractors will reject those attempts as untimely. Such rejections cannot be appealed through the Medicare administrative appeals process.[2]

3. CMS's decision to apply the time bar, and refuse to pay hospitals for services that CMS itself says are covered by Medicare, is unlawful on these facts. Instead, CMS must allow hospitals—including the five hospitals named above—to rebill in *all* cases where the initial Part A claim was timely filed and a RAC subsequently denied that claim on the basis that the inpatient admission was not reasonable or necessary. That is so for at least two reasons.

First, CMS need not require hospitals to file new Part B claims—and timely-filing limits accordingly are irrelevant—because CMS can simply use the already-timely-filed Part A claims

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[1] CMS stated in the proposed rule that, once the final rule issues, CMS plans to apply a one-year timely-filing limit, running from the date of treatment, to all attempts to rebill under Part B. As AHA will explain in comments to be submitted on the proposed rule, that approach is completely arbitrary and will not withstand judicial review if adopted. The vast majority of RAC denials do not even *occur* until more than a year has elapsed since the patient was treated. CMS's timely-filing approach thus would (i) acknowledge that CMS should allow Part B payment after RAC Part A denials and yet (ii) make it impossible for hospitals to seek such Part B payment in all but the rarest case. CMS should reject that disingenuous—and arbitrary and capricious—approach and simply pay hospitals for the reasonable services they provide.

[2] Moreover, hospitals with claims that *are* eligible for rebilling under Ruling 1455-R thus far have been blocked from filing rebilling claims by technical barriers and lack of agency guidance to claims processing contractors. That has prevented them from obtaining the reimbursement to which CMS says they are entitled.

to pay the hospitals, collecting supplemental information as needed. Nothing in the law prevents CMS from doing so. And there is no question that this approach is practically feasible; the DAB and administrative law judges already have ordered it done many times.[3] Indeed, it is arbitrary and capricious for CMS *not* to take this approach; given that CMS has acknowledged that the hospitals deserve to be reimbursed under Part B for the services provided, CMS cannot act simultaneously to block hospitals from ever collecting that payment.

Second, even if new Part B claim filings are required, CMS cannot apply the one-year timely-filing limit to bar those claims. To begin with, CMS is equitably estopped from doing so because CMS's persistent adherence to its unlawful policy incorrectly led hospitals not to submit those Part B claims and/or appeal on Part B grounds once the Part A denial issued, and CMS now concedes that it should have been paying those claims all along. Moreover, the one-year time limit is likewise equitably tolled. Finally, it would be arbitrary and capricious for CMS to apply the time limit to these claims given that (i) CMS long instructed hospitals not to submit them and/or appeal on Part B grounds, (ii) CMS now admits it should have been accepting such claims and paying on them, and (iii) CMS has the statutory authority to waive the time bar and correct its mistake.

4. The AHA and its members likewise are deeply concerned about two additional aspects of Ruling 1455-R. First, CMS asserted in the Ruling that once admitted, a patient forever retains his or her "inpatient" status—even after a contractor determines that the patient properly was an outpatient all along—and that as a result hospitals cannot rebill for certain services that require an "outpatient status." But the Medicare Act requires CMS to reimburse hospitals under Part B for *all* reasonable and necessary services provided that would have been covered if the patient had been treated on an outpatient basis, without limitation. CMS's proposal to carve out certain services cannot be reconciled with that requirement. In addition, CMS's bizarre approach—insisting that the patient should not have been admitted as an inpatient, but is an inpatient for purposes of payment, and yet purporting to pay hospitals using the payment methodology for "outpatients"—has effects on hospitals beyond payment for the services that were rendered. Second, to date our member hospitals have not yet been able to submit the limited number of claims that *are* eligible for rebilling under Ruling 1455-R to their Medicare contractors for Part B payment. CMS has stated several times that additional guidance is forthcoming, but our members remain confused about, and frustrated by, the process of determining whether and how they will be reimbursed for the services they provided. To the extent CMS continues to apply time bars in these Part B rebilling matters—which it should not—it must immediately clarify how to submit claims so that hospitals can submit their claims in a timely fashion.

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[3] *See, e.g.*, *In re: Hendrick Med. Ctr.*, M-11-410, 2012 WL 2324891, at 4–5 (DAB Apr. 23, 2012) (citing CMS manual provisions instructing contractors to use adjustment billing to "correct or supplement information previously submitted on a timely claim about specified services or items furnished to a specified individual"); *In re: Montefiore Med. Ctr.*, No. M-10-1121, 2011 WL 6960290, at 16 (DAB May 18, 2011) ("Consistent with the CMS manual provisions discussed above, the contractor shall work with the appellant to take whatever actions are necessary to arrange for billing, coverage and payment under Part B.").

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We respectfully request that you take the necessary action to ensure that hospitals can seek and receive the payments to which they are entitled on all claims like those described above, and not just on the small fraction covered by Ruling 1455-R. We ask that you respond to this letter at your earliest convenience, but in any event no later than May 1, 2013.

Sincerely,

/S/

Rich Umbdenstock
President and CEO