



**American Hospital
Association**

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Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1455-P Medicare Program; Part B Inpatient Billing in Hospitals; Proposed Rule (Federal Register, Vol. 78, No. 52, March 18, 2013)

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to permit hospitals to rebill under Medicare Part B for the reasonable and necessary care provided to patients after an inpatient Part A claim for that care is denied on the basis that the care could have been delivered in an outpatient setting.

For many years, the AHA urged CMS to allow hospitals to rebill to obtain full Part B payment for all reasonable and necessary services furnished to a patient when the only dispute is the setting in which needed care should have been delivered. Despite that urging, until the AHA brought suit against the agency last fall, CMS continued to maintain that hospitals could not, under these circumstances, rebill for full Part B payment. Thus, far too often hospitals were faced with a choice of forgoing anything but nominal payment or appealing through a burdensome and expensive process involving a series of administrative tribunals.

Importantly, CMS's proposed rule recognizes that the agency's prior policy of denying full payment for Part B claims, rather than for a very limited number of ancillary services, is unlawful. In an effort to fix that unlawful policy, the proposed rule would permit hospitals to rebill most services under Part B after a Medicare contractor determines that hospital inpatient services should have been provided in an outpatient setting. Such denials occur with growing frequency; according to data from more than 2,300 hospitals participating in the AHA's RACTrac survey, it is the most common form of denial by Recovery Audit Contractors (RACs). The proposed rule also would permit a hospital to rebill under Part B if, during a self-audit, it identifies that an inpatient who



already was discharged from the hospital should have been treated as an outpatient.

Despite this seeming progress, the proposed rule contains a number of provisions that would, in practice, seriously compromise hospitals' ability to rebill when there is a dispute about where services should have been provided. Unlike the Administrator's Ruling that allows hospitals the choice to rebill or challenge a payment denial through the appeals process, the proposed rule erects artificial and arbitrary limits on the timeframe and methods to submit any rebilled claim. **The Administrator's Ruling, albeit temporary and limited in the time period it covers, is far preferable to the proposed rule in a number of respects and CMS should adopt the less restrictive limits on rebilling contained in the Ruling on a permanent basis through a final rule.**

The proposed rebilling rule will require significant modifications in order to provide hospitals with a fair and equitable process for securing payment for the reasonable and necessary services provided to patients when there is a dispute about the setting in which care should have been delivered. Specifically, the final rule should:

- Permit rebilling of any denied claim that originally was timely filed, rather than restrict rebilling to services provided in the prior 12 months;
- Ensure full reimbursement of all reasonable and necessary services provided rather than arbitrarily exclude services that require "outpatient status;" and
- Restore full and fair appeal rights for hospitals that choose to exercise their right to appeal denied claims rather than arbitrarily narrow the scope of that review.

We address each of these modifications in detail, along with other recommendations for improving the proposed rule.

A TIMELY FILING LIMIT SHOULD NOT BE IMPOSED

While the Medicare statute, as amended by the *Patient Protection and Affordable Care Act*, generally requires a claim for payment under Part A or Part B to be submitted within one year of the date the care was provided, the statute also authorizes CMS to "specify exceptions" to this "timely filing" limit. And yet under the proposed rule, CMS insists on applying the 12-month time limit without exception. That is, services could not be rebilled under Part B if they were provided more than a year before they were challenged by an auditor for being provided in the wrong setting. This is an unfair and arbitrary restriction that will effectively prevent many, perhaps most, disputed Part A services from being rebilled under Part B. That is because many claims would fall outside of the CMS-proposed timely filing window for two reasons, neither of which is under a hospital's control.

First, auditors can and often do audit Part A services that are beyond the one-year timely filing window. RACs, for example, frequently audit services that are up to 3 years old, and Medicare Administrative Contractors (MACs) audit claims that are up to 4 years old

provided that they show good cause to do so. For example, Dignity Health – a system of 40 hospitals in three states – estimates that 60 percent of the inpatient services audited by its RAC were outside the one-year timely filing window *at the time the records were requested*. Nothing would prevent a contractor from choosing to audit claims for hospital services that are exclusively outside the timely filing window. Were a RAC to do so, it would completely eliminate hospitals' ability to rebill and receive reimbursement for services the auditor found reasonable and necessary had they been provided in the outpatient setting.

Second, delays in the audit and appeals process can result in timely filed claims being pushed beyond the timely filing window. When a RAC audits a claim for Part A services provided in the prior 12 months, by the time the RAC denies the claim it is frequently beyond the timely filing period, making the services ineligible for rebilling. Although the RAC Statement of Work clearly contemplates RACs completing their review of a claim within 60 days from receipt of the medical records, the latest AHA RACTrac data show that 38 percent of hospital RAC audits were completed after the 60-day deadline.

The sluggish audit process includes delayed communication of the audit outcome to hospitals via a demand letter and remittance advice issued by the MAC, which hospitals understand to be required before they can rebill under Part B or appeal the denial. CMS should either ensure that demand letters are issued timely or allow hospitals to rebill when they receive the audit results from the RAC.

In the unlikely situation that a claim is still within the proposed 12-month timely filing window, delays in the appeals process beyond this stage will almost certainly result in expiration of the allowed time period to rebill. The Medicare appeals process is overloaded with thousands of Part A claim appeals. The Department of Health and Human Services' (HHS) Office of Medicare Hearings and Appeals estimates 100,000 appeals are at the ALJ stage of appeal. In addition, Executive Health Resources, a national compliance management consulting firm, estimates that its 2,400 hospital clients have more than 250,000 appeals in process. Hospitals report to RACTrac that appeals through the entire process require two or more years to complete.

Given the significant number of claims that we anticipate would fall outside of the timely filing window and would therefore be ineligible for rebilling, hospitals would be left with one alternative to obtain payment for services that were reasonable and necessary – the appeals process. But this process is costly and burdensome to hospitals and the Medicare program as a whole. And forcing hospitals to use the appeals process undermines CMS's goal of lightening the burden of the lengthy appeals process – a rationale that CMS invokes for this proposed rule. **For these reasons, CMS should not include the timely filing requirement in any final rule permitting rebilling for inpatient services deemed medically necessary on an outpatient basis.**

THE TIMELY FILING LIMIT SHOULD BE FIXED

CMS has two readily available options to address the timely filing problem – both of which fall within the agency’s existing authority. First, the agency could simply remove the timely filing provision from the rebilling process by continuing to treat rebilled claims as “new” requests for Part B payment without invoking the one-year timely filing requirement. Congress gave CMS explicit authority to waive the one-year time limit, and this is precisely the type of situation in which a waiver would be appropriate.

As a second alternative, as with the rebilling process in the Administrator’s Ruling, CMS could allow hospitals to rebill using an “adjustment bill” rather than treating a rebilled claim as a new claim. This would avoid triggering the timely filing limit in the first place. In short, adjusting an initial reimbursement request would not require the hospital to submit a new claim, and thus the rebilled claim would not run afoul of the general requirement that hospitals submit reimbursement requests within one year of the date services were provided.

Under this second approach, the timely filing limits accordingly would be irrelevant; CMS would simply use the already-timely-filed Part A claims to pay hospitals, collecting supplemental information as needed. Nothing in the law prevents CMS from doing this, and there is no question that this approach is practically feasible. The Departmental Appeals Board and administrative law judges (ALJs) already have ordered it done many times. Given that CMS could simply allow hospitals to rebill through an adjustment bill, it would be arbitrary and capricious for CMS to refuse to do so and refuse to waive the one-year time limit. **We urge CMS to use either of these options to eliminate the unwarranted and unnecessary timely filing limit from the rebilling process.**

REMOVE EXCLUSIONS FOR SERVICES REQUIRING OUTPATIENT STATUS

The AHA remains concerned that the proposed rebilling rule continues to exclude certain services from rebilling under Part B. These include:

- Physical, speech and occupational therapy;
- Observation and related services provided by nurses and other personnel, e.g., therapists, that are furnished to an inpatient; and
- Self-administered drugs

But CMS *itself* acknowledges in the proposed rule that under the Medicare statute, hospitals are entitled to be fully reimbursed under Part B for the care that they provide. **The final rule must likewise ensure that hospitals are paid for all of the reasonable and necessary services they provide.**

CMS has proposed that the Medicare beneficiary be considered an inpatient, even though the Part A inpatient stay has been denied, and at the same time proposed that payment

would be made under the outpatient prospective payment system. As a result, hospitals would not be paid for some significant costs, including nursing and other staff resources necessary for the hospital to monitor, assess and treat the patient during the now denied inpatient stay. This is because there currently is no mechanism in the outpatient billing system to account for such resource expenditures. Therefore, we urge CMS to take whatever steps are necessary to ensure that rebilled claims include reimbursement sufficient to compensate hospitals for this care, including, without limitation, establishing a new code to facilitate rebilling these services.

FULL SCOPE OF ALJ REVIEW SHOULD BE MAINTAINED

Under the proposed rule, CMS would restrict the ability of an ALJ to review and determine the appropriateness of medical necessity denials of hospital inpatient claims. Specifically, CMS would allow the ALJs to determine only whether the services were reasonable and necessary under Part A and prohibit the ALJs from finding, as they frequently have to date, that the services were reasonable and necessary under Part B. In effect, an ALJ would no longer have the option to issue a partial denial – a decision that facilitates accurate Medicare payment.

The purpose of the Medicare appeals process is to enable impartial judgments on whether Medicare payments are made in compliance with the Medicare statute, regulations and rules. It is at the ALJ level where a serious and comprehensive review of the RAC's denial first takes place and where many hospital denials have been overturned.

The Medicare statute requires full Part B payment for Part A services that should have been furnished in another setting but otherwise were reasonable and necessary. Therefore, it is appropriate that appeals decisions address not only whether hospital services were medically necessary under Part A, but also whether they were medically necessary under Part B. Indeed, Congress specifically directed the HHS Secretary to streamline the Part A and Part B appeals process and procedures for this reason. Prohibiting ALJ assessments of both Part A and Part B medical necessity ignores the integral connection between Part A and Part B payment under Medicare statute, regulation and rules. By proposing to decouple Part A and Part B medical necessity assessments for these ALJ appeals, CMS compromises the appeals process and accurate payment for these services.

An appeals process that guarantees full review of claims denials by an ALJ also is important because a hospital's favorable decision on appeal is accorded little to no precedential value by RACs. RACs continue to review and deny substantially similar claims, forcing hospitals to continually engage the same cumbersome and expensive appeals process on a claim-by-claim basis. **We urge that the final rule eliminate this restriction on the scope of review because it unreasonably limits ALJs' prerogative to provide appropriate relief to hospitals that have appealed a payment denial.**

BENEFICIARY CO-INSURANCE AND DEDUCTIBLES SHOULD BE WAIVED

CMS proposes that hospitals would be required to refund any amount paid by the beneficiary (such as deductible and co-pays) for denied Part A services. But a beneficiary may face new out-of-pocket costs when a denied Part A service is rebilled under Part B. Specifically, beneficiaries would be liable for any applicable deductible and co-payment amounts under Part B, and the full cost of self-administered drugs, if the hospital submits a timely Part B inpatient claim.

Cost-sharing amounts for a particular service vary per beneficiary and are different under Part A versus Part B. Therefore, under the proposed rule, a beneficiary facing new out-of-pocket costs when a denied Part A case is rebilled under Part B may experience financial hardship and confusion, especially since beneficiaries originally admitted for hospital services do not anticipate that their inpatient care may be re-categorized as outpatient care years after their hospital stay.

To address this issue, hospitals should have the option to waive all new beneficiary financial liabilities resulting from the rebilling process or pursue payment from beneficiaries for rebilled cases as appropriate. Hospitals likely would need to make a decision on whether to waive such payments on a uniform rather than a case-by-case basis to avoid any suggestion of liability under the inducement prohibitions in the Anti-kickback law. Likewise, to address such liability concerns, CMS will need to clarify how and under what circumstances hospitals can inform a Medicare beneficiary of the hospital's payment policy if the beneficiary's hospital stay is rebilled. For hospitals that retain the option of billing beneficiaries, CMS should make clear that the hospital can and should bill secondary insurers, when available, to cover new beneficiary costs that result under the rebilling policy.

With regard to how the beneficiary will be notified of this change, we believe MACs should be given the obligation to calculate and provide notification of any new beneficiary cost sharing. This process should be modeled on the current notification process outlined in Chapter 7 of the Quality Improvement Organization manual. Under this process, a Medicare contractor notifies beneficiaries and providers (both hospitals and physicians) when Medicare payments for prior services are denied or changed. The beneficiary communication includes the reason for the denial, any new beneficiary payments and the process for making those payments.

OTHER REBILLING ISSUES

Improve explanation of the mechanics of rebilling. The proposed rule's explanation of how general acute hospitals would rebill for certain services is confusing. CMS proposes that hospitals bill for eligible services primarily using two billing protocols. The proposed rule clearly states that eligible inpatient services provided during the hospital

admission would be rebilled under the 12x process for a Part B inpatient claim. It also is clear that outpatient services provided during the three-day window preceding the inpatient admission – including emergency department visits, outpatient clinic visits, and observation services – may not be rebilled using this 12x billing process. **However, CMS does not explicitly state that these services can—and should—be rebilled under the 13x rebilling protocol. We believe it is important for CMS to clarify that observation, emergency department and clinic visits provided during the three-day window are eligible for rebilling under the 13x rebilling protocol.** Such clarification would help facilitate optimal rebilling under the new process.

Lack of a physician order should be rejected as a basis for denying payment. The lack of a physician order for outpatient services cannot become an acceptable rationale for excluding services that require outpatient status for reimbursement. The Medicare statute and regulations do not require a physician's authorization for outpatient care as a precondition for full outpatient payment. In addition, CMS under prior rebilling rules required no outpatient order when it permitted hospitals to rebill for the selected ancillary services that the agency's previous policy allowed hospitals to rebill. Finally, given that RACs and MACs are conducting retrospective audits following discharge of the patient, there is no means for the treating physician's order to be changed as part of the post-discharge rebilling process.

Implementation of Administrator's Ruling. The AHA continues to actively monitor CMS's implementation of the interim rebilling rules outlined in the Administrator's Ruling. We are concerned that the implementation of the rebilling process established under this Ruling is proceeding at a pace that will limit the opportunity for hospitals to effectively use the temporary rebilling process. Among the concerns identified are:

- The rebilling function will not be fully operational until July 1, per CMS's instructions to MACs;
- Hospitals are still waiting for instructions on how to withdraw appeals from the first two appeals stages, which is a mandatory precursor to rebilling;
- Due to a CMS system problem, demand letters for periodic interim payment hospitals, which CMS is requiring in order to initiate a rebill, are not currently being issued by MACs; and
- Given the vast backlog of claims in the appeals process, we expect a lengthy and perhaps manual process for appeals adjudicators to process and issue confirmations for requests for withdrawn appeals that will subsequently be rebilled.

Due to the lack of clear guidance to contractors regarding implementation of the interim policy, we are not confident that it will actually provide relief to hospitals before the final rule on rebilling takes effect. **Given the significant problems and delays in fully operationalizing the Administrator's Ruling, we urge CMS to allow hospitals to rebill all denials that are eligible for rebilling under the Administrator's Ruling even if the final rule on rebilling has already become effective.**

Site-of-Service Denials. As CMS makes clear, the cases covered in this proposed rule meet medical necessity standards for outpatient care. Therefore, we urge the agency to describe them in audit and appeals decisions as “site-of-service denials” rather than as “Part A medical necessity denials.” This distinction is important because it may lead to negative and inaccurate conclusions if this process is described as rebilling of “medically unnecessary services.” It is appropriate to seek payment through rebilling following a site-of-service denial and, to accurately describe this process, we urge CMS, its contracted auditors and appeals adjudicators to describe these cases as “site-of-service denials” that are eligible for rebilling for the alternative setting. This clarification would help accurately identify the denials that are eligible for rebilling.

Review Results Letters. AHA’s RACTrac survey reports persistent delays in MACs’ issuance of demand letters following denial of services by RACs. Some hospitals are receiving demand letters up to six months following the audit. In implementing any new rebilling policy, hospitals should not be required to endure long waits for demand letters before rebilling. Rather, we urge the agency to allow hospitals to use the more quickly issued RAC review results letter to initiate the rebilling option.

Rebilling Process for Non-inpatient Prospective Payment System Hospitals. CMS has asked for input on whether the Part B billing protocols used by hospitals other than general acute hospitals are compatible with the new rebilling policy. The AHA urges CMS to ensure that every type of hospital receives equitable application of the statutory requirement for full payment for all reasonable and necessary services. In addition, the agency should ensure that therapy services are included among the rebillable services – since therapy is a critical inpatient service in many hospitals, such as inpatient rehabilitation hospitals and long-term care hospitals. Further, CMS’s new requirement that outpatient therapy coding and documentation include a clinical assessment of functional status should be waived for therapy rebilled following a site-of-service denial. This is appropriate since the relevant therapy was provided as part of a prior inpatient stay, and the rebilling process allows no opportunity for an assessment of functional status.

Escalated Coding and Diagnosis-Related Group (DRG) Validation Denials. RACs and MACs conduct a variety of complex audits that involve case-by-case review of medical records and a subjective determination by an auditor of the accuracy of the claim. In addition to medical necessity reviews – the most common form of complex audit – complex audits also include DRG and coding reviews. Some appeals adjudicators reviewing claims denied due to a DRG or coding inaccuracy change the auditor’s original denial into a full medical necessity denial, rather than assessing only the accuracy of the DRG or coding on the claim. **AHA opposes this practice of expanding the type and fiscal impact of auditor denials during the appeals process, and we urge CMS and the HHS Secretary to cease this practice.** If these escalations are allowed to continue, however, we ask that CMS clarify that any medical necessity denials that occur through this type of expansion also are eligible for the rebilling option.

Marilyn Tavenner

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The AHA appreciates the opportunity to comment on the proposed rule on rebilling, which is an issue of great importance to our members. If you have any questions, please contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Rick Pollack

Executive Vice President