Regulatory ADVISORY
American Hospital Association™
April 3, 2013

CMS Rules on Rebilling

At a Glance

The Issue:

On March 18, the Centers for Medicare & Medicaid Services (CMS) issued an "Administrator's Ruling" making immediate (but temporary) changes to its existing rebilling policy, and a proposed rule, which would implement a permanent change. Under current Medicare rules, following an auditor's denial of a claim as not reasonable and necessary under Medicare Part A, hospitals are permitted to bill only for a very limited portion of the denied services – selected ancillary services – under Part B. Both recent actions by CMS address circumstances in which hospitals may be eligible for Part B payment following the denial of a Part A claim for services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient.

Our Take:

The AHA is pleased that CMS, through its Administrator's Ruling, has recognized that its existing rebilling policy is inconsistent with Medicare law and permitted rebilling for certain denied claims. However, we remain concerned that CMS's proposed long-term solution would limit the ability of hospitals to rebill and would not fully reimburse them for all reasonable and necessary services provided. We plan to press ahead with the litigation we initiated last year on this issue (http://www.aha.org/presscenter/pressrel/2012/121101-prrebilling.pdf) unless and until a final rule provides full Part B reimbursement without unreasonable restrictions. We believe the agency should adopt a final rule that ensures that hospitals receive full reimbursement for all reasonable and necessary services provided to Medicare beneficiaries in the past and future.

What You Can Do:

- Share this advisory with your senior management team, including your chief financial officer and your director of billing.
- Identify whether your hospital has denials of claims as not reasonable and necessary under Part A that are still eligible for appeal, or appeals currently in process, that you may want to rebill under Part B.
- Submit comments directly to CMS by May 17 describing how the proposed policy will impact your hospital's ability to be fairly reimbursed for the care you provide to patients.

Further Questions:

For questions, please contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

AHA's Member Advisories are produced whenever there are significant developments that affect the job you do in your community. A six-page, in-depth examination of this issue follows.

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CMS RULES ON REBILLING

BACKGROUND

On March 13, the Centers for Medicare & Medicaid Services (CMS) issued an "Administrator's Ruling," making immediate (but temporary) changes to its existing rebilling policy, and a proposed rule, which would implement a permanent change. Under current Medicare rules, following an auditor's denial of a claim as not reasonable and necessary under Medicare Part A, hospitals are permitted to bill only for a very limited portion of the denied services – the selected ancillary services listed in Appendix A – under Part B. Both actions by CMS permit rebilling for certain denied inpatient claims for services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient. Data from more than 2,000 hospitals participating in the AHA's RAC*Trac* survey, indicate that this is the most common form of denial by Recovery Audit Contractors (RACs).

This *Regulatory Advisory* describes both the Administrator's Ruling (http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06159.pdf) and the proposed rule (http://www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf). Public comments on the proposed rule are due to CMS by May 17.

ADMINISTRATOR'S RULING

The Administrator's Ruling replaces CMS's prior rebilling policy, which restricted payment for hospital inpatient services denied by a Medicare auditor that found the services medically necessary on an outpatient basis. The ruling, which took effect March 13, applies to all new denials, prior denials that are still eligible for appeal, and appeals currently in process, and will remain in effect until CMS issues a final rule.

Eligible Claims

The ruling allows hospitals to seek Part B payment for denied claims that are found by a Medicare auditor to lack medical necessity under Part A. In doing so, it waives the prior timely filing limitation for rebilled claims, which allows hospitals to rebill denials from any time period. Previously, hospitals had been able to rebill only those claims for selected ancillary services provided during the prior 12 months. However, the ruling states that "such services that require an outpatient status" cannot be billed for the time period the beneficiary spent in the hospital as

an inpatient, and specifies that outpatient visits, emergency department visits and observations services are examples of excluded services. **The AHA is concerned that, through this restriction, CMS is continuing to provide hospitals will less than full Part B reimbursement for services that were found to be reasonable and necessary.**

In addition, hospitals will be able to separately bill for outpatient services furnished during the three days prior to the inpatient admission, if the inpatient admission is denied as not reasonable and necessary.

Finally, for Part B inpatient claims submitted under this ruling, CMS will continue to treat the beneficiary as an inpatient, which means the beneficiary will incur no new out-of-pocket costs.

Billing and Appeals Process Changes

The ruling specifies that hospitals may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same date. Therefore, a hospital may not seek Part B reimbursement while simultaneously pursuing a Part A appeal for the same services. However, hospitals submitting a new Part B inpatient claim under this ruling will be able to exercise Part B appeals rights subsequently, if applicable.

In order to submit a Part B inpatient claim for a claim that is currently under appeal, hospitals must first submit a request for appeal withdrawal to the entity that is adjudicating the appeal (typically a Medicare Administrative Contractor (MAC), Qualified Independent Contractor (QIC) or Administrative Law Judge (ALJ)). Otherwise, the appeals level adjudicating the claim will continue processing all Part A appeals. Appeals that have been remanded by an ALJ to the QIC will be returned to the ALJ for adjudication of the appeal. The Office of Medicare Hearings and Appeals has issued further instructions on the appeal withdrawal process at www.hhs.gov/omha.

Hospitals must then submit a Part B claim within 180 days from the date of receipt by the hospital of the appeal dismissal notice. CMS states that it will assume that the "date of receipt" is five days following the date on the notice.

The agency indicated it will issue further operational guidance on this new billing process.

The ruling also restricts the scope of decisions by ALJs and other entities adjudicating appeals to only decide whether a Part A claim is reasonable and necessary under Part A, and prohibits addressing the medical necessity of the claim for another service for which the claim was not billed.

CMS's A-B Rebilling Demo

The ruling also terminates the Part A to Part B Rebilling Demonstration, which was launched in January 2013 to examine new payment protocols for this type of denial. Under the demonstration, approximately 380 hospitals were eligible for 90 percent of rebilled Part B payments and had to forgo all appeal rights.

PROPOSED RULE

This proposed rule would provide less relief to hospitals than they received under the Administrator's Ruling for denied claims that are found not reasonable and necessary under Part A. As in the ruling, hospitals would be able to submit a new Part B claim when an inpatient admission is later denied as not reasonable and necessary. However, unlike the ruling, the proposed rule would continue to apply CMS's existing timely filing rules to rebilled claims. The proposed rule also differs from the ruling in that it lacks a provision to limit additional beneficiary cost-sharing liability for care that is later paid through a Part B inpatient claim.

Eligible Claims

Unlike the Administrator's Ruling, the proposed rule retains CMS's current application of the timely filing rules, which restrict the rebilling option to services provided during the prior year. This provision would significantly reduce the number of Part A denials eligible for Part B payment, as RACs have the authority to audit services provided during the previous *three* years, and often audit services that were provided prior to the one-year timely filing window.

In addition to claims denied by a Medicare auditor, a hospital would be able to take advantage of the proposed rule's rebilling process if, during a self-audit, it identifies cases of inpatient care that should have been provided as outpatient care. This option applies to patients who have already been discharged.

The proposed rule notes that if the failure to rebill a Part B outpatient claim within the one-year timely filing window is due to an "error or misrepresentation" by CMS or a CMS contractor, then the timely filing restriction would not apply. This protection could be very relevant to hospitals facing substantial delays in key communication, such as from MACs informing hospitals of RAC denials, or for periodic interim payment (PIP) hospitals with RAC-related demand letters on hold due to CMS systems problems. These delays take up part of the one-year timely filing window, therefore reducing the related denials eligible for rebilling.

Under the proposed rule, CMS would expand the types of services that may be rebilled under Part B, from only ancillary services to also include:

- Ambulance services;
- Prosthetics and orthotics;
- Durable medical equipment supplied during the hospital stay;
- Diagnostic laboratory services;
- Mammography services; and
- Annual wellness visits.

However, the proposed rule states that "such services that require an outpatient status" cannot be billed for during the time period the beneficiary spent in the hospital as an inpatient and cannot be included in the Part B inpatient claim. CMS would exclude services that, by statute, Medicare definition or standard

Healthcare Common Procedure Coding System code, are defined as outpatient services, including the following exclusions:

- Outpatient visits;
- Emergency department visits;
- Observations services;
- Outpatient diabetes self-management training services; and
- Outpatient physical, speech-language and occupational therapy.

The AHA is concerned that this restriction is unreasonable and would continue to limit hospitals' Part B reimbursement for services that were found to be reasonable and necessary.

Consistent with the Administrator's Ruling, hospitals would be able to separately bill for outpatient services furnished during the three days prior to an inpatient admission. However, unlike under the ruling, a separate Part B outpatient claim for these services would be subjected to the one-year timely filing restriction.

Under the proposed rule, unless the beneficiary had knowledge of non-coverage of their Part A services in advance of the provision of services, the beneficiary would not be financially liable for denied Part A care. Therefore, hospitals would be required to refund any amount paid by the beneficiary (such as deductible and co-pays) for denied Part A services. However, 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. If the hospital fails to bill Part B in a timely manner, the hospital may not charge the beneficiary.

Billing and Appeals Process Changes

The proposed rule specifies the following settings as being eligible for the proposed rebilling process: general hospitals, long-term care hospitals (LTCH), inpatient psychiatric facilities, inpatient rehabilitation facilities (IRF), critical access hospitals, children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals that are excluded from billing under the outpatient prospective payment system (OPPS), such as LTCHs and IRFs, would be eligible to bill Part B inpatient services. These hospitals would need to rebill using their traditional Part B payment methodologies, such as the physician fee schedule. CMS is asking these hospitals to specify in their comments the types of services they plan to rebill under the new process to help the agency determine whether modifications to the existing Part B billing protocols are needed for these hospitals.

When dissatisfied with the decision of a Medicare auditor, under the proposed rule, a hospital would be able to either appeal their denial or submit a Part B inpatient claim, but may not pursue both options at the same time. If a hospital simultaneously pursues both actions for the same claim, CMS would deny the Part B claim.

If, during a self-audit, a hospital identifies cases of inpatient care that should have been provided as outpatient care, the hospital must cancel its Part A claim by submitting a "no pay/provider liable" Part A claim, indicating that the provider is liable for the cost of the Part A service. The hospital can then submit a Part B inpatient claims for the services that would have been reasonable and necessary if the patient had been treated as an outpatient.

If a beneficiary has an active Part A appeal, then the hospital may not file a Part B claim until the beneficiary's appeal is finalized, if the timely filing window has not expired. If a beneficiary does not have an active Part A appeal, the hospital's filing of a Part B inpatient claim would not affect that beneficiary's Part A appeals rights.

As with the Administrator's Ruling, the proposed rule restricts the scope of ALJs adjudicating the third stage of the Medicare fee-for-service appeals process. Specifically, the ruling states that ALJs, and other appeals adjudicators, may only decide whether a Part A claim is reasonable and necessary under Part A, and may not decide whether the claim would be reasonable and necessary under Part B.

NEXT STEPS

The AHA will submit comments to CMS on the proposed rule and strongly encourages hospitals to also file comments outlining how the agency's proposal will limit fair reimbursement for the care you provide to patients. The AHA will distribute a model letter to assist hospitals in developing their comments.

Comments are due by May 17 and may be submitted electronically at http://www.regulations.gov. Follow the instructions for "Comment or Submission." You may use Microsoft Word, WordPerfect or Excel; however, CMS prefers Microsoft Word. Please refer to file code CMS-1455-P. You also may submit comment letters by mail at the following address:

Centers for Medicare & Medicaid Services
Attention: CMS-1455-P
P.O. Box 8010
Baltimore, MD 21244-8010

FURTHER QUESTIONS

For questions, please contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Ancillary Services Currently Eligible for Part B Rebilling

Under current Medicare guidelines, when denied Part A coverage for inpatient services that were found to be appropriate at the outpatient level, hospitals can rebill for selected ancillary services. *The Medicare Benefits Policy Manual*, Chapter 6, Section 10 specifies the following ancillary services as reimbursable under this process:

- Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services,"§ 220 and § 230);
- Screening mammography services;
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).