Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1455-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

RE: CMS-1455-P Medicare Program; Part B Inpatient Billing in Hospitals; Proposed Rule

Dear Administrator Tavenner:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS or the Agency) proposed rule entitled Medicare Program; Part B Inpatient Billing in Hospitals in Federal Register, Vol. 78, No. 52, March 18, 2013). The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

CMS’ preamble language indicates that the Agency is aware that hospitals are not adequately reimbursed for all reasonable and necessary services provided to Medicare beneficiaries when Part A claims are denied. While AAMC supports CMS’ proposal to allow hospitals to self-audit and bill for certain Part B services on a Part B inpatient claim, the Association strongly opposes the timely filing restriction and the limitation on the scope of review for appeals. AAMC’s comments also address our concerns regarding reimbursement for “services requiring an outpatient status” and self-administered drugs, and patient responsibility for cost-sharing.

The Timely Filing Requirement should be Waived or Tolled While RAC Review and Appeals Are Pending

AAMC strongly opposes CMS’ decision to apply timely filing restrictions to claims that are rebilled as Part B inpatient claims and requests that CMS make substantial changes in the final rule. Under the proposed rule, the hospital would have to file the Part B inpatient claim within one year of providing the services. If the hospital does not see a reason to self-audit, and the Part A inpatient claim is not denied within the one year period, the hospital would no longer be able to submit the Part B inpatient bill and would receive no payment. This is likely to occur often since RACs review claims for services provided over the previous three years, and most often
review claims over a year old. RACs frequently deny inpatient admissions, but nearly three-quarters of these denials are reversed on appeal.\(^1\) Currently, the Claims Processing Manual allows providers to correct payment for services that are not “covered as billed.”\(^2\) Therefore, if a Part A claim is denied, contractors could determine whether the beneficiary is entitled to Part B services and the provider could rebill for these Part B services. The Medicare Appeals Council has not applied timely filing limits to these rebillings, viewing them as adjustment claims. The reasoning is that a provider is submitting specific supplemental information for a beneficiary to correct a Part A claim that was already timely filed. The CMS proposal seems to be an effort on the part of the Agency to deny to hospitals what is available to them under an administrative review.

The Association opposes the timely filing restriction, which will prevent hospitals from submitting Part B inpatient claims except in very limited circumstances. If CMS’ proposal is finalized, a hospital would not be able to simultaneously file a Part B inpatient bill and pursue an appeal, nor would a hospital be able to submit a Part B claim after exhausting appeal rights (because it would very likely fall outside the one year timely filing period).

AAMC strongly encourages CMS to finalize a rule that is consistent with decisions rendered by Administrative Law Judges, and eliminate or waive the timely filing requirement or allow the Part B inpatient bill to be treated as an adjustment claim, which would not be subject to the one year timely filing requirement. If the timely filing restriction is finalized, CMS’ proposal will continue inadequate payment for care provided to Medicare beneficiaries solely because of the setting in which the care was delivered. AAMC believes that hospitals should be able to rebill and be fully reimbursed for all medically necessary services furnished during an inpatient admission when the admission is subsequently denied but the services could be rebilled and paid for under Part B.

The AAMC strongly supports the CMS proposal to allow hospitals to self-audit, as this is a reasonable avenue for encouraging accurate billing. At the same time, the Association encourages CMS to provide a more detailed description of what constitutes a “self audit” for purposes of rebilling a Part A claim as a Part B inpatient claim. For instance, if the determination of an error is made through a financial internal review rather than as part of a utilization review, CMS should clarify whether such a claim could be rebilled.

**The Restriction on ALJ’s Scope of Review is Unreasonable and Should be Withdrawn**

Physicians are taught to rely on their “complex medical judgment” after looking at many clinical factors to determine if admission is necessary or not. In contrast, the RACs reviewing the

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\(^2\) Financial Management Manual (FMM)(CMS Pub. 100-06), ch. 3, § 170.1 (internally referring to the Part B payment policy in BPM (CMS Pub. 100-02), Chapter 6, § 10) and CPM (CMS Pub. 100-04), ch. 29, § 280.3 (“Claims Where There is Evidence That Items or Services Were Not Furnished or Were not Furnished as Billed.”), cited in Mark Polston, Inpatient Admission, *Short Stays and Observation Services: Caught Between a Rock and a Hard Place.*
admission decisions are instructed to determine solely from information in the record whether the services were medically necessary. The criteria in the program integrity manual for contractors and RACs are much more stringent than the medical judgment standard in the benefit policy manual. Contractors’ instructions regarding admissions decisions are that inpatient care is required “only if the beneficiary’s health would be significantly and directly threatened if care was provided in a less intensive setting.” This discrepancy has raised significant questions about the RAC review process.

Under the proposed rule, Administrative Law Judges (ALJs) would be limited in their scope of review when hospitals appeal claim denials. Currently, ALJs have the authority to decide whether a denied claim is reasonable and necessary under Part A or Part B. CMS proposes to restrict ALJs’ scope of review to a determination of whether the claim is reasonable and necessary under Part A. However, the Recovery Audit Contractor (RAC) review process has many flaws and improper denials occur frequently. When this happens hospitals should not have their recourse for an improper denial limited to Part A. Limiting appeal rights is not a fair or just solution to address the flaws in the RAC review process. CMS should consider other options that would better address the problems associated with RAC review such as working with hospitals and physicians to establish evidence-based clinical standards for admissions decisions so that providers would not be evaluated by RACs using separate criteria, resulting in frequent denials on review.

Hospitals Should be Able to Rebill Observation and Other Outpatient-Based Services That Are Denied

CMS proposes that when a Part A claim is denied because a hospital inpatient admission is not reasonable and necessary, Medicare would accept new, timely filed Part B inpatient claims and provide payment for all reasonable and necessary Part B inpatient services, except those that by statute, Medicare definition, or coding definition specifically require an outpatient status. CMS would exclude services including outpatient diabetes self-management training services, outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services, and outpatient visits, emergency department visits, and observation services. The proposed rule language is unclear regarding the process of billing for observation services and other services defined as outpatient. AAMC recommends that CMS state explicitly in the final rule that observation services and other outpatient-based services provided in the three-day bundling window could still be billed on a Part B inpatient claim, and any services requiring outpatient status provided outside that three day window could be billed on a Part B outpatient claim.

AAMC also is concerned that excluding observation services from the proposed inpatient Part B payment fails to reimburse hospitals for costs related to the routine care of these patients. “Observation” patients occupy the same routine beds and the same level of care is provided by the nursing staff as is provided to inpatients. The Association believes that the order for inpatient admission should be sufficient as an order for observation. Therefore, AAMC encourages CMS to reconsider the decision to exclude observation services from reimbursement.

3 Program Integrity Manual (PIM), (CMS Pub. 100-08), ch. 6, § 6.5.2.A.
Guidance is Needed on How to Recode a Part A Service that Is Subsequently Billed Under Part B

Under the proposed rule, a hospital could re-code the reasonable and necessary services that were furnished as Part B services, and bill them on a Part B inpatient claim. The hospital would have to maintain documentation to support the medical necessity of services and these would be reviewed like any other Part B claim. AAMC recognizes that the proposal will help claims processors process adjudications because there is a lot of additional administrative labor involved in changing claims from inpatient to outpatient. CMS will need to provide guidance on how hospitals should address certain recoding concerns associated with rebilling for certain services on a Part B inpatient claim and for other services on a Part B outpatient claim due to differences in coding requirements for Part A and Part B claims. For example, a hospital may not feel the need to record the start and stop time of infusions and injections, but would have to submit that information when rebilling under Part B.

Beneficiary Liability and Related Concerns

CMS’ proposal exposes Medicare beneficiaries to new liabilities because the Medicare statute provides different beneficiary cost-sharing responsibilities depending on whether they are receiving Part A or Part B services. Medicare beneficiaries who are admitted as inpatients pay a one-time deductible for all hospital services that the hospital provides for the first 60 days of a hospital stay. In contrast, Medicare beneficiaries who are treated as outpatients must pay a co-pay for each individual service provided to them. Patients who are treated as outpatients for observation services may incur greater financial liability than if they are admitted as inpatients. Beneficiaries may incur financial liability for Medicare Part B copayments and the cost of self-administered drugs that are not covered under Part B when provided in an outpatient setting. Significant problems emerge when patients face unanticipated restrictions in allowable covered benefits and unanticipated financial obligations for services.

After a denial of a Part A inpatient admission as not reasonable and necessary, and a determination that the beneficiary was not liable in accordance with section 1879 of the Act, the hospital is required to refund any amounts paid by the beneficiary (such as deductible and copayment amounts) for the services billed under Part A. In these circumstances, the beneficiary would not be liable for any out-of-pocket costs. However, if CMS’ proposed rule is finalized and the hospital submits a timely Part B claim after the Part A claim is denied, the beneficiary would be responsible for the applicable deductible and copayment amounts for the Medicare covered services and for the cost of items or services excluded from coverage under Part B. Not only would this shift substantial costs onto the shoulders of beneficiaries, but it will also impose significant administrative burdens on hospitals and other providers to collect these payments from patients long after the services were provided.

Additionally, under CMS’s proposal, if the hospital does not bill under Part B within the one year required for timely filing, the hospital may not charge the beneficiary for any costs related to the Part B items and services furnished, if the beneficiary would otherwise be entitled to have Part B payment made on his or her behalf. Instead of proposing a means to address the
substantial liability beneficiaries could incur under the proposed policy if the beneficiary is not enrolled in Medicare Part B. CMS encourages hospitals and beneficiaries to recognize the importance of billing supplemental insurers and pursuing an appeal of the Part A inpatient claim denial as appropriate. At the same time, CMS’ proposal will make it much harder for hospitals to pursue the appeals process and be reimbursed fairly.

Under CMS’ proposed policy, beneficiaries would be liable for Part B copayments for each Part B outpatient or Part B inpatient hospital service and for the full cost of drugs that are self-administered, but beneficiaries covered by Part D could submit a claim to their Part D plan to be reimbursed for these costs. Despite this reimbursement, beneficiaries could still incur significant financial liability because they would be responsible for the difference between the Part D plan allowance and the hospital’s charges. If the proposed rule were finalized, CMS would need to provide further guidance regarding reimbursement for self-administered drugs.

AAMC does not believe that the Medicare crossover process currently in place is sufficient to ensure that providers do not face substantial administrative burden and increased bad debt by having to bill their patients’ supplemental insurance plans or programs for balances owed following Medicare’s payment. AAMC encourages CMS to consider the impact on beneficiaries and the goal of fairly reimbursing hospitals for the services they provide to these beneficiaries. The Association would be happy to work with CMS to identify other policies that would prevent this additional liability for beneficiaries without shifting the costs to hospital, so that both Medicare patients and the hospitals treating them are not adversely affected by the Part B inpatient billing policy proposed in this rule.

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The AAMC appreciates this opportunity to provide comments on this proposed rule. If you have questions, please contact Ivy Baer, Senior Director and Regulatory Counsel at ibaer@aamc.org or Allison Cohen, Senior Policy and Regulatory Specialist at acohen@aamc.org. We both also may be reached at 202-828-0490.

Sincerely,

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cc: Ivy Baer, JD, MPH AAMC
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