Summaries:
Medicare Program; Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B): Notice of CMS ruling
and
Medicare Program; Part B Inpatient Billing in Hospitals: Proposed Rule (CMS-1455-P)

On March 13, 2013, CMS issued a Medicare ruling and a proposed rule addressing the situation of Part B billing following the denial of a Part A inpatient hospital claim by a Medicare review contractor on the basis that the inpatient admission was determined not reasonable and necessary. The ruling, which is effective immediately, is an interim measure that will remain in effect until the effective date of a final rule addressing the issues raised by numerous Administrative Law Judge and Medicare Appeals Council decisions. The subject proposed rule, entitled "Medicare Program; Part B Inpatient Billing in Hospitals," proposes a permanent policy that would apply to these situations on a prospective basis. The proposed rule is published in the March 18 Federal Register with a 60-day comment period closing at 5:00 PM on May 17. The ruling also is published in the March 18 Federal Register.

This document summarizes both the ruling and the proposed rule.

**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. CMS Ruling No. CMS-1455-R</td>
<td>1</td>
</tr>
<tr>
<td>II. Provisions of the Proposed Regulations</td>
<td>5</td>
</tr>
<tr>
<td>A. Proposed Payment of Medicare Part B Inpatient Services</td>
<td>6</td>
</tr>
<tr>
<td>B. Proposed Payable Part B Inpatient Services</td>
<td>8</td>
</tr>
<tr>
<td>C. Billing for Part B Outpatient Services in the Three-Day Payment Window</td>
<td>9</td>
</tr>
<tr>
<td>D. Applicability – Types of Hospitals</td>
<td>10</td>
</tr>
<tr>
<td>E. Beneficiary Liability Under Section 1879 of the Act</td>
<td>10</td>
</tr>
<tr>
<td>F. Applicable Beneficiary Liability: Hospital Services</td>
<td>11</td>
</tr>
<tr>
<td>G. Time Limits for Filing Claims</td>
<td>12</td>
</tr>
<tr>
<td>H. Appeals Procedures</td>
<td>12</td>
</tr>
<tr>
<td>I. Collection of Information Requirements</td>
<td>13</td>
</tr>
<tr>
<td>J. Regulatory Impact Analysis</td>
<td>14</td>
</tr>
</tbody>
</table>

**I. CMS RULING NO. CMS-1455-R**

Rulings are decisions of the CMS Administrator that serve as precedential final opinions, orders and statements of policy and interpretation. CMS Rulings are binding on all CMS components, Part A and Part B Medicare Administrative Contractors (MACs), Qualified Independent Contractors (QICs), the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and on the Medicare Appeals Council and Administrative Law Judges (ALJs) who hear Medicare appeals.
When a physician or other qualified practitioner admits a beneficiary to a hospital for provision of inpatient care, a Medicare claims review contractor, such as a Medicare Administrative Contractor (MAC), a Recovery Audit Contractor (RAC), or the Comprehensive Error Rate Testing (CERT) Contractor, may subsequently determine that the inpatient admission was not reasonable and necessary under section 1862(a)(1)(A) of the Act and deny the associated Part A claim for payment. Medicare policy, prior to this ruling, permitted hospitals to submit a subsequent "Part B Inpatient" claim for only a limited set of medical and other health services referred to as "Part B Inpatient" or "Part B Only" services and only when the Part B claim is submitted within the applicable time limit for filing a Part B claims.

In the ruling, CMS notes that hospitals’ appeals of these Part A inpatient claims denials to Administrative Law Judges (ALJs) and the Medicare Appeals Council frequently result in decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, and ordering payment of the services as if they were rendered at an outpatient or "observation level" of care. These decisions require Medicare to issue payment for all Part B services that would have been payable had the beneficiary been treated as an outpatient (rather than an inpatient), instead of limiting payment to only the set of Part B inpatient services that are designated in the Medicare Benefit Policy Manual (MBPM). The decisions also have required payment regardless of whether the subsequent hospital claim for payment under Part B is submitted within the otherwise applicable time limits.

Although decisions issued by the ALJs and the Medicare Appeals Council do not establish Medicare payment policy, CMS must effectuate each individual decision and the increasing number of these types of decisions has created numerous operational difficulties and led to the issuance of the ruling. The policies in the ruling supersede any other statements of policy on this issue and will remain in effect until the effective date of the aforementioned final regulation.

Chapter 6, Section 10 of the MBPM provides that a limited set of Part B inpatient services may be paid in the following circumstances:

i. No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission.

ii. The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made).

1 For more information, CMS refers readers to these sources: Internet Only Manual (IOM) Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 6, Section 10; Prospective Payment System for Hospital Outpatient Services, Proposed Rule, 63 FR 47560 (September 8, 1998) and Final Rule, 65 FR 18444 (April 7, 2000); Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002, Proposed Rule, 66 FR 44698 through 44699 (August 24, 2001) and Final Rule, 66 FR 59891 through 59893, and 59915 (November 30, 2001).

2 For more information on timely filing requirements, CMS refers readers to these sources: MBPM, Chapter 6, Section 10; Prospective Payment System for Hospital Outpatient Services, Proposed Rule 63 FR 47560 (September 8, 1998) and Final Rule, 65 FR 18444 (April 7, 2000); Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002, Proposed Rule, 66 FR 44698 through 44699 (August 24, 2001) and Final Rule, 66 FR 59891 through 59893, and 59915 (November 30, 2001); Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule (75 FR 73449 and 73627, November 29, 2010).
iii. The day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability).

iv. The patient was not otherwise eligible for or entitled to coverage under Part A.

The ruling applies only in the second circumstance, that is, when the admission was disapproved as not reasonable and necessary by a Medicare review contractor, and payment for the denied services was not made under the authority of section 1879 of the Act (i.e., waiver of liability) nor was the hospital’s responsibility for repayment of an overpayment waived under section 1870 of the Act. Current policy limiting rebilling under Part B will continue to apply in the other three circumstances.

The scope of the ruling expands the class of payable Part B services to include all services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, for example, outpatient visits, emergency department visits, and observation services. Such services that require an outpatient status cannot be billed for the time period the beneficiary spent in the hospital as an inpatient and cannot be included on the Part B inpatient claim. However, when no Part A payment is made because the inpatient claim is denied as not reasonable and necessary, hospitals may bill separately for the outpatient services furnished during the 3-day (or 1-day for non-IPPS hospitals) bundling payment window prior to the inpatient admission; these claims will be considered based on their status as the outpatient services that they were, including observation and other services that were furnished consistent with Medicare's requirements, absent the 3-day bundling requirement.

Applicability of the ruling is Part A hospital inpatient claims denials made: (1) while the ruling is in effect; (2) prior to the effective date of the ruling, but for which the timeframe to file an appeal has not expired; or (3) prior to the effective date of the ruling, but for which an appeal is pending. The ruling does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired prior to March 13, 2013, the effective date of the ruling, and it does not apply to inpatient admissions deemed by the hospital to be not reasonable and necessary (for example, through utilization review or other self-audit).

With respect to the thousands of appeals that are currently pending and are subject to the ruling, CMS is providing hospitals with notice of their right to withdraw pending appeals of Part A claim denials that are subject to the ruling, and instead submit Part B claims for payment. Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending, except where the appeal has been remanded from an ALJ to a QIC. Under the ruling, appeals of Part A claim denials that were remanded from the ALJ level to the QIC level will be returned to the ALJ level for adjudication consistent with the scope of the review specified in this ruling. QICs will send affected hospitals notice regarding this action. The Office of Medicare Hearings and Appeals (OMHA) will provide instructions for submitting requests for withdrawal of ALJ hearings, including cases that were remanded from an ALJ to a QIC. OMHA will post the instructions on its public website at www.hhs.gov/omha. Appellants also may call any OMHA Field Office (included in the Notice of Hearing sent by an ALJ and on the OMHA website) to request a copy of the instructions by mail or facsimile. Until and unless adjudicators receive a request for withdrawal, they will continue processing all pending Part A appeals that are subject to the ruling.
To prevent duplicate billing and payment, a hospital 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 dates of service. If a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, the hospital cannot also maintain its request for payment for the same services on the Part A claim. The hospital must either choose to no longer pursue an appeal of the Part A claim denial or must withdraw any pending appeal request on the Part A claim denial prior to the submission of the Part B claim. Once the hospital submits a Part B claim, parties will no longer be able to appeal the Part A claim, but they will be able to exercise their appeal rights for the subsequent Part B claim under existing procedures in 42 CFR part 405 subpart I.

**Time Period within Which a Provider Must Bill.** Consistent with the ALJ and Appeals Council decisions (but differing from the proposed rule), if the hospital elects to withdraw its Part A appeal and submit a Part B claim, the hospital will have 180 days from the date of receipt of the appeal dismissal notice to submit the claim(s). If the appeal of the Part A claim remains pending, the hospital may submit a Part B claim(s) if the Part A appeal is later withdrawn, or an unfavorable Part A appeal decision becomes final or binding; in this case, the hospital will have 180 days from the date of receipt of the final or binding decision, or the date of receipt of the dismissal notice to submit the Part B claim(s).

For example, if an appellant receives an unfavorable reconsideration decision but decides not to request a hearing before an ALJ, or the time to request a hearing expires, the reconsideration decision becomes binding, and the Part B claim(s) may be filed within 180 days of the date of receipt of the reconsideration decision. If a hospital receives a denial of a Part A inpatient claim subject to the ruling for which there is no pending appeal, and the denial is not subsequently appealed, the hospital will have 180 days from the date of receipt of the initial or revised determination on the Part A inpatient claim (that is, the date of the remittance advice) to submit its Part B claim(s). The date of receipt of an initial or revised determination, or an appeal decision or dismissal notice is presumed to be 5 days after the date of such notice or decision, unless there is evidence to the contrary.

CMS notes that it temporarily adopts these exceptions to longstanding policy concerning filing Part B inpatient and Part B outpatient claims as an interim measure until the final rule is issued. Thus, the ruling adopts (but explicitly without endorsement) the decisions of the ALJs and the Medicare Appeals Council that subsequent Part B rebilling by a hospital in situations covered by the ruling is supported by concepts of adjustment billing.

**Scope of Review for Part A Inpatient Claim Denials.** The ruling notes that its policies adhere to the recent appeal decisions for Part A inpatient claim denials even though they conflict with existing policy by providing payment under Part B (or consideration of payment for services furnished that the contractor determined to be covered and payable under Part B), even though a Part B claim had not been submitted for payment. Thus, CMS clarifies in the ruling that hospitals are solely responsible both for submitting claims for items and services furnished to beneficiaries and determining whether submission of a Part A or Part B claim is appropriate. As specified in 42 CFR 405.904(a)(2), once a hospital submits a claim, the Medicare contractor can

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3 Normally they would be considered new claims subject to the time limits for filing claims described in sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act, and 42 CFR 424.44.
make an initial determination and determine any payable amount. Under existing Medicare policy, if such a determination is appealed, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and such adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination.4 If a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim the provider has not yet submitted.

**Patient Status Under the Ruling.** For the Part B claims billed under this ruling, the beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after hospital discharge. The beneficiary is considered an outpatient for services billed on the Part B outpatient claim, and is considered an inpatient for services billed on the Part B inpatient claim.

**The Part A to Part B Rebilling Demonstration** is being terminated with details regarding termination of the demonstration to be communicated to hospitals and contractors in the future.

**Operational Considerations.** CMS will issue operational and any other regulatory guidance that is necessary to implement the ruling, including the mechanics of how hospitals should bill for Part B inpatient and Part B outpatient services under the ruling.

**II. PROPOSED RULE: PART B INPATIENT BILLING IN HOSPITALS**

In its rulemaking for the 2013 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) payment system, CMS noted concern about recent increases in the length of time that Medicare beneficiaries spend as hospital outpatients receiving observation services and invited public comment on a number of issues. The final rule summarized major comments received but established no new policies, noting that CMS would consider the comments and respond in future rules. The new proposed rule states that "hospital" means hospital as defined at section 1861(e) of the Social Security Act (the Act), but also includes critical access hospitals (CAHs) unless otherwise specified because CMS believes that the same policies regarding payment for inpatient services should apply under Part B in CAHs as apply in hospitals.

The policies in the proposed rule are largely the same as the ones in the ruling, with the most significant difference being a more restrictive policy on the timely filing of claims. The proposed rule does not consider the subsequent Part B claims to be adjustments to the originally submitted Part A claim. This and other differences are described below. Also, the proposed rule includes a discussion of beneficiary issues as well as impact analysis describing the effect of both the proposed rule and the ruling on the Medicare expenditures and beneficiary out-of-pocket costs.

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4 See 42 CFR 405.920, 405.940, 405.948, 405.954, 405.960, 405.968, 405.974, 405.1000, 405.1032, 405.1100, and 405.1128.
A. Proposed Payment of Medicare Part B Inpatient Services

The proposed rule notes that as early as 1968, the Medicare manuals provided for payment under Part B of only a limited list of ancillary medical and other health services furnished to inpatients of participating hospitals, and under current policy, the program continues to provide that the payable Part B inpatient services include only a limited set of ancillary services. Currently payable services prior to the ruling include:

- 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
- Epoetin Alfa (EPO)

As provided also by the ruling, the expansion of the class of payable services in the proposed rule would apply when the inpatient admission was disapproved as not reasonable and necessary by a Medicare review contractor, and payment for the denied services was not made pursuant to section 1879 of the Act (i.e., waiver of liability) nor was the hospital’s responsibility for repayment of an overpayment waived under section 1870 of the Act. Current policy limiting rebilling under Part B to the above-listed services will continue to apply in all other circumstances, such as when a beneficiary exhausts Part A benefits for hospital services or is not
entitled to Part A. Application of the new policy to situations involving hospital “self-audit” is described below.

**Beneficiary status as inpatient or outpatient: observation status.** In rulemaking for the 2013 OPPS, CMS noted that various stakeholders had expressed concern about increasing use of observation status. Concerns included the possibility that hospitals might be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be determined not reasonable and necessary and denied by electing to treat beneficiaries as outpatients receiving observation services, often for longer periods of time, rather than admitting them as inpatients. According to CMS, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had increased from approximately 3 percent in 2006 to approximately 8 percent in 2011. CMS stated that this trend is concerning because of its effect on Medicare beneficiaries. There could be significant financial implications for Medicare beneficiaries of being treated as outpatients rather than being admitted as inpatients.

To enable beneficiaries to make informed financial and other decisions prior to hospital discharge, Medicare allows the hospital to change a beneficiary's inpatient status to outpatient (using condition code 44 on a Part B outpatient claim) and bill all reasonable and necessary services that it provided to Part B as outpatient services if four conditions are satisfied:

1) the change in patient status is made prior to discharge;
2) the hospital has not submitted Medicare claim for the admission;
3) both the practitioner responsible for the care of the patient and the utilization review committee concur with the decision; and
4) the concurrence is documented in the medical record.

The hospital conditions of participation (CoPs) provide similar patient protections. For example, in accordance with 42 CFR 482.13(b), patients have the right to participate in the development and implementation of their plan of care and treatment, to make informed decisions, and to accept or refuse treatment. Informed discharge planning between the patient and the physician is important for patient autonomy and for achieving efficient outcomes.

CMS reports that hospitals have indicated that often they do not have the necessary staff (for example, utilization review staff or case managers) available after normal business hours to confirm physicians’ decisions to admit beneficiaries. Thus, for short-stay admissions, the hospitals may be unable to complete a timely review and change beneficiaries’ status from inpatient to outpatient prior to discharge in accordance with the condition code 44 requirements.

The proposed rule does not include any changes pertaining to observation status or to limiting beneficiary financial liability in cases involving rebilling under Part B due to change in patient status.

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5 See list of other circumstances on page 2 of this summary.
6 See Section 50.3, Chapter 1 of the Medicare Claims Processing Manual (MCPM) (Pub. 100-04); MLN Matters article SE0622, Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: “Inpatient Admission Changed to Outpatient,” September 2004
B. Proposed Payable Part B Inpatient Services

As does the ruling, which is effective immediately, the proposed rule would expand the scope of payable Part B services applicable to inpatient admissions that are denied due to application of the medically reasonable and necessary requirement. The expanded services encompass all services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, for example, outpatient visits, emergency department visits, and observation services. Services that require an outpatient status cannot be billed for the period the beneficiary spent in the hospital as an inpatient and cannot be included on the Part B inpatient claim. Thus, the proposed rule would exclude services that by statute, Medicare definition, or standard Healthcare Common Procedure Coding System (HCPCS) code are defined as outpatient services, including:

- outpatient diabetes self-management training services (DSMT) defined in section 1861(qq) of the Act;
- outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services (PT/SLP/OT or "therapy" services) defined in section 1833(a)(8) of the Act; and
- outpatient visits, emergency department visits, and observation services (G0378, Hospital observation service, per hour; and G0379, Direct referral for hospital observation care).

CMS would implement the new provision in proposed new 42 CFR 414.5, entitled, “Hospital inpatient services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) or § 485.641 after a beneficiary is discharged that the beneficiary’s inpatient admission was not reasonable and necessary, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B: (1) Services described in § 419.21(a) that do not require an outpatient status.”

"If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) or § 485.641 after a beneficiary is discharged that the beneficiary’s inpatient admission was not reasonable and necessary, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B: (1) Services described in § 419.21(a) that do not require an outpatient status."

For Part B inpatient services furnished by the hospital that are not paid under the OPPS, CMS proposes that when the inpatient admission is determined not reasonable and necessary, Part B payment would be made based on the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients (see 65 FR 18442 and 18443). As provided in 42 CFR 419.22, the services for which payment is made under other payment methodologies includes ambulance services; prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices; durable medical equipment supplied by the hospital for the patient to take home; clinical diagnostic laboratory services;
screening and diagnostic mammography services; and annual wellness visit providing personalized prevention plan services.

**Expansion of applicability of rebilling beyond ruling.** CMS proposes that the new policy would apply not only when CMS or a Medicare review contractor determines that the hospital inpatient admission was not reasonable and necessary, but also when a hospital determines under Medicare's utilization review requirements in sections 1861(e)(6)(1) and 1861(k) of the Act and 42 CFR 482.30 (42 CFR 485.641 for CAHs) that a beneficiary should have received hospital outpatient rather than hospital inpatient services, even when the beneficiary has already been discharged from the hospital (referred to as hospital "self-audit").

In this circumstance, CMS would continue requiring the hospital to submit a "no pay/provider liable" Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services (see section 40.2.2(E), Chapter 3 of the MCPM). Submission of this Part A claim would indicate that the provider is assuming financial liability for the denied items or services on the Part A claim consistent with section 1879 of the Act (and acknowledging that the beneficiary is not financially liable under section 1879 of the Act) for the cost of the Part A items and services. The claim also would ensure accurate cost reporting, reporting of utilization of inpatient days, and would trigger refund requirements of the Part A cost sharing under sections 1866(a) and 1879(b) of the Act and 42 CFR 411.402 of the regulations.

Submitting the provider-labile Part A claim also cancels any claim that may have already been submitted by the hospital for payment under Part A. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except for those services specifically requiring an outpatient status. Such a claim would have to be submitted within the timely filing period.

Note that the self-audit situation is not covered by the ruling. The proposed rule states that providing for additional payment under Part B when a hospital determines itself that an inpatient admission was not reasonable and necessary but hospital outpatient services would have been reasonable and necessary would reduce improper payments under Part A, and would reduce the administrative costs of appeals for both hospitals and the Medicare program.

**C. Billing for Part B Outpatient Services in the Three-Day Payment Window**

The proposed rule would not change the 3-day payment window policy, which requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a hospital that is not paid under the Inpatient Prospective Payment System (non-IPPS)) prior to the date of an inpatient admission to be bundled with the payment for the beneficiary's inpatient admission, if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital (Section 40.3, Chapter 3 and Section 10.12, Chapter 4 of the Medicare Claims Processing Manual (Pub. 100.04)). The current policy applies to all diagnostic outpatient services and non-diagnostic (i.e., therapeutic) services that are related to the inpatient
stay. If there is no Part A coverage or payment for the inpatient stay, services provided to the
beneficiary prior to the point of admission may be separately billed to Part B as the outpatient
services that they were.

D. Applicability - Types of Hospitals

CMS proposes that all hospitals billing Part A services would be eligible to bill the
proposed Part B inpatient services, including short-term acute care hospitals paid under the IPPS,
hospitals paid under the OPPS, long-term care hospitals (LTCHs), inpatient psychiatric facilities
(IPFs), inpatient rehabilitation facilities (IRFs), CAHs, children's hospitals, cancer hospitals, and
Maryland waiver hospitals. Hospitals paid under the OPPS would continue billing the OPPS for
Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR
419.20(b) would be eligible to bill Part B inpatient services under their non-OPPS Part B
payment methodologies.

Certain hospitals do not submit claims for outpatient services under Medicare Part B,
either because they do not have outpatient departments or because they have outpatient
departments but submit no claims to Medicare Part B (for example, state psychiatric hospitals).
In some circumstances, these hospitals are specifically excluded from the OPPS and may bill
these services under the hospital's pre-OPPS payment methodology, for example at reasonable
cost or the per diem payment rate, unless the services were subject to a payment methodology
that was established prior to the OPPS. Services subject to pre-OPPS payment methodologies
include PT/SLP/OT services; ambulance services; devices and supplies paid under the Durable
Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule; clinical
diagnostic laboratory services; screening and diagnostic mammography services; and the annual
wellness visit providing personalized plan prevention services.

The proposed rule solicits public comments from these hospitals regarding the types of
Part B inpatient services they anticipate billing Medicare under the proposal for payment of
additional Part B services. If under the proposed policies, the Part B inpatient services payable to
these hospitals would largely be limited to the ancillary services they currently bill Medicare,
these hospitals would continue billing Part B inpatient services under the current exception to
inclusion in the OPPS. However, if CMS receives public comments indicating that hospitals
subject to the exception in 42 CFR 419.22(r) would be eligible and seek payment for additional
Part B inpatient services under this proposed rule, CMS would consider finalizing a policy to
require these hospitals to bill the OPPS.

E. Beneficiary Liability Under Section 1879 of the Act

CMS recognizes that the expansion of services that can be billed under Part B following a
Part A denial may create a unique liability issue for Medicare beneficiaries that did not
previously exist. When a Part A inpatient admission is denied as not reasonable and necessary
under section 1862(a)(1)(A) of the Act, or a hospital submits a "provider liable/no-pay" claim
indicating that the hospital has determined that an inpatient admission is not reasonable and
necessary, a determination of financial liability for the non-covered inpatient admission is made
under section 1879 of the Act. The Medicare contractor determines whether the hospital and the
beneficiary knew, or could have reasonably been expected to know, that the services were not covered. If neither the hospital nor the beneficiary knew, or could reasonably have been expected to know, that the services were not covered, then Medicare makes payment for the denied services.

Unless the beneficiary had knowledge of non-coverage in advance of the provision of services (typically through a Hospital Issued Notice of Non-Coverage (HINN)), the beneficiary will not be financially liable for the denied Part A services in accordance with section 1879 of the Act. Because hospitals are expected to have knowledge of Medicare coverage and payment rules, hospitals are often determined liable under section 1879 of the Act for the cost of the non-covered items and services furnished. Following a denial of a Part A inpatient admission as not reasonable and necessary and a determination that the beneficiary was not financially liable, 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. (See, 42 CFR 411.402.) The beneficiary would have no out-of-pocket cost in this scenario.

However, under the Part B inpatient billing policy proposed in this rule, if the hospital subsequently submits a timely Part B claim after the Part A claim is denied, the financial protections afforded under section 1879 of the Act to limit liability for the denied Part A claim cannot also be applied to limit liability for the covered services filed on the Part B claim. The beneficiary (who may previously have had no out-of-pocket costs for the denied Part A claim) is responsible for applicable deductible and copayment amounts for Medicare covered services, and for the cost of items or services never covered (or always excluded from coverage, such as most self-administered drugs) under Part B of the program. Note however, that if a hospital fails to bill under Part B in a timely manner, in accordance with section 1866(a)(1)(A)(i) of the Act, 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 Part B payment.

CMS does not believe that the existing beneficiary liability notices (the HINN and Advance Beneficiary Notice of Noncoverage (ABN)) are applicable or relevant for the Part B inpatient billing process described in the proposed rule to alert beneficiaries to the possible change in deductible and cost-sharing if a Part A inpatient claim is denied and a Part B claim is subsequently submitted. These notices must be given prior to the provision of an item or service that is expected to be denied, and cannot be issued retroactively (that is, after the receipt of the post-payment Part A inpatient claim denial). CMS invites public comment on recommendations for notification to beneficiaries in these situations, consistent with its current notice policies.

F. Applicable Beneficiary Liability: Hospital Services

As noted, beneficiaries would be liable for Part B copayments for each hospital Part B outpatient or Part B inpatient service as well as for the full cost of drugs that are usually self-administered, which section 1861(s)(2)(B) of the Act does not include. CMS also notes that beneficiaries having Part D coverage for self-administered drugs may incur higher out-of-pocket expenses if they must receive the self-administered drug from a hospital, rather than a community pharmacy, due to the hospital pharmacy’s status as a non-network pharmacy. Beneficiaries would be responsible for the difference between the Part D plan's plan allowance
and the hospitals' charges, and the difference may be significant. CMS solicits comment on whether it should consider additional policies to mitigate or prevent the potential additional liability for beneficiaries under the proposal to allow rebilling under Part B for denied Part A services.

The proposed rule notes that most supplemental insurers or benefit programs (including Medigap plans that market Medicare supplemental insurance policies, employer retiree plans, FEHBP, TRICARE, and Medicaid) participate in Medicare's coordination of benefits (COB) or claims crossover process. Such payers sign national agreements with Medicare to facilitate the automatic transfer of Medicare-adjudicated professional as well as facility claims to them. CMS pledges to work with all supplemental payers to educate them concerning the proposed new policies.

G. Time Limits for Filing Claims

Sections 1814(a)(1), 1835(a), and 1842(b)(3)(B) of the Act establish time limits for filing Medicare Part A and B claims. Section 424.44 of the regulations implements those sections of the Act and requires that all claims for services furnished on or after January 1, 2010 be filed within 1 calendar year after the date of service unless an exception applies. In comments received as part of the 2013 physician fee schedule rulemaking process, CMS was urged to create an exception to the time limits for filing claims so that hospitals are permitted to file inpatient Part B only claims for any inpatient cases that are retrospectively reviewed by a Medicare Recovery Audit Contractor (RAC) or other review entity and determined not to be medically necessary in an inpatient setting. CMS declined to create the exception and reaffirms that decision in the proposed rule.

Thus, in the proposed rule, CMS proposes a new § 414.5(b) requiring that claims for billed Part B inpatient services be rejected as untimely when those Part B claims are filed later than 1 calendar year after the date of service. Note that the agency’s proposal differs from the ruling, which it has issued simultaneously and in which CMS adopted (but did not endorse) the policies stipulated by the ALJ and Appeals Council decisions to allow 180 days to submit Part B claims. The proposed rule treats the affected Part B claims as new claims subject to the timely filing requirements, rather than adjustment claims.

The proposed rule also notes that the exception at § 424.44(b)(1), which extends the time for filing a claim if failure to meet the deadline was caused by error or misrepresentation of an employee, contractor or agent of HHS (commonly referred to as the "administrative error" exception), would not apply in situations where a provider bills the originally submitted Part A claim incorrectly. Finally, CMS reminds providers that determinations that a provider failed to submit a claim timely are not appealable (42 CFR 405.926(n)).

H. Appeals Procedures

A hospital dissatisfied with an initial or revised determination by a Medicare contractor to deny a Part A claim for an inpatient admission as not reasonable and necessary may either submit Part B inpatient or outpatient claims (consistent with this proposed rule) or file a request
for appeal of the denied Part A claim following the procedures in 42 CFR Part 405 subpart I. To prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment for the same services provided to a single beneficiary on the same dates of service. Before the hospital submits a Part B claim, it must ensure that there is no pending appeal request on the Part A claim (i.e., an appeal for which there is no final or binding decision or dismissal.) If a hospital submits a Part B claim for payment without withdrawing its appeal request, the Part B claim would be denied as a duplicate.

Significantly, if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot utilize the Part B billing process proposed in this rule to extinguish a beneficiary's appeal rights. A hospital's submission of a Part B claim would not affect a beneficiary's pending appeal or right to appeal the Part A claim. If a beneficiary has a pending Part A appeal for an inpatient admission denial, then any claims re-billed under Part B by the hospital would be denied as duplicates by the Medicare contractor. When the beneficiary’s Part A appeal becomes final or binding or dismissed, then the hospital may submit a Part B claim provided it is filed within 12 months from the date of service.

The proposed rule notes that many ALJ and Appeals Council decisions ordered payment under Part B after upholding denial of the Part A claim, but warns that existing Medicare policy would not allow such actions in the adjudication of Part A appeals. Specifically, the proposed rule states that under Medicare regulations, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and the adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination. Thus, if a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim, not an issue involving any potential Part B claim the hospital has not yet filed. Appeals adjudicators may not order payment for items and services not yet billed under Part B. Rather, payment for items and services that may be covered under Part B may only be made in response to a Part B claim submitted by the hospital that is timely filed under proposed 42 CFR 414.5(b) and 42 CFR 424.44.

Recognizing that some beneficiaries who are not enrolled in Medicare Part B may have other health insurance that might pay for some or all of the Part B items and services, CMS strongly encourages hospitals to submit Part B claims to Medicare before billing the beneficiary so that, when appropriate, the beneficiary's supplemental insurer receives the claim.

I. Collection of Information Requirements

The Paperwork Reduction Act of 1995 (PRA) requires a 60-day notice in the Federal Register to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. As required by the PRA, the proposed rule poses several questions and invites public comments. The proposed rule states a belief that the proposed rule’s requirements would not impose any new or revised reporting or recordkeeping requirements and would not impose any new or revised burden estimates.
J. Regulatory Impact Analysis

CMS estimates that the proposed rule meets the requirements for triggering an impact analysis. It estimates that the proposed rule may have a significant impact on approximately 2,053 hospitals with voluntary ownership and approximately 708 small rural hospitals. The impact analysis examines the payment impact on Medicare benefit expenditures over the next 5 years. The four columns of Table 1 show the following information:

– Column 1: impact of the ALJ and Appeals Council decisions;
– Column 2: impact of the ruling to acquiesce nationally to the ALJ and Appeals Council decisions;
– Column 3: impact of the proposed rule with 12-month timely filing restrictions;
– Column 4: combined impact

The estimates for each column of Table 1 assume that the policy in the preceding column is already in place. Specifically, the estimated cost for the ruling is relative to a baseline that includes the effect of the appeal decisions. Similarly, the estimated costs under this proposed rule are in relation to a baseline that includes both the appeal decisions and the ruling in place.

**TABLE 1. ESTIMATED IMPACT ON MEDICARE PROGRAM EXPENDITURES FOR HOSPITAL SERVICES**  
(Current year dollars (in millions))

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Appeal Decisions</th>
<th>CMS Ruling 1455-R</th>
<th>Part B Inpatient Billing with 12-Month Timely Filing Restriction Proposed Policy</th>
<th>Total Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$290</td>
<td>$560</td>
<td>$0</td>
<td>$850</td>
</tr>
<tr>
<td>2014</td>
<td>$410</td>
<td>$770</td>
<td>$−1,140</td>
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<tr>
<td>2015</td>
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<tr>
<td>2016</td>
<td>$430</td>
<td>$830</td>
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<tr>
<td>2017</td>
<td>$460</td>
<td>$870</td>
<td>$−1,280</td>
<td>$50</td>
</tr>
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</table>

CMS notes that the key differences between the ruling and the proposed policy are: (1) the proposed policy would apply the current timely filing restriction to the subsequent Part B inpatient claims re-billed after the Part A claim denial (that is, the Part B inpatient claims would only be paid if they are billed within 12 months of the date of service, which, as described previously, is not the case for the subsequent Part B inpatient claims re-billed under the Ruling); and (2) the proposed policy would apply when hospitals determine through self-audit that an inpatient admission is not reasonable and necessary (also subject to the timely filing limits).

In doing the impact analysis, CMS assumed short-stay inpatient utilization would increase by 1 percent as a result of the appeal decisions because hospitals would be able to re-bill
after an appeal. It assumed short-stay inpatient utilization would increase by an additional 3 percent under the ruling since hospitals could re-bill under Part B without the expense of an appeal. Due to the timely filing restrictions and lower Part B payment rate for rebilling, it assumed there would be no increase in any inpatient utilization resulting from the proposed regulatory change to restrict inpatient Part B billing to the timely filing requirement of 12 months from the date of service, relative to circumstances prior to the appeal decisions. The 12-month timely filing restriction imposed by the proposed regulation would greatly limit the capacity in which a hospital could re-bill and thereby substantially reduces the number of Part B inpatient claims re-billed by hospitals, largely offsetting the higher costs arising from the appeal decisions and the ruling. CMS emphasizes that the estimated financial effects are very sensitive to certain specifications of the proposed policy. For example, if the 12-month timely filing restriction on rebilling were to apply from the "date of denial", rather than from the "date of service", then the savings under the proposed policy would be much smaller than shown here.

Table 2 provides similar information concerning the impact of the ruling and proposed rule on beneficiaries’ out-of-pocket expenditures.

**Table 2—Estimated Impact on Beneficiaries’ Out-of-Pocket Expenses for Part A and Part B Services**

[Current year dollars (in millions)]

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Part A</th>
<th>Part B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appeal Decisions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$20</td>
<td>$20</td>
<td>$40</td>
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<tr>
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</tr>
<tr>
<td>2013</td>
<td>50</td>
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<td>10</td>
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<td></td>
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</tr>
<tr>
<td>2013</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>70</td>
<td>-20</td>
<td>50</td>
</tr>
<tr>
<td>2014</td>
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</tr>
<tr>
<td>Calendar year</td>
<td>Part A</td>
<td>Part B</td>
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</tr>
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<tr>
<td>2017</td>
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</table>

**Note:** Totals do not necessarily equal the sums of rounded components.