Submitted Electronically

May 16, 2013

Marilyn Tavenner
Acting 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 (Federal Register, Vol. 78, No. 52, March 18, 2013)

Dear Ms. Tavenner:

The Florida Hospital Association (FHA), on behalf of its more than 200 hospital and health system members, appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would permit rebilling a Part A claim that has been denied because the hospital inpatient admission was later determined not to be medically reasonable and necessary. We are pleased that CMS acknowledges in the proposed rule that its prior policy of paying a hospital for only a very limited set of specific ancillary services when the only dispute is in which setting care should have been delivered to the patient was contrary to Medicare law. Medicare law requires reimbursement for all reasonable and medically necessary items and services and provides that these services must be paid under Part B if they cannot be paid under Part A.

CMS's proposal to allow rebilling in certain circumstances is a welcome policy change that is consistent with the legal obligation in the Medicare law. However, we believe that CMS's proposal significantly restricts a hospital's ability to rebill claims so that the practical effect of the proposal would be to continue denying fair payment for the reasonable and medically necessary items and services hospitals provide to Medicare patients. We urge CMS to issue a final rule that provides full Part B reimbursement for Medicare-contractor denied claims without the unreasonable restrictions included in the proposed rule. The agency should ensure that hospitals receive full reimbursement for all reasonable and necessary care provided to Medicare beneficiaries when the recovery audit contractor (RAC) or any other Medicare contractor determines that the care should have been delivered in a different setting.

The proposal would limit the timeframe by which any claims must be rebilled, specifically restricting eligibility to services provided only during the prior year. We urge CMS to remove the timely filing deadline for billing Part B services after a Part A medical necessity denial. Given that the Medicare Recovery Auditors have a rolling three-year look back period, it is unfair to penalize hospitals by limiting their ability to bill for medically necessary services. Frequently, the one-year period for submitting a timely rebill expires before the RAC review is completed or before it has even begun.

In its proposed rule, CMS states -

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

At the same time that CMS states that these services should appropriately be paid under Part B, it calls for an arbitrary time limit for such rebilling.

We believe that, with this proposed rule, CMS is violating its legal requirement to pay hospitals for all care that is reasonable and necessary. If a Medicare auditor finds that hospital care should have been provided on an outpatient rather than an inpatient basis, Medicare should provide full outpatient payment for the services provided. CMS should permit hospitals that submitted and were paid for a claim for inpatient services under Medicare Part A, which claim subsequently was denied by a Medicare review contractor on the grounds that the inpatient admission was not reasonably and necessary, to rebill for full Part B payment in all cases where the original Part A claim was timely submitted.

The proposed rule would also restrict the administrative law judges' (ALJs) scope of review when claim denials are appealed by a hospital. The sole decision for appeal if this proposal is finalized is whether the claim is reasonable and necessary under Part A, and the ALJs can never decide whether the claim is reasonable and necessary under Part B. CMS should remove this restriction on the ALJs' scope of review.

Finally, while CMS would permit separate billing for a range of outpatient services furnished during the three days prior to an inpatient admission, the agency proposes to exclude from eligible reimbursement any services it has now designated as "requiring an outpatient status." In identifying these excluded services, CMS incorrectly classifies physical, speech-language and occupational therapy as belonging in this category of services "requiring an outpatient status," and we urge CMS to correct that mistake in classification.

Again, the FHA appreciates the opportunity to provide these comments. If you have any questions, please contact me at (407) 841-6230 or via email at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services