RAC Summit
Washington, D.C.
Dec 5, 2013

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Part B Rebilling When Part A Denied

Steven J. Meyerson, M.D
SVP, Regulations and Education Group
Accretive Physician Advisory Services
231 S La Salle St, Ste 1600
Chicago, IL 60604
smeyerson@accretivehealth.com

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Medicare Part A

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Part A

- Inpatient acute hospital, inpatient rehab, SNF
- DRG – flat payment for entire stay.
- Deductible for days 1-60: $1,184
- ICD-9 coding – diagnoses and procedures

Medicare Part B

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Part B

- Outpatient: Office, outpatient hospital, ED, observation
- Annual deductible: $147 (2014)
- Copayment: 20% of Medicare allowable
- Paid by fee schedule
- APC = Ambulatory Payment Classification under OPPS – bundled payment for outpatient surgery and procedures
- CPT = HCPCS codes - for diagnostics, procedures

Inpatient Part B Rebilling When No Part A Claim

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- Hospital could bill limited list of Part B “ancillaries” when Part A claim is denied or deemed not billable, when the patient has exhausted Part A benefits or is not eligible for Part A.
- Referred to as “Part B only” billing. Surgical and other procedures (e.g., vascular and cardiac procedures) couldn’t be billed if they were performed during a denied inpatient stay. (See Appendix A.)
- These claims were subject to the timely filing restriction – one year from date of service.
  - Timely filing rules can be found in the Claims Processing Manual, Chapter 1, Section 70.

Benefit Policy Manual, Chapter 6, Section 10

Part B Billing Allowed for Services Not Covered by Part A

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"These services, when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and not covered under Part A. They are:

- Physicians' services (including the services of residents and interns in unapproved teaching programs);
- Influenza vaccine and pneumococcal vaccine and its administration;
- Hepatitis B vaccine and its administration;
- Screening mammography services;
- Screening pap smears and pelvic exams;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self management training services; and
- Prostate screening."

Benefit Policy Manual, Chapter 6, Section 10

The O'Connor Case

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- Administrative Law Judge (ALJ) at the third level of appeal gave a "partially favorable decision" to O'Connor Hospital (CA) regarding a 2007 RAC denial of a 2004 Part A claim.
- ALJ denied Part A coverage because inpatient hospitalization services weren't reasonable and necessary, but found that "the observation and underlying care are warranted."
- CMS appealed the case to the Medicare Appeals Council, asserting that "the ALJ erred as a matter of law by ordering Medicare payment for 'the observation and underlying care' provided to the beneficiary because those services are not separately billable under Part A…

The O'Connor Case

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Feb 2010: …the Medicare Appeals Council "does not agree that the case contains an error of law." The Council cited references …to point out the inconsistencies in CMS' position. Section 10 in Chapter 6, "Hospital Services Covered Under Part B," of the Medicare Benefit Policy Manual "clearly indicates that payment may be made for covered hospital services under Part B, if a Part A claim is denied for any one of several reasons," says the Council.

FierceHealthFinance, 3/24/2010

(http://www.fiercehealthfinance.com)

Part B Rebilling Time Line

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- Following O'Connor case – additional ALJ orders for Part B and observation payment – not paid.
- CMS Memorandum TDL-12309, July 13, 2012: Allowed MACs to execute ALJ orders for payment of Part B with observation if ordered by judge.
- CMS-1455-R: The Interim Rule, March 13, 2013: Allowed rebilling of Part A claims denied for lack of medical necessity and after withdrawal of appeals
- CMS-1455-P: Proposed Rule, March 22, 2013 - Part B Inpatient Billing in Hospitals (Federal Register)
- CMS 1599-F: August 13, 2013: IPPS Final Rule included Part B rebilling. (Modified 42CFR Parts 412,413 and 414)

CMS-1455-R: Legal Victory!
CMS Reverses Course

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"Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy, we believe that, under section 1832 of the Act, Medicare should pay 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, when Part A payment cannot be made for a hospital inpatient claim **because the inpatient admission is determined not reasonable and necessary**…"

CMS-1455-R

CMS-1455-R: The Interim Rule Finalized in IPPS

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- Effective when announced, March 13 – Finalized by 2014 IPPS Final Rule effective 10/1/13.
- Can bill full Part B if Part A denied only if based on inpatient admission not reasonable and necessary.
- Does not cover other reasons for Part A denial (no Part A or Part A benefits exhausted)
- Hospitals with cases in appeal process must withdraw appeals and rebill for Part B payment.
- Part A to Part B (A/B) Rebilling Demonstration was discontinued.

CMS Manual, Pub 100-20 One-Time Notification, Transmittal 1203
March 22, 2013, Change Request 8185

Rebilling Allowed after Notice of Dismissal

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- In order for the Part B claim(s) to be processed, the Part A appeal must be final or binding, or dismissed following a request for withdrawal.
- The provider must have received a Notice of Dismissal from the adjudicating entity. (It is not adequate to request withdrawal and have proof that it has been received.)
- QIC and ALJ send acknowledgement of receipt of appeal request. Wait for receipt before requesting withdrawal because it provides appeal number to reference on withdrawal request.
- MACs may not provide an acknowledgement.

CMS-1455-R: The Interim Rule Finalized in IPPS

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"The Ruling does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired, and it does not apply to inpatient admissions determined by the hospital to be not reasonable and necessary (for example, through utilization review or other self- audit)."

Federal Register / Vol. 78, No. 160 / p. 50909

- Under the 2014 IPPS final rule, self-denied cases admitted after October 1, 2013 *can* be rebilled in full.
- For self-denials prior to Oct 1, hospital paid for ancillaries only.

2014 IPPS Final Rule: Allows Part B Rebilling after Self-denial

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"We are finalizing our proposal that when a Medicare Part A claim for hospital inpatient services is denied because the inpatient admission was determined not reasonable and necessary, or if a hospital determines under 42 CFR 482.30(d) or § 485.641 after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, the hospital may be paid for the Part B 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."

CMS-1599-F, 2014 IPPS Final Rule

Federal Register / Vol. 78, No. 160 / p. 50505

Applies to All Hospitals Billing Part A

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D. Applicability—Types of Hospitals

We propose that all hospitals billing Part A services 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.

Federal Register / Vol. 78, No. 52 / March 18, 2-13 Proposed Rules

ALJ and MAC Powers Limited

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- ALJ's and Appeals Council may only decide win or lose on Part A appeal - no part B awards.
- Can only rule on the Part A claim before them – not a Part B claim that hasn't been submitted
- No awards of observation for denied Part A claim.
- Can't override timely filing.
- "In making a decision on that Part A claim, an appeals adjudicator may not develop information, or make a finding, with respect to a Part B claim that does not exist."

Federal Register / Vol. 78, No. 52 / p. 50928

Inpatient Part B Billing Following Self-Denial

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- Self-denial: When a hospital determines, through UR review after discharge, that an inpatient stay is not billable under Part A.
- Inpatient cannot be converted to outpatient after discharge.
- Can bill Part B for self-denied Part A services.
- Hospital must follow requirements of CoP (42 CFR, 482.30) including UR physician review, discussion with attending and notification of patient, attending physician and hospital billing office within 2 days.
- Include documentation of review process in record.

Condition Code 44

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CC 44 converts inpatient to outpatient.

<u>Alternative to rebilling after denial.</u>

Required criteria:

- The change in patient status is made prior to discharge;
- The hospital has not submitted a Medicare claim for the admission
- Both the practitioner responsible for the care of the patient and the utilization review committee concur with the decision; and
- The concurrence is documented in the medical record

Medicare Claims Processing Manual (MCPM) (Pub. 100-04) Chapter 1, Section 50.3 ; MLN Matters article SE0622

Inpatient Part B Billing Following Self-Denial

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"…hospitals must follow our policies requiring physician involvement and concurrence in hospital decisions regarding patient status and the medical necessity of hospital inpatient admissions under the Condition Code 44 rules and the CoPs."

"The Interpretive Guidelines for hospital utilization review under the CoPs are provided on the CMS Web site at: *http://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf# page312*."

Federal Register / Vol. 78, No. 52 / p. 50914

Inpatient Part B Billing Following Self-Denial

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"Use of Condition Code 44 or Part B inpatient billing pursuant to hospital self-audit is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols…

…the need for hospitals to correct inappropriate admissions or report Condition Code 44 should become increasingly rare."

Federal Register / Vol. 78, No. 52 / p. 50914

Rebilling for Therapy Allowed

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- Proposed rule (1455-P) did not allow Part B rebilling of PT, OT, SLP provided during a denied inpatient stay.
- IPPS Final Rule – reversed proposed policy and allows rebilling therapy along with other *inpatient* Part B services.
- Therapy also can be billed on *outpatient* Part B claim if provided prior to the admission order.
- Rebilled therapy included in annual therapy caps. "Part B inpatient services must be furnished in accordance with Medicare's coverage and payment rules under Part B."
- Rule on applying therapy caps at CAHs is pending MPFS final rule.

Federal Register / Vol. 78, No. 52 / p. 50911

Timely Filing

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- Rebilled Part B claim treated as a new claim, not an adjustment.

  "…an adjustment claim supplements information on a claim that was previously submitted without changing the fundamental nature of that original claim. In these Part B claim situations, however, the fundamental nature of the originally filed claim is changed completely (from a Part A claim to a Part B claim)." (CMS-1599-F)

- Timely filing was waived under the ruling and proposed rule. Not applied to admissions before October 1, 2013.
- Timely filing has been reinstated for admissions after October 1.

  –Timely filing: Claim must be filed within one year of date of service (date of admission).

CMS: Correct Billing = Timely Filing, No Problem!

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"Hospitals…have the ability to avoid being disadvantaged by the 1-calendar year time limit to file claims and by any subsequent RAC audit if they bill correctly by following Medicare's guidelines for hospital inpatient admissions."

Federal Register / Vol. 78, No. 160 / p. 50923

Public Comments on Timely Filing

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CMS received 395 comments on CMS 1455-P

- "Over 300 commenters" were opposed to timely filing.
- One (1) commenter supported the proposal.

Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations

- The single comment in favor came from the American Coalition for Healthcare Claims Integrity (ACHCI)
- Who is the ACHCI? A non-profit created in 2009 by the RACs, ZPICs and MIC.

Time Frame for Rebilling After Denial

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Watch the calendar

- Appeal timeframe (120 days + 5 days for mail) must not have expired. (Can't rebill old denials that weren't appealed.)
- Hospital has 180 days + 5 from "most recent adjudication" to file Part B claim (denial or notice of acceptance of withdrawal)
- Determinations that a provider failed to submit a claim timely are not appealable. (42 CFR 405.926(n))

Three Day Payment Window

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"If there is no Part A coverage for the inpatient stay, services provided to the beneficiary prior to the point of admission in the 3 calendar day (or 1 calendar day for a non-IPPS hospital) payment window prior to the hospital inpatient admission may be separately billed to Part B as the outpatient services that they were."

Federal Register / Vol. 78, No. 160 / p. 50910

Rebilling Procedure

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- Hospitals may self-discover inpatient errors per CoP for UR (see CFR 482.30) or rebill after contractor denial.
- Self-denial - submit provider liable Part A claim (TOB 11X)
- "Once the Part A claim denial is posted in the claims history, the Part B claim(s) can be submitted."
- Recode and submit Part B bill with ICD-9 codes, HCPCS/CPT codes and revenue codes.
- Bill Part B for outpatient services provided by the hospital prior to admission on outpatient (13X) bill.
- Bill for services provided during the denied inpatient stay on an inpatient Part B (12X) bill.

CMS Manual, Pub 100-20 One-Time Notification, Transmittal 1203

March 22, 2013, Change Request 8185;

MLN Matters SE1333

Condition Code W2

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"By using the "W2" condition code on the Part B claim(s), the hospital acknowledges that

- the Part B claim is a duplicate of the previously denied Part A claim,
- that no payment shall be made with respect to the items or services included on the Part A claim, and
- that any amounts collected from the beneficiary with respect to the Part A claim will be refunded to the beneficiary."

CMS Manual, Pub 100-20 One-Time Notification, Transmittal 1203
March 22, 2013, Change Request 8185

Condition Code W2

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"By using the "W2" condition code, the hospital attests that

- there is no pending appeal with respect to a previously submitted Part A claim, and
- that any previous appeal of the Part A claim is final or binding or has been dismissed, and
- that no further appeals shall be filed on the Part A claim.

Contractors shall reject as unprocessable any Part B claims subject to this interim policy that do not contain the "W2" condition code."

CMS Manual, Pub 100-20 One-Time Notification, Transmittal 1203
March 22, 2013, Change Request 8185

Remains Inpatient

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- Status remains inpatient when rebilled. ("There is no provision to change a beneficiary's status after he or she is discharged from the hospital.")
- "Rebilling under the Ruling does not impact skilled nursing facility (SNF) eligibility."

CMS Manual, Pub 100-20 One-Time Notification, Transmittal 1203
March 22, 2013, Change Request 8185

3 Day Stay for SNF

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"The beneficiary must have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH."

42 CFR 409.30

3 Day Stay for SNF

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"…the 3-day inpatient hospital stay which qualifies a beneficiary for "posthospital" SNF benefits need not actually be Medicare-covered, as long as it is medically necessary."

". . . the qualifying hospital stay must have been medically necessary. Medical necessity will generally be presumed to exist…The intermediary will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice."

Medicare Benefit Policy Manual, Chapter 8, Section 20.1

3 Day Stay for SNF

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The "substantial departure from normal medical practice" language was developed specifically to target those rare situations where the 3-day stay is clearly unnecessary by any reasonable standard. For example, the MAC could determine that a hospital stay was medically unnecessary for purposes of qualifying for post-hospital SNF coverage in situations where the care is so clearly unnecessary that it appears that the patient was admitted to the hospital solely for the purpose of attempting to qualify the beneficiary inappropriately for "posthospital" SNF benefits."

Federal Register / Vol. 78, No. 160 / p. 50921

Beneficiary Responsibility

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- Part B rebilling creates “a unique liability issue for Medicare beneficiaries that did not previously exist.”
- Beneficiaries are responsible for Part B deductible, copayments and for the cost of drugs that are usually self-administered.
- Not responsible for denied Part A charges unless HINN was provided in advance.
- Beneficiaries entitled to a refund of any amounts they paid to the hospital for the Part A claim that is denied. Can’t be used to offset patient’s Part B responsibility. (Refund process under review by CMS)

Supplemental Insurance Copayment Refund

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- Coordination of benefits with supplemental insurers: Medicare's coordination of benefits (COB) or claims crossover process. They will follow CMS payment timeframe.
- If this refund is not made, the Medicare program indemnifies the beneficiary or authorized representative for any amounts paid... Any indemnification payments made by Medicare are considered an overpayment to the hospital. Accordingly, in order to avoid incurring an overpayment, hospitals should refund any cost-sharing amount to a supplemental insurer.

Federal Register / Vol. 78, No. 160 / p. 50918

What To Do Now: Claim by Claim Review

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- Review all pending appeals at any level.
- Decide which to continue to appeal and which to withdraw to get Part B payment.
- Consider withdrawing and rebilling:
  - Surgical cases and procedures when admission order preceded the procedure: Can be rebilled and get full APC payment.

    (Example: ICD APC = $31,000, DRG = $42,000)
  - “Weak” Part A appeals

    (Poor physician documentation, questionable need for inpatient, lack of first level or secondary review, zero or one-day stays lacking strong documentation)

CMS to Educate Beneficiaries

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"…we intend to conduct an educational campaign to ensure that beneficiaries are aware of the on-going review of inpatient claims and the potential financial liability resulting from a Part A claim denial with subsequent Part B billing."

Federal Register / Vol. 78, No. 160 / p. 50919

Appendix A

Part B Ancillary Rebilling

Inpatient Part B Rebilling

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Services payable under Inpatient Part B when no payment under Part A:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental)

Benefit Policy Manual, Chapter 6, Section 10

Inpatient Part B Rebilling

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"The Medicare Benefits Policy Manual (Chapter 2, Section 10) includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but who do have Part B coverage, on the day that they receive an implanted prosthetic device.

The processing of claims for these services is discussed in the Medicare Claims Processing Manual (Chapter 4, Section 240)."

MLN Matters Number: MM6050 Revised ; Related Change Request (CR) #: 6050 ; Effective Date: January 1, 2009

CMS: Pacemakers and ICDs are Prosthetic Devices

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"Cardiac pacemakers are covered as prosthetic devices under the Medicare program"

National Coverage Determination (NCD) for Cardiac Pacemakers (20.8)

AICD – "Benefit Category: Prosthetic Devices"

National Coverage Determination (NCD) for Implantable Automatic Defibrillators (20.4)

Cardiac stents – Check with MAC

Inpatient Part B Rebilling

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Services payable under Inpatient Part B when no payment under Part A:

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes
- Outpatient physical therapy, speech-language pathology services, and occupational therapy

Benefit Policy Manual, Chapter 6, Section 10

Inpatient Part B Rebilling

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Services payable under Inpatient Part B when no payment under Part A:

- Screening mammography
- Screening pap smears
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Colorectal screening
- Bone mass measurements
- Diabetes self-management
- Prostate screening
- Ambulance services

Benefit Policy Manual, Chapter 6, Section 10

Inpatient Part B Rebilling

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Services payable under Inpatient Part B when no payment under Part A:

- 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).

Benefit Policy Manual, Chapter 6, Section 10

Appendix B

Procedure for Withdrawal of Appeals

How to Withdraw Appeals

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For withdrawal of a redetermination from the MAC, 42 CFR 405.952: **Withdrawal or dismissal of a request for a redetermination.**

(a) *Withdrawing a request.* A party that files a request for redetermination may withdraw its request by filing a written and signed request for withdrawal. The request for withdrawal must contain a clear statement that the appellant is withdrawing the request for a redetermination and does not intend to proceed further with the appeal. The request must be received in the contractor's mailroom before a redetermination is issued. The appeal will proceed with respect to any other parties that have filed a timely request for redetermination.

How to Withdraw Appeals

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For withdrawal of a reconsideration from a QIC, 42 CFR 405.972: Withdrawal or dismissal of a request for a reconsideration.

(a) *Withdrawing a request.* An appellant that files a request for reconsideration may withdraw its request by filing a written and signed request for withdrawal. The request for withdrawal must—

(1) Contain a clear statement that the appellant is withdrawing the request for reconsideration and does not intend to proceed further with the appeal.

(2) Be received in the QIC's mailroom before the reconsideration is issued.

How to Withdraw Appeals

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For withdrawal of a request for an ALJ Hearing, the Office of Medicare Hearings and Appeals has provided information on their website.

OMHA has specifically requested that you follow the instructions found at their website and complete the form below.

http://www.hhs.gov/omha/Data/cms-ruling.pdf

OMHA website link http://www.hhs.gov/omha/index.html

Withdraw those at ALJ or remanded to QIC per instructions at www.hhs.gov/omha

How to Withdraw Appeals

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If claim was remanded to QIC and returned to ALJ for Part A ruling

Or

Appeal has been assigned to an ALJ:

Please send your completed request to the assigned ALJ at the appropriate OMHA Field Office, at the address provided below. If you need assistance identifying the correct Field Office, please call any office for assistance.

OMHA Mid-Atlantic Field Office
1700 N. Moore St., Suite 1600
Arlington, VA 22209-1912
Phone: 866-231-3087

OMHA Midwestern Field Office
200 Public Square, Suite 1300
Cleveland, OH 44114-2316
Phone: 866-236-5089

OMHA Southern Field Office
100 SE 2nd Street, Suite 1660
Miami, FL 33131-2100
Phone: 866-622-0382

OMHA Western Field Office
27 Technology Drive, Suite 100
Irvine, CA 92618-2364
Phone: 866-495-7414

http://www.hhs.gov/omha/Data/cms-ruling.pdf

How to Withdraw Appeals

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If claim was remanded to QIC and you haven't been notified that it was returned to the ALJ

Or

Appeal has not been assigned to an ALJ for hearing or you're not sure to which ALJ –

Send request for withdrawal to:

CMS Ruling Processing Unit
OMHA Central Operations Division
200 Public Square, Suite 1260
Cleveland, OH 44114-2316

How to Withdraw Appeals From ALJ

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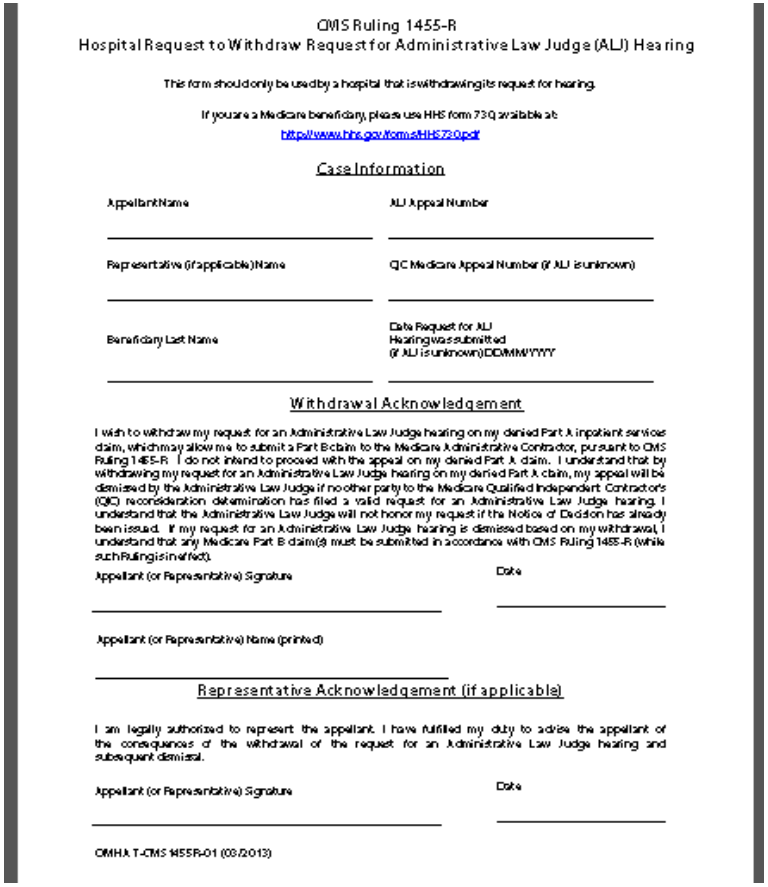
Hospital Request to Withdraw Request for Administrative Law Judge (ALJ) Hearing Form



CMS Ruling 1455-R
Hospital Request to Withdraw Request for Administrative Law Judge (ALJ) Hearing

This form should only be used by a hospital that is withdrawing its request for hearing.

If you are a Medicare beneficiary, please use HHS form 730 available at:
http://www.hhs.gov/forms/HHS730.pdf

Case Information

Appellant Name

ALJ Appeal Number

Representative (if applicable) Name

QIC Medicare Appeal Number (if ALJ is unknown)

Beneficiary Last Name

Date Request for ALJ Hearing was submitted (if ALJ is unknown) DD/MM/YYYY

Withdrawal Acknowledgement

I wish to withdraw my request for an Administrative Law Judge hearing on my denied Part A inpatient services claim, which may allow me to submit a Part B claim to the Medicare Administrative Contractor, pursuant to CMS Ruling 1455-R. I do not intend to proceed with the appeal on my denied Part A claim. I understand that by withdrawing my request for an Administrative Law Judge hearing on my denied Part A claim, my appeal will be dismissed by the Administrative Law Judge if no other party to the Medicare Qualified Independent Contractor's (QIC) reconsideration determination has filed a valid request for an Administrative Law Judge hearing. I understand that the Administrative Law Judge will not honor my request if the Notice of Decision has already been issued. If my request for an Administrative Law Judge hearing is dismissed based on my withdrawal, I understand that any Medicare Part B claim(s) must be submitted in accordance with CMS Ruling 1455-R (while such Ruling is in effect).

Appellant (or Representative) Signature

Date

Appellant (or Representative) Name (printed)

Representative Acknowledgement (if applicable)

I am legally authorized to represent the appellant. I have fulfilled my duty to advise the appellant of the consequences of the withdrawal of the request for an Administrative Law Judge hearing and subsequent dismissal.

Appellant (or Representative) Signature

Date

OMHA T-CMS 1455R-01 (03/2013)

http://www.hhs.gov/omha/Data/cms-ruling.pdf

Appendix C

Financial Impact of Part B Rebilling

Financial Impact

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"The actual costs or savings would depend substantially on possible changes in behavior by hospitals, and such behavioral changes cannot be anticipated with certainty."

"The estimates are especially sensitive to the assumed utilization changes in inpatient and outpatient utilization."

CMS-1455-P

Financial Impact

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

Calendar Year	Appeal Decisions (1)	CMS Ruling 1455-R (2)	Part B Inpatient Billing with 12-Month Timely Filing Restriction Proposed Policy (3)	Total Impact (4)
2013	$290	$560	$0	$850
2014	$410	$770	$−1,140	$40
2015	$410	$780	$−1,160	$40
2016	$430	$830	$−1,210	$50
2017	$460	$870	$−1,280	$50

Source: CMS 1455-P

Thank you.

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