

Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

May 17, 2013

*Submitted electronically*

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

Dear Acting Administrator Tavenner:

On behalf our 84,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) Part B Inpatient Billing in Hospitals proposed rule. Physical therapy is an integral service provided to patients in the inpatient acute care hospital setting. Physical therapists work in a collaborative mode with physicians, nurses, respiratory therapists and other health care professionals to ensure that patients with acute critical conditions receive optimal care during their inpatient stay by attending multi-disciplinary rounds and constant communication with other providers and the patient.

The proposed rule seeks to allow hospitals to submit for reimbursement all Part B services (except for services that specifically require an outpatient status) when a Medicare Part A inpatient hospital claim has been denied due to the decision that the inpatient stay was not reasonable and necessary. CMS states these services must meet the requisite criteria to be reimbursed if the hospital had furnished the services as an outpatient hospital stay and the patient is enrolled in Medicare Part B. While APTA supports CMS in its efforts to mitigate financial liability when a hospital receives a denial for an inpatient stay for medically necessary services, we strongly feel that this proposed rule misses the mark to adequately address this issue. Therefore, we strongly urge CMS to make substantial revisions to this proposed policy before it is finalized.

## **Recommendations**

Specifically, we urge the agency to make the following modifications:

- 1) Rescind its interpretation that physical therapy services are considered “outpatient services” only and allow hospitals to bill for these under the inpatient Part B billing rules when properly furnished, originally, under an inpatient hospital plan of care.
- 2) Exempt physical therapy services provided during the inpatient hospital stay that are subsequently rebilled under Medicare Part B from the therapy cap and functional limitation reporting requirements.
- 3) Set clear parameters for the length and scope of the observation period to safeguard against undue penalization of hospitals and post-acute care providers when complying with Medicare rules and regulations regarding the therapy functional limitation requirements, therapy financial limitations/manual medical review process, and qualifying 3 day hospital stay for skilled nursing facility (SNF) Part A stay.
- 4) Allow for inpatient hospital claims submitted prior to this proposed and interim ruling in which the timeframe for appeals has expired to be resubmitted under Medicare Part B for services that were medically necessary.
- 5) Eliminate the proposal that there be a one year timely filing limit for the claims resubmitted under Part B.

## **Detailed Rationale of Recommendations**

### ***Misinterpretation of Physical Therapy Services***

In the proposed rule, CMS states:

*“Specifically, we propose to revise our Part B inpatient billing policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services specifically requiring an outpatient status. We would exclude services that by statute, Medicare definition, or standard Healthcare Common Procedure Coding System (HCPCS) code are defined as outpatient services, including ... 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” These services are, by definition, provided to hospital outpatients and not inpatients. Hospitals could only submit claims for Part B inpatient services that were furnished to an inpatient in accordance with their Medicare and standard Healthcare Common Procedure Coding System (HCPCS) code definitions, and in accordance with Medicare coverage and payment rules.” [Emphasis added]*

We assert that this interpretation is wholly inaccurate and does not reflect the total breadth of therapy services provided under the Medicare benefit. Section 1833(a)(8) states that the following services are covered under the Medicare program: “*B) outpatient physical therapy services, outpatient speech-language pathology services) and outpatient occupational therapy services furnished— (i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A*”. [Emphasis added]

Clearly, the statute recognizes that there is a Medicare benefit that covers physical therapy services furnished during an inpatient hospital stay under Medicare Part A (inpatient hospital) setting in addition to Part B. The Medicare Act requires without limitation that CMS to reimburse hospitals under Part B for all reasonable and necessary services provided that would have been covered if the patient had been treated on an outpatient basis. CMS’s proposal to carve out certain services from payment is not consistent with that requirement. **APTA strongly believes that all services provided to a patient during their inpatient hospital stay that meet the Medicare delineated criteria as being reasonable and necessary for treatment of the patients illness or injury should be covered and subsequently reimbursed by Medicare under the Part B benefit if the inpatient admission is denied.**

Excluding physical therapy services from being rebilled as Part B services if denied under Medicare Part A, creates a disincentive for hospitals to provide these services to patients during the inpatient hospital stay for fear of denials and noncoverage. This may create barriers to access to care for Medicare beneficiaries in the acute care setting. Furthermore, a lack of physical therapy services in the acute care setting as a result of this policy will cause a diminished quality of care because patients will not receive physical therapy services that could aid in faster recovery and serve as a less costly alternative to surgical interventions. The anticipated effects of this policy are counter to the basic tenets of health reform and the Triple Aim.

Research<sup>1</sup> has proven that early mobilization of the patient, namely in the intensive care unit (ICU), improves health of individuals by preventing complications associated with bed rest and increases functional ability which allows patients to receive care in less costly post-acute settings. Early specialized physical therapy in the acute care setting prevents extra days spent in the ICU and decreases length of stay in the hospital. Physical therapists working in the acute care setting detect functional impairments early in the disease process and provide appropriate interventions, proper discharge recommendations, and detailed documentation that allow for a seamless transition to next level of care.

---

<sup>1</sup> Morris PE, Goad A, Thompson C, Taylor K, Harry B, Passmore L, Ross A, Anderson L, Baker S, Sanchez M, Penley L, Howard A, Dixon L, Leach S, Small R, Hite RD, Haponik E.

Early intensive care unit mobility therapy in the treatment of acute respiratory failure. *Crit Care Med.* 2008;8:2238-2243. Smith BA, Fields CJ, Fernandez N. Physical therapists make accurate and appropriate discharge recommendations for patients who are acutely ill. *Phys Ther.* 2010;5:693-703.

Under the Inpatient Prospective payment System (IPPS), Medicare reimburses hospitals a predetermined per-discharge rate based primarily on two factors: 1) the patient's condition and related treatment strategy, and 2) market conditions in the facility's location. Using information about patients' diagnoses, procedures, age, and discharge destination reported on hospital's claims, Medicare assigns the patients to diagnosis related groups (DRGs), which group patients who have similar clinical problems. These patients are expected to require similar amounts of hospital resources. Groups expected to require more resources would receive higher payment rates. The PPS payment rates are set at a level that would cover costs that reasonably efficient providers would incur in furnishing high quality care. The payment rates are adjusted for the local market. Payment rates are increased for facilities that operate residency programs, treat a disproportionate share of low-income patients and for other factors.

The hospital receives the full DRG payment amount when the patient is discharged. Medicare reduces DRG payments when the patient is transferred to another PPS hospital. In these cases the transferring hospital is paid a per diem amount for each day before the transfer occurs, up to a maximum of the full DRG amount. For certain DRGs, the hospital does not receive the full DRG payment when a patient is transferred to a post-acute care setting (SNF, rehab hospital, home health). Instead, the hospital receives a per diem rate for the services. Physical therapy services provided during an inpatient stay are bundled into the payment amount to the acute care hospital under the PPS system.

**Therefore, APTA strongly recommends that CMS rescind its current proposed interpretation that physical therapy services provided in the acute care setting during the subsequently rebilled inpatient stay are designated "outpatient services" only and allow hospitals to bill for medically necessary physical therapy services that were appropriately furnished during the inpatient stay under the Part B Inpatient Billing provisions. If the services would be considered by Medicare to be medically necessary for the patient, they should be covered by Medicare regardless of the setting in which they are provided.**

If CMS continues to deny physical therapy services to be billed under the Part B Inpatient Billing provisions, CMS should clarify whether it is permissible for the hospital to provide the patient with a Hospital Issuance Notice of Non-Coverage (HINN) specifically for the services that have been identified in this proposed rule as excluded from Part B Inpatient Billing. We note that CMS has stated in the proposed rule that it does not believe the Advance Beneficiary Notice (ABN) nor the HINN is sufficient to notify the beneficiary of their liability under the Part B Inpatient Billing proposed rule, but the agency is silent to whether the HINN or ABN would be appropriate in those situations where the hospital is providing services that have been expressly excluded under this proposed rule.

### ***Compliance with Outpatient Therapy Regulatory Requirements***

Per statutory requirements, CMS places an annual per beneficiary Medicare financial limitation on outpatient therapy services (herein referred to as the therapy cap). Each year this annual

amount is updated, and the 2013 therapy cap amount is \$1900 for physical therapy and speech language pathology services combined. There is a separate \$1900 amount allotted for occupational therapy services in 2013. In previous years, outpatient hospitals were exempt from the therapy cap, but the Middle Class Tax Relief and Job Creation Act of 2012<sup>2</sup> applied the financial limitation to the outpatient hospital setting from October 1, 2012 until December 31, 2012. The application of the therapy cap to hospitals was extended until December 31, 2013 by the American Taxpayer Relief Act of 2012<sup>3</sup>. As part of the therapy cap requirements for 2013, outpatient therapy providers are required to append a KX modifier to claims over the \$1900 limit to receive an automatic exception. For claims exceeding \$3700, Congress has mandated that therapy claims go through a manual medical review process in which providers are required to send specific documentation to Recovery Audit Contractors (RAC) to receive either pre or post payment approval for the additional therapy services.

In addition, the Middle Class Tax Relief Act mandated that CMS, as of July 1, 2013<sup>4</sup>, collect information on the claim forms regarding the beneficiaries function and condition. All practice settings that provide outpatient therapy services must include this information on the claim form. Specifically, the policy will apply to PT, OT, and SLP services furnished in hospitals, critical access hospitals, skilled nursing facilities, CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians and non-physician practitioners. Under the functional limitation reporting requirement for outpatient therapy services, nonpayable G-codes and modifiers will be mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, a minimum every 10th visit and discharge.

The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or physical therapy services provided as part of the patient's inpatient stay is critical to compliance for hospitals under these new functional limitation reporting requirements and with regard to the therapy cap. By classifying these physical therapy services as "outpatient services" only, places an undue administrative burden on hospitals to comply with the therapy cap, manual medical review and functional limitation reporting requirements for services that have been appropriately provided under an inpatient hospital plan of care.

**Therefore, we strongly recommend that CMS exempt hospitals from the therapy cap and the functional limitation reporting requirements for physical therapy services that are furnished under the inpatient stay even though the services provided during the inpatient stay may be subsequently rebilled under the Part B Inpatient Billing policy after a denial is received under the Part A benefit.**

---

<sup>2</sup> Pub.L. 112-96, H.R. 3630, 126 Stat. 156, enacted February 22, 2012

<sup>3</sup> Pub.L. 112-240, H.R. 8, 126 Stat. 2313, enacted January 2, 2013

<sup>4</sup> The functional limitation reporting requirement is currently undergoing a testing phase from January 1 – June 30, 2013.

### *Effect of Proposal on Observation Status*

APTA believes that CMS should set parameters regarding the amount of time a patient can remain on observation status. As acknowledged in the proposed rule, the number of patients being placed under observation status for more than 48 hours has increased significantly in recent years. These prolonged observation periods are having an impact on Medicare outpatient therapy utilization, as well the financial liability of the beneficiary and the provider. We recommend setting a timeframe for an observation period of no more than 24 hours. This will help to set a bright line standard for hospitals as well as post-acute care providers such as home health agencies and skilled nursing facilities. As noted in the proposed rule, in skilled nursing facilities, it is required that patients have a qualifying three day hospital stay in order to receive services under the Medicare Part A SNF benefit. Often times, SNFs find it challenging to discern whether this requirement has been met because of prolonged hospital observation periods. Thus, denying thousands of Medicare beneficiaries' access to medically necessary services under the SNF Part A benefit each year.

The same holds true for home health agencies that are trying to distinguish inpatient hospital admissions to determine whether the patient has been discharged or readmitted to the home health agency during the 60 day home health episode. The increasing length of the observation period is creating an administrative burden for post-acute care providers to comply with quality measurement programs regarding the prevalence of hospital readmissions for their patient populations and other regulatory requirements such as functional reassessments in the home health setting.

Secondly, when considering payment implications, APTA strongly recommends that CMS consider the effect that payment for inpatient hospital services under Medicare Part B such as during the observation period, may have on calculations of the therapy cap. Due to risk of denials when classifying patients for an inpatient stay, there are instances where a patient's entire stay in the hospitals, which sometimes spans as much 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted towards the cap. We believe that this is unfair to the patient as it may limit their access to physical therapy in the outpatient setting, when in fact these services should have been billed as inpatient services.

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the observation period and the inpatient short stay. The decision to admit should be solely based on the clinical condition of the patient and in which setting their medical needs can be safely and effectively addressed. **Therefore, we recommend that CMS take the necessary steps to ensure that payments are accurately aligned in tandem with setting parameters for the observation period. We believe that addressing payment and defining the observation period will help hospitals who are operating with limited resources while resolving issues regarding the three day qualifying hospital stay for SNFs and other complicating factors.**

### ***Disposition of Denials Prior to the Ruling and or Effective Date of the Final Rule***

In the proposed rule, CMS states:

*“...the Ruling is effective on its date of issuance. It applies to Part A hospital inpatient claims that were denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary, as long as the denial was 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...”* [Emphasis added]

As the agency is fully aware, there are numerous Medicare inpatient stays that were denied prior to the promulgation of this proposed rule and the companion Ruling. These denials have been barred from reimbursement under the Part A to B Rebilling Demonstration and have not received any relief through the Medicare appeals process. Nevertheless, these cases would now meet the criteria set forth in the Ruling and current proposal. APTA asserts that it is inequitable for CMS to deny these providers payment for medically necessary services based on the technicality of expired timeframes. **Therefore, we urge CMS to institute an appropriate look back period so that these claims can be adjudicated appropriately.**

### ***Application of One-Year Timely Filing Limit***

CMS stated in the proposed rule that, once the final rule is issued, CMS plans to apply a one-year timely-filing limit, which would run from the date of the treatment to all attempts to rebill under Part B. This approach would result in the inappropriate denial of coverage for medically necessary services. The vast majority of RAC denials do not even occur *until* more than a year has elapsed since the patient was treated. CMS's timely-filing approach would make it impossible for most hospitals to receive payment under Medicare Part B payment due to the timing of RAC Part A denials. **APTA urges CMS to amend the policy to eliminate this limit on filing and pay hospitals for medically necessary services.**

### **Conclusion**

Once again, we applaud CMS for taking a step in the right direction in issuing the proposed regulation and companion ruling. We look forward to working with the agency to make substantial revisions to the proposed policy prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the inpatient hospital setting. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, JD Director of Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org. Thank you for your time and consideration on this very important issue.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS  
President

PR: rdd