Part A to Part B Rebilling Demonstration:

General Information

Updated **Q1.1: Where can I receive additional information about the Part A to Part B Rebilling "AB Rebilling" Demonstration, such as how to enroll?**

A1.1: For information about the AB Rebilling demonstration, please refer to https://www.cms.gov/CERT/04_ABrebillingDemo.asp#TopOfPage.
To access a slide presentation about the demonstration, including enrollment instructions, please refer to https://www.cms.gov/CERT/downloads/Rebilling_Demo_Outreach_1129.pdf. Enrollment began on December 12th at 2:00PM ET, and Participant Requests (enrollment applications) will be accepted on a voluntary, first come basis (please see Q1.2 below).

Updated **Q1.2: When can providers begin signing up for the AB Rebilling Demonstration?**

A1.2: Enrollment began December 12, 2011 at 2:00PM ET. Participant Requests received in advance of this will not be considered, and may preclude your participation. For more information about this voluntary, first come enrollment process please refer to the Provider Outreach and Education slides, available at: https://www.cms.gov/CERT/downloads/Rebilling_Demo_Outreach_1129.pdf.

Please refer to https://www.cms.gov/CERT/downloads/EnrollmentApp_v6_112911.pdf to access the enrollment (Participant Request) application.

Q1.3: Which providers are eligible to participate in the AB Rebilling demonstration?

A1.3: To participate in the demonstration, a facility must not be receiving periodic interim payments from CMS, and must be a Medicare-participating hospital as defined by the Social Security Act §1886(d), a category which includes all hospitals paid under the Medicare Inpatient Prospective Payment System, but excludes:

-Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS),
-Inpatient Rehabilitation Facilities (IRFs),
-Long-Term Care Hospitals (LTCHs),
-Cancer hospitals,
-Critical Access Hospitals (CAHs), and
-Children's hospitals.

Q1.4: When will the demonstration begin?

A1.4: The demonstration will begin January 1, 2012.

Updated **Q1.5: What claims can be resubmitted in the demonstration?**

A1.5: Inpatient claims denied during a Medicare Administrative Contractor, Recovery Auditor, ZPIC, Comprehensive Error Rate Testing (CERT) or other Centers for Medicare & Medicaid Services (CMS) contractor audit after January 1, 2012 that are denied because the services were provided in the incorrect setting can be resubmitted as a new claim for the outpatient services provided. In addition inpatient claims

self-identified by a provider because the services were provided in the incorrect setting can be resubmitted as a new claim for the outpatient services provided.

Q1.6: What is the benefit of participating in this demonstration, if we may already rebill for "ancillary" Part B payment?

A1.6: This demonstration will permit providers to receive 90% of the total Part B payment that they may have received if the claim was originally correctly submitted for outpatient payment. This eliminates the previous rebilling restrictions, which permitted providers to rebill for a limited list of ancillary services.

Q1.7: If we are not one of the hospitals selected for the AB Rebilling demonstration, will we be able to rebill any of our claims during the 3 year demonstration program?

A1.7: No. This demonstration will be limited to the 380 participants for the entirety of the three years.

Providers who are not participating in the demonstration will continue to use existing CMS policy and billing procedures, as stated in CMS' frequently asked question response (#9462), available at: https://questions.cms.hhs.gov/app/answers/detail/a_id/9462/kw/ancillary.

Providers who are not participating in the demonstration can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Benefit Policy Manual. That list can be found in Ch. 6, Section 10: http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf. For providers not participating in the demonstration, rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. Normal timely filing rules can be found in the Claims Processing Manual, Chapter 1, Section 70: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

Q1.8: Why is the demonstration restricted to 380 participants?

A1.8: This demonstration represents significant policy and payment adjustments for CMS. As such, it needs to be conducted through a limited demonstration first to determine the impact and potential for national implementation.

New **Q1.9: I am assuming that beds associated with exempt units such as Acute Rehabilitation or Adult Psychiatric or Transitional Rehabilitation units would not be counted as part of the bed size – is that correct? Also the nursery bassinets are not included.**

A1.9: Correct. Rehabilitation or psychiatric units within your facility, as well as nursery bassinets, should be excluded from the bed count. This count should be for operating (not licensed) beds.

New **Q1.10: Will Medicare Advantage plans be impacted by this (or the Power Mobility Device) demonstration?**

A1:10: No, these demonstrations will not have any impact on Medicare Advantage plans.

New **Q1.11: Number 10 of the application refers to Chain Organization. Does CMS mean to inquire if the hospital is part of a health system?**

A1.11: Yes.

Part A to Part B Rebilling Demonstration:

New **Q1.12: If I am submitting applications for all of the hospitals in our system, can I submit more than one application under one e-mail (assuming they are the same size facility as defined by the demonstration program) or do I need to submit one e-mail per application.**

A1.12: Please submit each application separately.

New **Q1.13: Who do we contact if our application has not gone through?**

A1.13: Please contact the general mailbox at ABRebillingDemo@cms.hhs.gov. This will allow us to continue to use timeliness as a method of determining the order of applications.

Q1.14: I have additional questions. Where can I send additional questions?

A1.14: Additional questions can be sent to ABRebillingDemo@cms.hhs.gov.

Background

Q2.1: We are a PPS hospital and receive Periodic Interim Payments (PIP). Why can't we participate in the demonstration?

A2.1: The restriction on PIP and other specialty hospital participation was meant to allow for smooth implementation, with data similar enough that it will lend to accurate evaluation of the program and its potential for national implementation. Acute hospitals paid under IPPS were chosen because these facilities often make inpatient versus outpatient short stay determinations and their claim-based payment systems allow for detailed evaluation of the demonstration impact. At this time, PIP providers remain excluded.

Q2.2: Our facility receives bi-weekly pass through payments from CMS. Can you tell me if this would exclude our facility from participation?

A2.2: No, this will not exclude your participation in the demonstration

Q2.3: Is Bad Debt Pass-Through considered a periodic interim payment facility for the purposes of the AB Rebilling Demonstration?

A2.3: Bad-Debt Pass-through payments are not considered PIP payments.

Q2.4: Many if not all Rural Community Hospital (RCH) demonstration sites receive Periodic Interim Payments (PIP) and would not qualify for this demonstration. Nevertheless, it could be tremendously helpful to the RCHs if they could participate. Can FI/MACs pay RCHs in a manner that will allow them to participate in the Rebilling Demonstration?

A2.4: This demonstration will only alter the system for receiving "rebilled" Medicare payment for the AB Rebilling demonstration participants. It will not adjust any other payment policy, such as how FI/MACs pay RCHs. The restriction on PIP and other specialty hospital participation was meant to allow for quick implementation, with data similar enough that it will lend to accurate evaluation of the program and its potential for national implementation. Acute hospitals paid under IPPS were chosen because these

facilities often make inpatient versus outpatient short stay determinations and their claim-based payment systems allow for detailed evaluation of the demonstration impact. At this time, PIP providers remain excluded.

Q2.5: Our Health System has 2 hospitals with different Tax IDs, would each hospital have to apply separately for the RAC Demonstration Project or would we able to apply once as a Health System?

A2.5: Facilities will be defined by their 6-digit Online Survey, Certification, and Reporting (OSCAR) number for the purposes of this demonstration. Please submit your Participant Requests (enrollment applications) appropriately. Should your Health System have 2 hospitals with different OSCAR numbers, each hospital would have to apply separately to be considered for inclusion in the demonstration.

Operational Details of the Demonstration

New **Q3.1: Some denials are via the Remittance Advice. Will there be specific instructions that differentiate rebilling for denials via demand letters versus denials via the remittance advice or other methods?**

A3.1: While the remittance advice is the official notification of a denial, all of the denials in this demonstration will be for medical necessity reviews. Medical necessity reviews always have a review results letter, a demand letter and a remittance advice. Please use the review results letter as the official denial date for the purposes of claims being available for this demonstration.

Q3.2: Will Timely filing be waived?

A3.2: Yes, timely filing restrictions will be waived for demonstration participants. Providers who are not participating in this demonstration should abide by the policy provided on slide #2 of the "Provider Outreach and Education" (https://www.cms.gov/CERT/downloads/Rebilling_Demo_Outreach_1129.pdf) and Answer 1.7 of this document.

New **Q3.3: How long to rebill from date of demand letter?**

A3.3: Providers shall rebill the outpatient services within 120 days of receipt of the denial.

New **Q3.4: May we rebill claims denied for lack of MD order?**

A3.4: No. Claims denied due to lack of physician order admitting the beneficiary as an inpatient will not be eligible for rebilling purposes.

Q3.5: If we participate in this demonstration project, will we be able to bill as a 131 bill type or just a 121 bill type?

A3.5: It is important to CMS that the claims remain inpatient to ensure beneficiary protections. CMS envisions systems changes to allow this change in billing practice to occur. Demonstration participants will be given detailed information on how to rebill throughout the demonstration once the list of participants is finalized.

Part A to Part B Rebilling Demonstration:

New **Q3.6: While we understand that the beneficiary may not be charged any additional out-of-pocket expenses due to changes in the deductible/co-insurance when the claim is rebilled, how will this impact supplemental or secondary insurance?**

A3.6: The CMS will not dictate provider relationships with supplemental or secondary insurance companies for the purposes of this demonstration. The protection described above is solely meant to ensure the beneficiary will not incur any additional out-of-pocket expenses as a result of this demonstration.

New **Q3.7: How will cross-over claims and other secondary claims be handled?**

A3.7: The CMS will not dictate provider relationships with supplemental or secondary insurance companies for the purposes of this demonstration. However, that arrangement should ensure that the beneficiary does not incur any additional out-of-pocket expenses.

Q3.8: Will the Part B claim amounts include lab services and x-rays?

A3.8: Providers will be paid for any Part B services that would have been payable if the claim was originally submitted as an outpatient claim for payment.

New **Q3.9: Since providers may not bill self- administered drugs to the beneficiary, does that also mean that providers should not bill them on the claim, or will providers bill the charges for the self-administered drug and CMS will deny them appropriately?**

A3.9: Correct, please omit these from the claim.

Q3.10: May hospitals accepted into the demonstration chose which claims to rebill for Part B payment, once the appeals process has been completed on the inpatient claims?

A3.10: To participate in the demonstration providers will waive their appeal rights for all claims impacted by the demonstration (i.e. 2 day or less inpatient short stay claims). Providers will still be able to use the discussion period. This will allow providers to question the decision outside of the normal appeals process.

Q3.11: What if we withdraw from the demonstration? Will we regain our appeal rights?

A3.11: Yes. Providers will regain appeal rights to all claims that were not impacted by the demonstration (i.e. any 2 day or less inpatient short stay claim from the date of withdraw forward will be afforded normal appeal rights).