

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



REVISED products from the Medicare Learning Network® (MLN)

- **“ICD-10-CM/PCS The Next Generation of Coding,”** Fact Sheet, ICN 901044, Downloadable and Hard Copy.

MLN Matters® Number: SE1333 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims

Note: This article was revised on September 22, 2014, to add links to MLN Matters® article MM8445 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8445.pdf>) and to MM8666 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8666.pdf>). MM8445 discusses provider and beneficiary liabilities under the Final Rule 1599-F. **It is important to note that MM8445 describes changes when the payment can not be made because an inpatient admission is not reasonable and necessary and otherwise there are no changes to the policies for billing Part B under other circumstances.** MM8666 implements revised policies related to payment of hospital Part B inpatient services charges. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

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What You Need to Know

This article conveys temporary instructions for the implementation of that portion of final rule 1599-FI that relates to billing for Part B services that were provided during a hospital inpatient stay, for which Medicare denied payment. Make sure billing staff are aware of these instructions.

Background

For Admissions on or after October 1, 2013

When an inpatient admission is found to be not reasonable and necessary, the Centers for Medicare & Medicaid Services (CMS) will 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 that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.

Hospitals are required to maintain documentation to support the services billed on a Part B inpatient claim for services rendered during the inpatient stay.

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services. **Any coinsurance or deductible collected for the Part A claim must be refunded.** Whether or not the hospital had submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. **The hospital would indicate Provider Liability period on the Part A claim by including the Occurrence Span Code “M1” and the inpatient admission Dates of Service.** The hospital could then submit an inpatient claim for payment under Part B on a Type of Bill (TOB) 12X for inpatient 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 where those services specifically require an outpatient status.

For Part B inpatient services furnished by the hospital that are not paid under the Outpatient Prospective Payment System (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment would be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

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All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), hospitals paid under the OPSS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPSS would continue billing the OPSS for Part B inpatient services. Hospitals that are excluded from payment under the OPSS in 42 CFR 419.20(b) would be eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. For example, beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid.

CMS notes that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the "Medicare Benefit Policy Manual" (Chapter 6, Section 10), which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> on the CMS website.

Hospitals may continue to bill Part B for outpatient services provided to the beneficiary prior to the point of inpatient admission in the 3 calendar day (or 1 calendar day for a non-IPPS hospital) payment window prior to the admission, including those services that require an outpatient status (see the "Medicare Claims Processing Manual" Chapter 4, Section 10.12, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c02.pdf>). These services should be billed on a 131 Part B outpatient TOB and must be filed timely (within 1 calendar year of date of service) in order to be paid.

Services provided prior to the point of inpatient admission are outpatient services and may not be included on the 121 Part B inpatient claim; services provided after the point of admission are inpatient services and may not be included on the 131 Part B outpatient claim. Two complementary claims are therefore necessary if some services are provided before admission and others are provided after admission. In placing services on the appropriate claim, hospitals should use the same billing and coding rules used for assigning dates of service to services that cross midnight, using the start of the service to determine correct claim placement unless other specific instructions are provided, and ensuring that services are not double billed. If inpatient only services, such as procedures on the inpatient only list, were delivered prior to the point of admission, they cannot be paid because they were provided as outpatient services; they may not be reported on the 121 Part B inpatient claim because they were provided prior to the point of admission. If outpatient only services, such

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as outpatient observation, were continued after the point of admission, the post admission services cannot be paid because they were provided as inpatient services; the time may not be included on the 131 Part B outpatient claim because it was provided after the point of admission.

Appeals

If a hospital chooses to submit a Part B claim for payment following the denial of an inpatient admission on a Part A claim, the hospital cannot also maintain its request for payment for the same services on the Part A claim (including an appeal of the Part A claim). In this situation, before the hospital submits a Part B claim, it must ensure that there is no pending appeal request on the Part A claim. In addition, if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot submit a Part B claim in order to extinguish a beneficiary's appeal rights. Therefore, the hospital's submission of a Part B claim does 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, any claims re-billed under Part B by the hospital will be denied as duplicates by the Medicare contractor. Once a Part B claim is filed, there are no further appeal rights available with respect to the Part A claim. However, the hospital and beneficiary have appeal rights with respect to an initial determination made on the Part B claim under existing policies set forth at 42 CFR Part 405, Subpart I.

Billing Tips

For “self-audit” claims, providers shall submit a Part A Provider Liable claim. The inpatient claim must indicate the following information on the UB-04 claim form when billed to Medicare:

- Type of Bill (TOB) 110 in Form Locator (FL) 4.
- Non-covered days.
- The services from admission through discharge.
- The appropriate patient status.
- Occurrence Span Code “M1” and dates of service.
- Non-covered charges for all services rendered.
- All diagnosis codes.
- All procedures codes.

After the inpatient claim has processed and a Remittance Advice (RA) has been issued, a Part B inpatient claim (TOB 12X) can be submitted. **For Part A Inpatient admissions denied as not reasonable and necessary**, providers shall submit a qualifying Part B inpatient claim (TOB 12x) with:

1. A treatment authorization code of A/B Rebilling submitted by a provider.

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NOTE: Providers billing an 837I shall place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

REF*G1*A/B Rebilling~

2. A condition code "W2" attesting that this is a rebilling and no appeal is in process; and
3. The original, denied inpatient claim (CCN/DCN/ICN) number

NOTE: Providers billing an 837I shall place DCN in the Billing Notes loop 2300/NTE in the format:

NTE*ADD*ABREBILL12345678901234~

For DDE or paper Claims, Providers shall place the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".

NOTE: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.

Inpatient Part B Hospital Services

Inpatient Part B services include services which are not strictly provided in an outpatient setting. Examples of services that are strictly provided in an outpatient setting include services such as Diabetes Self-Management Training (DSMT), Clinic Visits, Emergency Department, and Observation Services (**this is not a complete listing**). Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made. Examples of routine nursing services that are captured in the Room and Board rate include patients that receive from the floor nurse IV infusions and injections, blood administration, and nebulizer treatments. These services **are not separately billable** Inpatient Part B services.

Medicare pays under Inpatient Part B for the non-physician medical and other health services listed in the "Medicare Benefit Policy Manual," Chapter 6, Section 10.1. The revenue codes listed in the table below are a guide for providers to use when a service is non-covered at the revenue code level. Some revenue codes allow many services, some of which are covered and some of which are non-covered by Medicare Inpatient Part B for inpatients. When a revenue code can be sometimes covered, sometime not covered, providers should use the HCPCS to determine if the service is covered (i.e., Revenue Code

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0942 is not listed below. However, when DSMT services are billed with this revenue code, the DSMT service remains non-covered under Medicare Inpatient Part B).

Revenue Codes not covered under Inpatient Part B Medical Necessity Denials							
010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390	0391	0399	045x	050x	051x	052x	054x
055x	056x	057x	058x	059x	060x	0630	0631
0632	0633	0637	064x	065x	066x	067x	068x
072x	0762	082x	083x	084x	085x	088x	089x
0905	0906	0907	0912	0913	093x	0941	0943
0944	0945	0946	0947	0948	095x	0960	0961
0962	0963	0964*	0969	097x	098x	099x	100x
210x	310x						

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

Implantable Prosthetic Devices

When a hospital that is not paid under the OPSS furnishes an implantable prosthetic device that meets the criteria for coverage in "Medicare Benefit Policy Manual," Chapter 6, Section 10, to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPSS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B due to Part A medical necessity denial, the hospital should report the HCPCS that describes the device as outlined under OPSS rules. The OPSS hospital **should not** report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, when the Part A claim has been medically denied. The OPSS hospital should only report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, due to no Part A coverage or Part A benefits exhausted.

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Additional Information

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

You may also want to review MLN Matters® article MM8445 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8445.pdf>) and to MM8666 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8666.pdf>).

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