CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1203	**Date: March 22, 2013**
	Change Request 8185

SUBJECT: CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims

I. SUMMARY OF CHANGES: This Change Request will implement the CMS Administrator's Ruling which permit providers to rebill inpatient Part A claims that are denied by a Medicare contractor for the reason that the inpatient level of care was not medically necessary for Part B payment for the full array of services provided without changing the patient"s status. This Change Request includes specific guidance for accepting claims rebilled by Part A to Part B (A/B) Rebilling.

EFFECTIVE DATE: March 13, 2013
IMPLEMENTATION DATE: July 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1203	March 22, 2013	Change Request: 8185

SUBJECT: CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims

EFFECTIVE DATE: March 13, 2013
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner may admit the beneficiary for inpatient care or treat him or her as an outpatient. In some cases, when the physician admits the beneficiary and the hospital provides inpatient care, a Medicare claims review contractor such as a Medicare Administrative Contractor (MAC), Recovery Audit Contractor, or the Comprehensive Error Rate Testing Contractor subsequently determines that the inpatient admission was not reasonable and necessary under section 1862(a)(1)(A) of the Act and therefore denies the associated Part A claim for payment. To date under the Medicare program, in these cases hospitals may bill a subsequent so-called “Part B inpatient” claim for only a limited set of medical and other health services referred to as “Part B Inpatient” or “Part B Only” services, specified in Section 10, Chapter 6 of the Medicare Benefit Policy Manual (MBPM) (Pub. 100-02). These Part B claims are considered new claims that are subject to the timely filing restrictions.

On March 13, 2013, CMS issued an Administrator's Ruling (CMS-1455-R) establishing that when a Part A inpatient claim for a hospital inpatient admission is denied because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient. Specifically, the hospital may submit a Part B inpatient claim for more services than just those listed in Section 10, Chapter 6 of the MBPM to the extent additional reasonable and necessary services were furnished. Hospitals also may bill separately for outpatient services furnished in the three-day payment window (or one-day payment window for non-IPPS hospitals) prior to the inpatient admission as the outpatient services that they were on an outpatient Part B claim. Hospitals may only submit claims for Part B inpatient and Part B outpatient services that are reasonable and necessary in accordance with Medicare coverage and payment rules and must maintain documentation to support the services for which they are rebilling. The Part B inpatient and Part B outpatient claims that are filed later than 1 calendar year after the date of service are not to be rejected as untimely by Medicare’s claims processing system as long as the corresponding denied Part A inpatient claim was filed timely in accordance with 42 CFR 424.44.

The policy in the Administrator Ruling’s supersedes any other statements of policy on the issues therein and remains in effect until the effective date of the regulations that finalize CMS’s proposed rule titled, "Medicare Program; Part B Inpatient Billing in Hospitals", which was issued concurrently with the Administrator Ruling.

B. Policy: Under the interim policy established in CMS-1455-R, when a Part A claim for a hospital inpatient admission is denied because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for more services than just those listed in section 10, Chapter 6 of the Medicare Benefit Policy Manual. The hospital may submit a Part B inpatient claim for payment for the services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except those services that by statute, Medicare definition, or coding definition specifically require an outpatient status (e.g., outpatient visits, emergency department visits, and observation services).

Current Medicare policy requires payment for certain outpatient services furnished on the date of an inpatient admission or during the three calendar days prior to the date of the inpatient admission (or one calendar day for non-IPPS hospitals) to be bundled with the payment for the inpatient stay. *See* Section 10.12, Chapter 4 of the Medicare Claims Processing Manual (Pub. 100-04). Where, however, no Part A payment is made because the Part A inpatient claim is denied on the basis that the inpatient admission was not reasonable and necessary, hospitals may bill separately for the outpatient services furnished during the three-day (or one-day for non-IPPS hospitals) payment window prior to the inpatient admission as the outpatient services that they were, including observation and other services that are furnished in accordance with Medicare's requirements. Because services provided during the three-day (or one-day for non-IPPS hospitals) payment window prior to the denied inpatient admission are outpatient services, they cannot be included on the Part B inpatient claim. Instead, hospitals may bill for these services on a Part B outpatient claim, which, in accordance with the policy announced in CMS-1455-R, will not be subject to the usual timely filing restrictions. Hospitals may only submit claims for Part B inpatient and Part B outpatient services that are reasonable and necessary in accordance with Medicare coverage and payment rules. Hospitals must maintain documentation to support the services billed on Part B inpatient and Part B outpatient claims for services rendered during the inpatient stay and the three-day (or one-day for non-IPPS hospitals) payment window prior to the inpatient admission.

This interim policy applies to Part A hospital inpatient claims that were denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, as long as the denial is/was made: (1) while the Administrator Ruling is in effect; (2) prior to the effective date of the Administrator Ruling, but for which the timeframe to file an appeal has not expired; or (3) prior to the effective date of the Administrator Ruling, but for which an appeal is pending. The interim policy does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal has expired. In addition, this interim policy does not apply to other instances in which we currently provide for limited Part A to Part B rebilling when a beneficiary has no Part A coverage for an inpatient hospital stay (e.g., exhausted Part A benefit days).

Under CMS Ruling 1455-R, Part B inpatient and/or Part B outpatient claims that are filed later than 1 calendar year after the date of service shall not be rejected or denied as untimely by Medicare's claims processing system as long as the original corresponding Part A inpatient claim was filed timely in accordance with 42 CFR 424.44. If the denial of the Part A inpatient claim subject to CMS Ruling 1455-R is not appealed, the hospital will have 180 calendar days from the date of receipt of the contractor's initial or revised determination on the Part A inpatient claim (i.e., the remittance advice) to submit Part B inpatient and/or Part B outpatient claims. If the hospital or beneficiary appeals the denial of the Part A inpatient claim subject to CMS Ruling 1455-R, and the hospital or beneficiary receives a decision that an inpatient level of care was not reasonable and necessary, the hospital will have 180 calendar days from the date of receipt of the final or binding appeal decision to submit Part B inpatient and/or Part B outpatient claims. If an appeal of a Part A inpatient claim subject to CMS Ruling 1455-R is withdrawn or dismissed, the hospital will have 180 calendar days from the date of receipt of the dismissal order to submit Part B inpatient and/or Part B outpatient claims. The date of receipt of a determination, decision or notice is presumed to be five days from the date of the determination, decision or notice, unless there is evidence to the contrary.

Under the interim policy, the beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital. To that end, to receive payment the hospital shall submit the Part B rebilling claims that are required under current policy, i.e., a Part B inpatient 12X TOB and an 11X inpatient Provider Liable TOB. On the 12X TOB, the hospital must recode the services that were furnished as Part B services, and must, when available, provide the Healthcare Common Procedure Coding System (HCPCS) code(s), Current Procedure Terminology (CPT) code(s) and revenue code(s) that describe the medically necessary services that were ordered and rendered in accordance with Medicare rules and regulations, and that are documented in the medical record. We note that because the beneficiary's patient status remains inpatient, rebilling under the Ruling does not impact skilled nursing facility (SNF) eligibility.

As explained in the Ruling, hospitals are solely responsible for both submitting claims for items and services furnished to beneficiaries and determining whether submission of a Part A or Part B claim is appropriate. Once a hospital submits a claim, the Medicare contractor can make an initial determination and determine any payable amount. Accordingly, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and appeals adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination. If a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim the provider has not yet submitted.

The Ruling provides hospitals with notice of their right to submit Part B claims following denial of a Part A inpatient admission as described above, provided the hospital withdraws any pending appeal of the Part A claim denial. We note that CMS-1455-R applies only to claim denials by a Medicare review contractor and not to hospital self-audits. Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending. Until and unless an appeal is withdrawn by the appellant, contractors will continue processing all pending Part A appeals that are subject to the Ruling. The Ruling also established a policy for handling appeals remanded from the ALJ level to the QIC level. Remanded cases will be returned to the ALJ level for adjudication of the Part A claim appeal. Information regarding requests for withdrawal will be available to appellants on OMHA's public website at www.hhs.gov/omha.

In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service. Thus, if a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, consistent with the Ruling, the hospital cannot also maintain its request for payment for the same services on the Part A claim. In this situation, the hospital must withdraw any pending appeal request on the Part A claim before submitting a Part B claim. If a contractor determines that a hospital has submitted a Part B claim for payment while a Part A appeal is pending (i.e., the request has not been withdrawn and a decision on the request has not been issued), the Part B claim for payment shall be denied as a duplicate and the Part A appeal will continue. Once the hospital submits a Part B claim, parties will no longer be able to request further appeals of the Part A claim. Rather, parties will be able to exercise their appeal rights for the subsequent Part B claim under existing procedures in 42 CFR part 405 Subpart I. If a Part A appeal is mistakenly processed after a hospital submits a Part B claim, no additional payment shall be made with respect to the Part A claim in effectuating the Part A decision.

Hospitals submitting Part B inpatient claims subject to this interim policy shall include condition code "W2" on the claim. 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. 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.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility						
		A/B MAC	D M E	F I	C A R	R H H	Shared-System Maintainers	Other

		Part A	Part B	MAC		RIER	I	FISS	MCS	VMS	CWF	
8185.1	FISS shall no longer allow A/B demonstration claims to be accepted. Demonstration claims with a Demonstration Code of 65, 66, and 67 shall not be accepted.							X				
8185.2	FISS shall accept 121 and 131 type of bill (TOB) claims being resubmitted with the appropriate Part A to Part B Rebilling treatment authorization code by a provider. The appropriate treatment authorization code is "A/B Rebilling". This shall be entered on the first iteration of the treatment authorization field when submitted.							X				
8185.3	FISS shall recognize and process 121 TOB claims with: 1. a treatment authorization code of A/B Rebilling submitted by a provider in 8185.2. **NOTE: Once CR 8185 is implemented, providers billing a 837I will be instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:** REF*G1*A/B Rebilling~ 1. a condition code "W2" attesting that this is a rebilling and no appeal is in process, 2. the original, denied inpatient claim (CCN/DCN/ICN) number, and 3. last adjudication date. **NOTE:** The DCN and last adjudication date shall be included in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234-99999999~ **For DDE or paper Claims**, Providers will be instructed to use a condition code "W2" and to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper) and the following format: A/B Rebilling	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	The word "ABREBILL", the original, denied inpatient DCN/CCN/ICN and last adjudication date shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234-99999999". **NOTE:** The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial and the second number string above (99999999) is meant to represent the most recent adjudication date in mmddyyyy format.											
8185.3.1	FISS shall review the rebilling claim upon receipt as though it was an adjustment claim for payment. The claim shall be marked as unclean with condition code "64"							X				
8185.3.2	FISS shall validate the existence of an 11x medical necessity denial claim (e.i., contractor review medical necessity denial) based on the DCN in remarks. If the claim is offline, FISS shall suspend the A/B Rebilling for A/MAC retrieval and validation.	X			X			X				
8185.3.3	If an 11x medical necessity denial claim does not exist based on the DCN submitted on the claim, then FISS shall create a reason code that will be used to RTP the claim to the Provider.	X			X			X				
8185.3.4	Contractors shall Return to Provider a TOB 121 or 131 A/B Rebilling claim that does not have a medical denied 11x claim in history that matches the DCN in remarks.	X			X			X				
8185.3.5	FISS shall validate that Condition Code "W2" is present on an 12x and 13x claim prior to processing either a 12x or a 13x A/B rebilling claim. If a condition code “W2” is not present, then FISS shall create a reason code that will be used to RTP the claim to the Provider. This edit shall be bypassed if the claim being processed is a contractor submitted adjustment.							X				
8185.3.6	FISS shall update reason code files to allow condition code “W2”. Any contractor who has editing to prevent the usage of “W2” shall update their files to allow	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	condition code “W2”.											
8185.3.7	Contractors shall Return to Provider a TOB 121 or 131 A/B Rebilling claim that does not have a Condition Code "W2".	X			X			X				
8185.3.8	FISS shall not allow observation services (Revenue Code 762) and outpatient visits (Revenue Code 45x and 51x) to be billed on the A/B Rebilling 121 TOB claim. This line level edit shall be bypassable. **NOTE:** This includes G0378 and G0379, 99201-99215, and 99281-99285.							X				
8185.3.9	FISS shall not allow services not covered under Part B (e.g., Room and Board Revenue Codes 0100 - 0239) to be billed on the Part B inpatient rebilling. This line level edit shall not be bypassable.							X				
8185.3.10	FISS shall bypass edits that only allow certain revenue codes to be covered on 12X type of bill (TOB), including edits tied to the revenue code file with exceptions noted in above requirements.							X				
8185.4	FISS shall permit providers to rebill for all of the services that would have been payable if the claim was originally ordered and submitted as an outpatient claim for payment (except for services that by definition could not be provided to a hospital inpatient, see 8185.3.8).							X				
8185.5	FISS shall pay the rebilled claim as if the provider had originally submitted the claim for services as an outpatient claim for payment based on the OPPS Pricer amount, lab fee amount, or other applicable payment methodology with applicable deductible and coinsurance amounts. **NOTE:** Beneficiaries will not be held harmless from any out of pocket expenses due to the change in payment, but are entitled to refunds of any amount already paid to the hospital consistent with IOM 100-4, Ch. 30 §§30.1.2, 30.2.2.							X				
8185.6	FISS shall accept 131 type of bill (TOB) claims for							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	outpatient services that were originally bundled into the inpatient claim for the 3 day payment window (for IPPS hospitals) and the 1 day payment window (for non-IPPS hospitals) being resubmitted with the appropriate Part A to Part B Rebilling treatment authorization code by a provider. The appropriate treatment authorization code is "A/B Rebilling".											
8185.7	FISS shall recognize and process 131 TOB claims for outpatient services that were bundled into the inpatient claim for the 3 day payment window (for IPPS hospitals) and the 1 day payment window (for non-IPPS hospitals) with: 1. a treatment authorization code of A/B Rebilling submitted by a provider in 8185.2. **NOTE:** Once CR 8185 is implemented, providers billing a 837I will be instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*A/B Rebilling~ 1. a condition code "W2" attesting that this is a rebilling and no appeal is in process, 2. the original, denied inpatient claim (CCN/DCN/ICN) number, and 3. last adjudication date. **NOTE:** The DCN and last adjudication date shall be included in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234-99999999~ **For DDE or paper Claims**, Providers will be instructed to use a condition code "W2" and to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper) and the following format:	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	A/B Rebilling The word "ABREBILL", the original, denied inpatient DCN and last adjudication date shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234-99999999". **NOTE:** The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial and the second number string above (99999999) is meant to represent the most recent adjudication date in mmddyyyy format.											
8185.8	FISS shall bypass timely filing edits on both 13x and 12x A/B Rebilling claims as long as the corresponding Part A claim was filed timely and the provider submitted 13x and 12x claims were received within the administrator's ruling 180 day time frame of the 11x most recent adjudication (payment, denial, dismissal, etc.) as identified by the date found in the second 8 digit numeric segment of remarks with mmddyyyy segment. Contractor Submitted adjustments will need to be bypassed by the contractor.	X			X			X				
8185.9	Contractors shall identify and use the mass adjustment process for A/B demonstration claims that were processed from March 13, 2013 until implementation of this CR (Demonstration claims contain a Demonstration Code of 65 or 66), contractors shall add the treatment authorization code "A/B Rebilling" and process adjustments to any 12x claim that was paid at 90% to allow 100% payment utilizing the ECPS Mass Adjustment process.	X			X							
8185.10	FISS shall remove demo code 65 or 66 and all coding associated with the reduction if present on a claim that has A/B Rebilling present in the Treatment Authorization field.							X				
8185.11	Contractors shall dismiss redetermination requests of Part A 11x claims if the provider has previously billed a 131 or 121 A/B rebilling claim. However, Contractors shall accept appeal requests of A/B	X			X							

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	rebilled 131 or 121 claims.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8185.12	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ann Marshall, 410-786-3059 or ann.marshall@cms.hhs.gov (for policy issues) , Fred Rooke, 404-562-7205 or fred.rooke@cms.hhs.gov (for institutional claims processing issues)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.