CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1247	**Date: June 10, 2013**
	Change Request 8277

Transmittal 1243, dated May 31, 2013, is being rescinded and replaced by Transmittal 1247, dated June 10, 2013, to correct coding and remarks requirements for Part B claim in BR 8277.17 and BR8277.18. All other information remains the same.

SUBJECT: Implementation of CMS Ruling 1455-R (Medicare Program; Part B Billing in Hospitals)

I. SUMMARY OF CHANGES: On March 13, 2013 the Centers for Medicare and Medicaid Services (CMS) issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B inpatient and/or Part B outpatient services following a denial of a claim for an inpatient admission as not reasonable and necessary. CMS issued CR8185 which sets forth requirements for contractors to implement CMS Ruling 1455-R, effective for claims processed after July 1, 2013. The purpose of this Change Request is to set forth requirements for contractors to implement CMS Ruling 1455-R until such time as the operating instructions and necessary system changes in CR 8185 can be fully implemented.

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: 1247	Date: June 10, 2013	Change Request: 8277

Transmittal 1243, dated May 31, 2013, is being rescinded and replaced by Transmittal 1247, dated June 10, 2013, to correct coding and remarks requirements for Part B claim in BR 8277.17 and BR8277.18. All other information remains the same.

SUBJECT: Implementation of CMS Ruling 1455-R (Medicare Program; Part B Billing in Hospitals)

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

I. GENERAL INFORMATION

A. Background: On March 13, 2013 the Centers for Medicare and Medicaid Services (CMS) issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B inpatient and Part B outpatient services following a denial of a Part A claim by a Medicare review contractor on the basis that the inpatient admission was not reasonable and necessary. CMS issued CR8185 which sets forth requirements for contractors to implement CMS Ruling 1455-R (the Ruling), effective for claims processed on or after July 1, 2013. The purpose of this CR is to provide instructions for implementing CMS Ruling 1455-R until such time as the operating instructions in CR8185 are implemented.

As explained in CMS Ruling 1455-R, Medicare review contractors, such as the Medicare Administrative Contractors (MACs), Recovery Auditors Contractors (RACs), and the Comprehensive Error Rate Testing Contractor (CERT) have conducted extensive post-payment reviews of hospital inpatient admissions in recent years, denying many Part A claims for hospital inpatient admissions determined not reasonable and necessary under section 1862(a)(1)(A) of the Act. Prior to the issuance of the Ruling, following these claim denials, Medicare permitted hospitals to bill a subsequent 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, provided the claim was submitted within the otherwise applicable time limit for filing claims and the Part B services were reasonable and necessary. (See, IOM Pub. 100-2 (Medicare Benefit Policy Manual (MBPM), Ch. 6, §10; IOM Pub. 100-4 (Medicare Claims Processing Manual (MCPM)), Ch. 1, §70). Hospitals could also bill a Part B outpatient claim for all reasonable and necessary hospital outpatient services that were furnished in the 3-day (1-day for hospitals not paid under the Inpatient Prospective Payment System or IPPS) payment window prior to the inpatient admission and were bundled into the Part A claim for initial payment (MCPM, Ch. 4, §10.12). The statutory timely filing deadline applied to the subsequent Part B claims that were required for payment of these Part B inpatient and Part B outpatient services. In an increasing number of cases, hospitals that appealed these Part A inpatient claim denials to the Administrative Law Judges (ALJs) and the Medicare Appeals Council received decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, but ordering payment of the services as if they were rendered at an outpatient or "observation level" of care. Moreover, these decisions required payment regardless of whether the subsequent hospital claim(s) for payment under Part B were submitted within the otherwise applicable time limit for filing Part B claims.

The ALJ and Medicare Appeals Council decisions providing for payment of all reasonable and necessary Part B services under these circumstances are contrary to CMS' longstanding policies that permit billing for only a limited list of Part B inpatient services and require that the services be billed within the usual timely filing restrictions. While decisions issued by the ALJs and the Medicare Appeals Council do not establish Medicare payment policy, we are bound to effectuate each individual decision. The increasing number of these types of decisions has created numerous operational difficulties. The Ruling acquiesces to the approach taken in these decisions on the issue of subsequent Part B billing following the denial of a Part A hospital inpatient claim on the basis that the admission was not reasonable and necessary. CMS Ruling

1455-R establishes a standard, interim process for effectuating these decisions and handling pending hospital claims denials and appeals until CMS establishes a final policy on this issue through notice and comment rulemaking. Thus, the policy announced in CMS Ruling 1455-R, which became effective upon issuance on March 13, 2013, supersedes any other statements of policy on the issues therein, and remains in effect until the effective date of the final regulations for the concurrently issued proposed rule, CMS-1455-P, "Medicare Program; Part B Billing in Hospitals".

B. Policy: Applicability

CMS Ruling 1455-R only applies to denials of Part A hospital inpatient claims when the inpatient admission was determined not reasonable and necessary by a Medicare review contractor (provided payment was not made under the waiver of liability provision (§1879 of the Act), and repayment of any Part A overpayment was not waived (§1870 of the Act). In this situation, under the Ruling the hospital may submit a Part B inpatient claim for all Part B services that would have been payable to the hospital had the beneficiary originally been treated as a hospital outpatient rather than admitted as a hospital inpatient, except when those services specifically require an outpatient status (for example, outpatient visits, emergency department visits, and observation services). Services that require an outpatient status cannot be billed for the time period the beneficiary spent in the hospital as an inpatient and cannot be included on the Part B inpatient claim. Hospitals may also bill separately for outpatient services provided in the 3-day payment window (1-day for non-IPPS hospitals) prior to the inpatient admission as the outpatient services that they were on a Part B outpatient claim, including services that require an outpatient status. See CMS Ruling 1455-R, and the section below titled "Billing Part B Claims" for further information regarding submission of Part B inpatient and Part B outpatient claims, and for patient status under the Ruling. Consistent with the ALJ and Medicare Appeals Council decisions (to which CMS acquiesces in the Ruling), the timely filing deadline will not be applied to Part B claims filed under the Ruling as long as the corresponding denied Part A inpatient claim was filed timely.

CMS Ruling 1455-R applies to the claim denials described above and made: (1) while the Ruling is in effect; (2) prior to the effective date of the Ruling (March 13, 2013), but for which the timeframe to file an appeal had not expired as of the effective date of the Ruling; 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 had expired prior to the effective date of this Ruling, and it does not apply to inpatient admissions deemed by the hospital to be not reasonable and necessary (for example, through utilization review or other hospital self-audit).

Treatment of Pending Appeals and Appeal Rights Under the Ruling

The Ruling provided hospitals with notice of their right to submit Part B claims following the denial of a claim for a Part A hospital inpatient admission as described above, provided the hospital withdraws any pending appeal of the Part A claim denial. 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 hospital's withdrawal request must identify the claims being appealed and explain that the appeal request is being withdrawn so the hospital may submit Part B claim(s) in accordance with CMS Ruling 1455-R.

The Ruling also established a policy for handling appeals remanded from the ALJ level to the Qualified Independent Contractor (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 the Office of Medicare Hearings and Appeal's (OMHA's) public website at www.hhs.gov/omha.

If a contractor determines that a hospital has submitted a Part B claim, under the Ruling, 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 under the Ruling, 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 under the Ruling, no additional payment shall be made with respect to the Part A claim in effectuating the Part A decision.

Scope of Review for Part A Hospital Inpatient Claim Denials

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 hospital 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.

Billing Part B Claims Under the Ruling

Under the interim policy described in the Ruling, 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 under the Ruling, the hospital shall submit the Part B claims that are required under the policy preceding the Ruling, i.e., a Part B inpatient 12X TOB. Services furnished after the time of the hospital inpatient admission must be billed on the 12X TOB, and services furnished in the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission must be billed on a 13X Part B outpatient TOB. On the 12X and 13X claims, 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.

For 12x claims billed under the Ruling, until the system changes set forth in CR8185 are implemented in the July quarterly release, CMS will use system logic implemented with the Part A to Part B (A/B) Rebilling Demonstration to process claims as follows. Until the July quarterly release providers will follow billing instructions contained in the business requirements below. The hospital will initially be paid the amount it would have been paid under the demonstration, at 90% of the net amount that would be payable (after subtracting deductibles and co-insurance) if the provider had originally submitted a claim for hospital outpatient services based on the OPPS Pricer amount or other applicable fee schedule amount. (For Maryland Waiver providers, the 90% will be based on the Part B payment that would have been available if the claim were originally paid as an outpatient claim.) Payments are claim, not line, level. When CR 8185 is implemented in July, contractors will mass adjust all 12x TOB claims that are processed under this temporary methodology in accordance with the Ruling for full Medicare payment.

Effective 03/13/2013, contractors must update the Provider File to allow all hospitals the ability to bill under these methods which were used for the A/B Rebilling Demonstration, and shall remove any termination dates in the Rebill Code field. Additionally, contractors shall bypass timely filing edits on Part B outpatient claims (Type of Bill 13x) when billed using the instructions in this CR. Contractors shall no longer accept claims with a treatment authorization code of “SPN66” indicating that this claim is being rebilled due to a provider self-audit, because the provisions of the Ruling do not apply to hospital self-audit.

Time Period Within Which a Provider Must Bill

Under the Ruling, Part B inpatient and Part B outpatient claims subject to the Ruling that are filed later than one 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).

1. If a hospital with a pending appeal for a Part A hospital inpatient claim denial subject to the Ruling withdraws its appeal, it will have 180 days from the date of receipt of the dismissal notice to file its Part B claim(s).

2. If a hospital with a pending appeal for a Part A hospital inpatient claim denial subject to the Ruling does not withdraw its appeal, the hospital has 180 days from the date of receipt of the final or binding unfavorable appeal decision (or subsequent dismissal notice following a withdrawal) to submit its Part B claim(s). For example, if an appellant receives an unfavorable reconsideration decision but decides not to request a hearing before an ALJ, or the time to request a hearing expires, the reconsideration decision becomes binding, and the Part B claim(s) may be filed within 180 days of the date of receipt of the reconsideration decision.

3. If a hospital receives a denial of a Part A hospital inpatient claim subject to the Ruling for which there is no pending appeal, and the denial is not subsequently appealed, the hospital will have 180 days from the date of receipt of the initial or revised determination on the Part A claim (that is, the date of the remittance advice) to submit its Part B claim(s).

4. The date of receipt of an initial or revised determination, or an appeal decision or dismissal notice is presumed to be 5 days after the date of such notice or decision, unless there is evidence to the contrary.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8277.1	Contractors shall continue processing all pending Part A appeals that are subject to CMS Ruling 1455-R unless the request is withdrawn.	X				X							
8277.2	If the appellant withdraws the request for pending appeal on a Part A inpatient claim subject to CMS Ruling 1455-R, the contractor shall dismiss the original appeal request. Contractors shall use the model draft dismissal notice in attachment 1. A party's request for withdrawal of a pending appeal must identify the claim(s) (or lower level appeal(s)) at issue and should explain the withdrawal is pursuant to Ruling CMS-1455-R.	X				X							
8277.3	When issuing appeal decisions for claims subject to CMS Ruling 1455-R, contractors shall include additional language in the Medicare Redetermination Notice explaining the options	X				X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	available to the hospital to submit its Part B claim(s). See model language in attachment 2.												
8277.4	In conducting a redetermination for claims subject to CMS Ruling 1455-R, a contractor's scope of review shall be limited to the claim(s) that are before them on appeal. In making a redetermination decision, contractors shall not make a finding regarding coverage or order payment for items or services that have not yet been billed or have not yet received an initial determination.	X				X							
8277.5	Part B inpatient and Part B outpatient claims subject to the CMS Ruling 1455-R that are filed later than 1 calendar year after the date of service shall not be denied as untimely as long as the corresponding denied Part A claim was filed timely in accordance with 42 CFR 424.44. Contractors shall manually bypass timely filing edits, if necessary, to process both the Part B inpatient and Part B outpatient claims subject to the Ruling.	X				X							
8277.6	A hospital with Part A claim denial subject to CMS Ruling 1455-R that has not appealed the denial shall have 180 calendar days from the date of receipt of the initial determination (or revised initial determination in the case of a postpayment review and denial), to submit its Part B claim(s) under the Ruling.	X				X							
8277.7	A hospital with a final or binding appeal decision on a Part A claim denial subject to CMS Ruling 1455-R shall have 180 calendar days from the date of receipt of the final or binding appeal decision to submit its Part B claim(s) under the Ruling.	X				X							
8277.8	A hospital with a pending appeal of a Part A claim denial subject to CMS Ruling 1455-R that withdraws its appeal request shall have 180 calendar days from the date of receipt of the dismissal notice to file its Part B claim(s) under the Ruling.	X				X							
8277.9	Contractors shall dismiss a request for redetermination for a Part A claim subject to CMS	X				X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Ruling 1455-R if the contractor determines the hospital has submitted a Part B inpatient or outpatient claim for the same beneficiary and the same dates of service. The contractor shall use the dismissal notice provided in attachment 3.												
8277.10	If a hospital has submitted a Part B claim under CMS Ruling 1455-R, and a party subsequently files a request for redetermination of the Part B inpatient claim, the contractor shall process the appeal request in accordance with existing procedures in IOM Pub. 100-04, Ch. 29.	X				X							
8277.11	If a hospital has submitted a Part B claim under CMS Ruling 1455-R, then the contractor shall not issue any payment for the Part A claim in response to a fully favorable appeal decision or an effectuation notice regarding the Part A claim. The contractor shall ensure the Part A claim remains denied and shall annotate the Part A claim remarks screen to reflect a favorable appeal decision for that claim, but additional payment could not be made as a result of the submission of Part B claim(s) pursuant to Ruling CMS-1455-R.	X				X							
8277.12	Starting in June 2013 for activity beginning in March 2013, for appeals at the redetermination level, contractors shall submit a report on the 20th of each month for the previous month's activity via email to their respective Contracting Officer's Representative and Business Function Lead containing the following information: 1. # completed redeterminations subject to CMS Ruling 1455-R 2. # redetermination requests subject to CMS Ruling 1455-R withdrawn by the appellant and dismissed 3. # Part A redetermination requests dismissed by the contractor because the hospital previously filed a Part B claim under the Ruling (see, BR8277.9) 4. # Part B inpatient claims submitted subject to CMS Ruling 1455-R	X				X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	5. # Part B outpatient claims submitted subject to CMS Ruling 1455-R 6. # Part A redetermination requests received for claims subject to CMS Ruling 1455-R 7. # Part B redetermination requests received where the party is disputing a paid Part B claim billed under CMS Ruling 1455-R (see, BR8277.10) Reports shall include data for the previous month and aggregate data for previous reporting periods. Contractors shall maintain, and produce upon request, claim level data on redeterminations processed and withdrawn and dismissed for claims subject to CMS Ruling 1455-R.												
8277.13	Contractors shall also continue to submit monthly reports as outlined in TDL-13057/12309 for rebilled claims following appeals at other levels.	X				X							
8277.14	Reporting requirements set forth in CR7738 with regard to rebilled Part B claims shall continue until further notice.	X				X							
8277.15	The contractor shall designate a contact person in case additional information is requested from CMS.	X				X							
8277.16	Contractors shall update the Provider Specific File - Rebill Demonstration screen with a “Y” and an effective March 13, 2013; remove any termination dates in the Rebill Code field - to allow all hospitals and critical access hospitals (CAHs) to temporarily bill Part B claims under the methods required for such claims under the A/B Rebilling Demonstration, and as described in this CR 8277, until CR 8185 is implemented.	X				X							
8277.17	Contractors shall instruct providers to bill Part B claims as follows until CR 8185 is implemented: Providers shall submit 121 TOB claims with a treatment authorization code of 65. **NOTE:** SPN No. 65-- rebilled claims due to	X				X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	auditor denials Place the appropriate treatment authorization code into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*SPN65~ For DDE or paper Claims, Providers will be instructed to use fields: 5/MAP1715 (for DDE) or Treatment Authorization field #63 (for paper) and the following format: SPN65 The original, denied Part A inpatient claim (CCN/DCN/ICN) number, last adjudication date, and provider attestation of compliance with the requirements of Ruling CMS-1455-R shall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R For DDE or Paper Claims, The original, denied Part A inpatient DCN/CCN/ICN, last adjudication date, and provider attestation of compliance with the Ruling CMS-1455-R shall be added to the Remarks Field (form locator #80) as follows: 12345678901234-99999999-CMS1455R NOTE: The numeric strings above (12345678901234) are meant to represent original Part A inpatient claim CCN/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. The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.												

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8277.18	Contractors shall instruct providers to submit TOB 131 claims for services rendered as part of the 3 day payment window as follows until CR 8185 is implemented: The original, denied Part A inpatient claim (CCN/DCN/ICN) number, last adjudication date, and provider attestation of compliance with the requirements of Ruling CMS-1455-Rshall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R For DDE or Paper Claims, the original, denied Part A inpatient DCN/CCN/ICN and provider attestation of compliance with the requirements of Ruling CMS-1455 shall be added to the Remarks Field (form locator #80) as follows: 12345678901234-99999999-CMS1455R NOTE: The numeric strings above (12345678901234) are meant to represent original Part A inpatient claim CCN/DCN/ICN numbers from the inpatient denial and the second number string above (99999999) is meant to represent the last recent adjudication date in mmddyyyy format. The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.	X				X							
8277.19	Contractors shall manually review and bypass timely filing edits for claims that are utilizing the ECPS Mass Adjustment process in CR 8185.9 where the receipt date of the original 121 is within the 180 days of the last adjudication date found in remarks (plus an additional five calendar days for mailing). If the original claim submitted does not meet this criterion, the original claim should be cancelled and payment recouped as not timely filed and the adjustment shall not be processed for	X				X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	payment.												
8277.20	Contractors shall use the following messages when denying a Part A claim for an inpatient admission subject to the CMS Ruling 1455-R: New MSN Message 36.8 English - Your inpatient hospital stay is denied. Since you didn't know Medicare would deny these services, you aren't responsible. Your provider may resubmit this claim under Part B. You may be responsible for coinsurance and deductible for covered services. Spanish - Su estadía ha sido denegada. Ya que usted no sabía que Medicare no pagaría, usted no es responsable por el pago. Su proveedor puede enviar la reclamación nuevamente para que lo pague la Parte B. Usted tal vez tenga que pagar el coseguro y el deducible por los servicios cubiertos.	X				X							
8277.21	Contractors shall use the following messages when processing a Part B claim subject to the CMS Ruling 1455-R: New MSN Message 36.9 English - This claim for inpatient services was originally denied by Medicare and resubmitted by your provider under Part B. You're responsible for any coinsurance and deductible for covered services. Spanish - La reclamación por los servicios de su estadía fue denegada por Medicare inicialmente y fue presentada nuevamente por su proveedor para que lo cubra la Parte B. Usted tendrá que pagar el coseguro y deducible correspondiente a los servicios cubiertos.	X				X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8277.22	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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.	X				X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes 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): Maria Ramirez, 410-786-1122 or Maria.Ramirez@cms.hhs.gov, David Danek, 617-565-2682 or David.Danek@cms.hhs.gov, Fred Rooke, 404-562-7205 or Fred.Rooke@cms.hhs.gov

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.

Attachments (3)

Attachment 1

Model Dismissal Notice

Order of Dismissal Pursuant to CMS Ruling 1455-R: Dismissal in Response to a Request for Withdrawal

MONTH, DATE, YEAR

Medicare Number of Beneficiary:
111111111 A

APPELLANT'S NAME

ADDRESS

CITY, STATE ZIP

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

Re: Include claim identifier of appeal number
Beneficiary name
Dates of Service

Dear Appellant's Name or Representative:

This letter is in response to your request to withdraw the appeal of a Part A inpatient admission claim denial subject to CMS Ruling 1455-R. Consistent with your request and CMS Ruling 1455-R your request for appeal is hereby dismissed.

As a result of this dismissal action, you may take either of the following actions:

(1) Submit Part B inpatient and/or outpatient claims. Under CMS Ruling 1455-R, you will have 180 calendar days from the date that you receive this notice to submit claims for (a) reasonable and necessary Part B inpatient services that would have been payable had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, (for example, outpatient visits, emergency department visits, and observation services); and/or (b) reasonable and necessary Part B outpatient services that would have normally been bundled with the inpatient stay, including observations services, which were furnished within the 3 calendar day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission. (See the CMS Ruling for important details on documentation requirements, what services may be claimed, and when to submit the claim.) OR

(2) Request we vacate the dismissal, or request a reconsideration of the dismissal. If you disagree with this dismissal, you may submit a request to vacate this dismissal, or request a reconsideration of this dismissal by a Qualified Independent Contractor. However, please note that you may not file Part B inpatient and/or outpatient claims in accordance with CMS Ruling 1455-R while you have a pending appeal of a Part A inpatient admission denial.

If you would like us to vacate this dismissal, your request must be received by this office at the address above within 6 months of the date of receipt of this notice. Alternatively, if you think we have incorrectly dismissed your request, you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within **60 days** of receipt of this notice. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

Insert QIC Address

Sincerely.

Reviewer Name

Contractor Name

A Medicare Contractor

Attachment 2

Templates

MEDICARE REDETERMINATION NOTICE (MRN) – MAC DECISION

ADDITIONAL LANGUAGE TO BE INCLUDED AT THE END OF THE MRN.

CMS Ruling 1455-R MRN Language

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued CMS-Ruling 1455-R. The CMS Ruling was published at Volume 78 page 16614 of the Federal Register on March 18, 2013, and is also available on the CMS website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf

CMS Rulings are binding on Medicare Administrative Contractors (MACs) pursuant to 42 C.F.R. sections 401.108 and 405.1063. The CMS Ruling applies to denials of certain Medicare Part A inpatient hospital admissions that were determined to be not reasonable and necessary, and allows for billing under Part B as summarized below.

Please note: In accordance with CMS Ruling 1455-R, 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 claim for an inpatient admission, the hospital cannot also maintain its request for payment for the same services on the Part A claim**.** A hospital must either choose to no longer pursue an appeal of the Part A claim denial or must withdraw any pending appeal request on the Part A claim denial prior to the submission of the Part B claim

As a result of this unfavorable appeal decision, you may take either of the following actions:

(1) **Submit Part B inpatient and/or outpatient claims**. Under CMS Ruling 1455-R, you will have 180 calendar days from the date that you receive this notice to submit claims for (a) reasonable and necessary Part B inpatient services that would have been payable had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status (for example, outpatient visits, emergency department visits, and observation services); and/or (b) reasonable and necessary Part B outpatient services that would have

normally been bundled with the inpatient stay, including observations services, which were furnished within the 3 calendar day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission. (See the CMS Ruling for important details on documentation requirements, what services may be claimed, and when to submit the claim.) OR

(2) **Continue to appeal your Part A claim under existing procedures in 42 CFR Subpart I.** Additional information on filing a reconsideration request is included with this decision and a form is attached. Please note that in accordance with CMS Ruling 1455-R, you may not file a Part B inpatient and/or outpatient claims while you have a pending Part A inpatient admission claim appeal.

Any subsequent appeal of a Part A claim subject to CMS Ruling 1455-R filed after a Part B claim is submitted will be dismissed in accordance with the Ruling.
Attachment 3

Model Dismissal Notice

Order of Dismissal Pursuant to CMS Ruling 1455-R: Invalid Part A Appeal Request When a Part B Claim Has Been Submitted

MONTH, DATE, YEAR

Medicare Number of Beneficiary:
111111111 A

APPELLANT'S NAME

ADDRESS

CITY, STATE ZIP

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

Re: Include claim identifier of appeal number
Beneficiary name
Dates of Service

Dear Appellant's Name or Representative:

This letter is in response to your request for a redetermination for a Part A claim subject to CMS Ruling 1455-R. We have determined that a Part B inpatient claim for the same beneficiary and the same dates of service has already been processed. In accordance with CMS Ruling 1455-R, a hospital may not file an

appeal request for a Part A inpatient admission denial when it has filed a Part B claim for the same beneficiary and the same dates of service. Therefore, we are dismissing your appeal request.

If you disagree with this dismissal, you have two options:

1. You may request that we vacate our dismissal. Your request to vacate this dismissal must be received by this office at the address above within 6 months of the date of receipt of this notice.

2. If you think we have incorrectly dismissed your request, you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this notice. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

Insert QIC Address