Quick Reference: Temporary Instructions for Submitting Part B claims Under Administrator Ruling CMS-1455-R

On March 13, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Ruling CMS-1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a Part A claim for an inpatient admission as not reasonable and necessary.

A copy of the ruling can be found at the following link:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf

CMS Ruling 1455-R Fact Sheet can be found at the following link:
http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4558

CMS has issued instructions to contractors to address the automation of claims processing which will be implemented in the July 2013 quarterly system release.

Until this process is implemented, providers shall follow these Temporary Instructions for the Part B Type of Bill (TOB) 12x.

For electronic submissions, providers are instructed to place the appropriate (pre-authorized) code into Loop 2300 REF02 (REF01 = G1). Please note, the loop and segment are included for billing purposes, but only SPN65 needs to be present in the field:

REF*G1*SPN65~

(The above code shall not include any spaces, and should appear as SPN65)

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format:

NTE*ADD*12345678901234-99999999-CMS1455R~

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the

provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: 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.

For DDE or Paper Claims, Providers are instructed to use fields: 5/MAP1715 (for DDE) or first line of the Treatment Authorization field #63 (for paper) and the following format:

SPN65 (the code shall not include any spaces, and should appear as SPN65)

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be added to the Remarks Field (form locator #80) on the claim in the format:

12345678901234-99999999-CMS1455R

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: 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.

Providers shall follow these Temporary Instructions for the Part B Type of Bill (TOB) 13x.

For electronic submissions, providers are instructed to place the appropriate remarks:

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format:

NTE*ADD*12345678901234-99999999-CMS1455R~

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: 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.

<u>For DDE or Paper Claims</u>, Providers are instructed to place the appropriate remarks:

The original, denied inpatient claim (CCN/DCN/ICN) number, last adjudication date, and "CMS1455R" shall be added to the Remarks Field (form locator #80) on the claim in the format:

12345678901234-99999999-CMS1455R

The numeric strings above (12345678901234) are meant to represent original claim CCN/DCN/ICN numbers from the inpatient denial, the second number string above (99999999) is meant to represent the last adjudication date in mmddyyyy format, and the "CMS1455R" is the provider's validation that there is no appeal in process for the services being billed and the provider has complied with all other requirements in the Administrator's Ruling, CMS-1455-R.

NOTE: 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.

Please Note:

- The hospital may submit a Part B inpatient claim (12x) for the Part B 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 where those services specifically require an outpatient status such as outpatient visits, emergency department visits, observation services, that are, by definition, provided to hospital outpatients and not inpatients. Consistent with existing Medicare policy, where no Part A payment is made because the inpatient admission is denied as not reasonable and necessary, hospitals may bill separately for outpatient services (13x) provided in the three-day 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. See Section 10.12, Chapter 4 of the Medicare Claims Processing Manual (Pub. 100-04). Because services provided during the three-day payment window are outpatient services, they cannot be included on the Part B inpatient claim. Instead, hospitals should bill for these services on a Part B outpatient claim in accordance with this policy.

- For the Part B 12x claim, the hospital will be initially be paid at 90% of the net amount that would be payable (after subtracting deductibles and co-insurance) if the provider had originally submitted the claim as outpatient services based on the OPPS Pricer amount or lab fee amount. (For Maryland Waiver providers, the 90% will be based on the outpatient

payment that would have been available if the claim were originally paid as an outpatient claim for payment.) Payments are claim, not line, level. When CR 8185 is implemented in July, contractors will mass adjust all TOB 12x rebilling claims that were processed under this temporary methodology for full Medicare payment.

Claim Examples

Since the billing concepts are new to most providers, we have provided sample claims for the most common scenarios of billing Part B claims under CMS Ruling 1455R. This concept can be applied to any of the scenarios that require split billing.

131 BILLING EXAMPLE #1

SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW

Field	Value
4 TYPE OF BILL	0131
6. STATEMENT COVERS PERIOD FROM	03312012
6. STATEMENT COVERS PERIOD THROUGH	04012012
8 PATIENT NAME (a)	MEDICARE SMITH
50 PAYER NAME (A)	MEDICARE
52 REL INFO	Y
53 ASG BEN	Y
56 NPI	9876543210
58 INSURED'S NAME (A)	SMITH, MEDICARE
59 P. REL	18
60 INSURED'S UNIQUE ID	987654321A
80 REMARKS	12345678901234-03152013-CMS1455R (DCN) (LAST ADJUCATION DATE) (ATTESTATION)

PAGE __1__ OF __1__ CREATION DATE TOTALS

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

SUBSEQUENT RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY. THE PROVIDER APPEALED THIS DECISION. DURING THE REVIEW PROCESS CMS 1455R BECAME EFFECTIVE. THE PROVIDER RECEIVED A 1ST LEVEL APPEAL DECISION DATED 03-15-2013 AND THE PROVIDER DECIDED NOT TO APPEAL TO THE 2ND LEVEL.

THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE APPEAL DECISION TO FILE PART B CLAIMS UNDER RULING CMS-1455-R.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEF

121 BILLING EXAMPLE #1

Field	Value
4 TYPE OF BILL	0121
6. STATEMENT COVERS PERIOD FROM	04012012
6. STATEMENT COVERS PERIOD THROUGH	04022012
8 PATIENT NAME a	MEDICARE SMITH
42 REV. CD. / 43 DESCRIPTION / 44 HCPCS/RATES/HPPS CODE / 45 SERV. DATE / 46 SERV. UNITS / 47 TOTAL CHARGES / 48 NON-COVERED CHARGES / 49	
PAGE	PAGE __1__ OF __1__
CREATION DATE	
TOTALS	
50 PAYER NAME A	MEDICARE
52 REL INFO A	Y
53 ASG BEN A	Y
56 NPI	9876543210
58 INSURED'S NAME A	SMITH, MEDICARE
59 P. REL A	18
60 INSURED'S UNIQUE ID A	987654321A
63 TREATMENT AUTHORIZATION CODES A	SPN65
80 REMARKS	12345678901234-03152013-CMS1455R
	(DCN) (LAST ADJUCATION DATE) (ATTESTATION)

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

SUBSEQUENT RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY. THE PROVIDER APPEALED THIS DECISION. DURING THE REVIEW PROCESS CMS 1455R BECAME EFFECTIVE. THE PROVIDER RECEIVED A 1ST LEVEL APPEAL DECISION DATED 03-15-2013 AND THE PROVIDER DECIDED NOT TO APPEAL TO THE 2ND LEVEL.

THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE APPEAL DECISION TO FILE PART B CLAIMS UNDER RULING CMS-1455-R.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

131 BILLING EXAMPLE #2

SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW

Field	Value
4 TYPE OF BILL	0131
6. STATEMENT COVERS PERIOD FROM	03312012
6. STATEMENT COVERS PERIOD THROUGH	04012012
8 PATIENT NAME	MEDICARE SMITH
50 PAYER NAME (A)	MEDICARE
52 REL INFO	Y
53 ASG BEN	Y
56 NPI	9876543210
58 INSURED'S NAME (A)	SMITH, MEDICARE
59 P. REL	18
60 INSURED'S UNIQUE ID	987654321A
80 REMARKS	12345678901234-02152013-CMS1455R

(DCN) (LAST ADJUCATION DATE) (ATTESTATION)

PAGE __1__ OF __1__ CREATION DATE TOTALS

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY AND THE MEDICARE ADMINISTRATIVE CONTRACTOR ISSUED A DENIAL ON A REMITTANCE ADVICE DATED FEBRUARY 15, 2013. CMS 1455-R BECAME EFFECTIVE ON MARCH 13, 2013. THE RULING APPLIES TO THE DENIAL. THE PROVIDER MAY EITHER (1) APPEAL THE DENIAL WITHIN 120 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE, OR (2) THE PROVIDER MAY SUBMIT ITS PART B CLAIM(S) WITHIN 180 DAYS OF THE DATE OF RECEIPT OF THE REMITTANCE ADVICE. THE DATE OF RECEIPT IS PRESUMED TO BE 5 DAYS AFTER THE DATE PRINTED ON THE REMITTANCE ADVICE. THE PROVIDER MAY NOT BOTH APPEAL THE DENIAL AND SUBMIT PART B CLAIMS.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

121 BILLING EXAMPLE #2

UB-04 claim form (filled fields):

- 4 TYPE OF BILL: 0121
- 6. STATEMENT COVERS PERIOD — FROM: 04012012 THROUGH: 04022012
- 8 PATIENT NAME (a): MEDICARE SMITH
- PAGE __1__ OF __1__ CREATION DATE TOTALS
- 50 PAYER NAME (A): MEDICARE
- 52 REL INFO (A): Y
- 53 ASG BEN (A): Y
- 56 NPI: 9876543210
- 58 INSURED'S NAME (A): SMITH, MEDICARE
- 59 P. REL (A): 18
- 60 INSURED'S UNIQUE ID (A): 987654321A
- 63 TREATMENT AUTHORIZATION CODES (A): SPN65
- 80 REMARKS: 12345678901234-02152013-CMS1455R
  (DCN) (LAST ADJUCATION DATE) (ATTESTATION)

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

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UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

131 BILLING EXAMPLE #3

SERVICES PROVIDED DURING THE 3-DAY PAYMENT WINDOW

4 TYPE OF BILL: 0131

6. STATEMENT COVERS PERIOD FROM: 03312012 THROUGH: 04012012

8 PATIENT NAME: MEDICARE SMITH

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

SUBSEQUENT RECOVERY AUDITOR CONTRACTOR REVIEW DETERMINED THAT THE INPATIENT ADMISSION WAS NOT REASONABLE AND NECESSARY. THE PROVIDER APPEALED THIS DECISION. DURING THE APPEALS PROCESS CMS-1455-R BECAME EFFECTIVE. THE PROVIDER REQUESTED A WITHDRAWAL OF THEIR APPEAL AND THE CONTRACTOR ISSUED A DISMISSAL NOTICE DATED 04-15-2013.

THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE DISMISSAL NOTICE TO SUBMIT THE PART B CLAIMS. THE DATE OF RECEIPT OF THE DISMISSAL NOTICE IS PRESUMED TO BE 5 DAYS FROM THE DATE ON THE NOTICE.

PAGE 1 OF 1 — CREATION DATE — TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A MEDICARE		Y	Y			9876543210

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A SMITH, MEDICARE	18	987654321A		

80 REMARKS:
12345678901234-04152013-CMS1455R
(DCN) (LAST ADJUCATION DATE) (ATTESTATION)

121 BILLING EXAMPLE #3

UB-04 CMS-1450

Field	Value
4 TYPE OF BILL	0121
6. STATEMENT COVERS PERIOD FROM	04012012
6. STATEMENT COVERS PERIOD THROUGH	04022012
8 PATIENT NAME a	MEDICARE SMITH
23	PAGE __1__ OF __1__
50 PAYER NAME A	MEDICARE
52 REL INFO A	Y
53 ASG BEN A	Y
56 NPI	9876543210
58 INSURED'S NAME A	SMITH, MEDICARE
59 P. REL A	18
60 INSURED'S UNIQUE ID A	987654321A
63 TREATMENT AUTHORIZATION CODES A	SPN65
80 REMARKS	12345678901234-04152013-CMS1455R (DCN) (LAST ADJUCATION DATE) (ATTESTATION)

THE PATIENT, MEDICARE SMITH, WENT TO THE ED OF THE HOSPITAL ON 03-31-2012 AND RECEIVED OBSERVATION SERVICES. THE PATIENT WAS ADMITTED ON 04-01-2012 TO THE HOSPITAL AND DISCHARGED ON 04-02-2012.

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THE PROVIDER HAS 180 DAYS FROM THE DATE OF RECEIPT OF THE DISMISSAL NOTICE TO SUBMIT THE PART B CLAIMS. THE DATE OF RECEIPT OF THE DISMISSAL NOTICE IS PRESUMED TO BE 5 DAYS FROM THE DATE ON THE NOTICE.