



Test Your Medicare Claims Now! After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

MLN Matters Number: MM5907

Related Change Request (CR) #: 5907

Related CR Release Date: February 8, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1446CP

Implementation Date: July 7, 2008

Update to Common Working File (CWF) Edits 7284 and 7548

Note: This article was updated on July 6, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Indian Health Service (IHS) or Tribal Hospitals billing Medicare contractors (Medicare Administrative Contractors (A/B MACs) or Fiscal Intermediaries (FIs)) for services provided to American Indian/Alaskan Native (AI/AN) Medicare beneficiaries admitted to an IHS/Tribal facility for social reasons.

Impact on Providers

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5907 in order to clarify instructions for IHS or Tribal Hospitals regarding payment methodology for social admissions and outpatient services rendered at separate facilities.

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Background

CR 3452, Transmittal 596 issued on June 24, 2005 implemented instructions to edit IHS and tribal facility claims for social admissions. A related MLN Matters article may be reviewed by going to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3452.pdf> on the CMS website.

Key Points of CR5907

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, Type of Bill (TOB) 12X during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13X or 72X. The CWF returns an A/B crossover edit and an IUR is created in any of these situations.

- The IUR 7284 is created for type of bill (TOB) 12X with an IHS provider number when the date of service on the claim is equal to or overlaps a claim in history with TOB 13X or 72X.
- The IUR 7548 is created for TOB 12X with an IHS provider number with a line item date of service is equal to or the day following the discharge date on a TOB 11X.
- The IURs 7284 or 7548 are bypassed when the beneficiary was not entitled to Medicare Part A at the time the services on TOB 12X were rendered.

Additional Information

To see the official instruction (CR5907) issued to your Medicare FI or A/B MAC, refer to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1446CP.pdf> on the CMS website.

If you have questions, please contact your Medicare FI or A/B 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. .

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