

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



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October 1, 2013

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### Implementing the Part B Inpatient Payment Policies from CMS-1599-F

**Note: This article was revised on September 22, 2013 to add a link to MLN Matters® article SE1333. 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. MM8445 was previously updated to add a link to MM8666 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8666.pdf>) as a companion piece which implements revised policies relating to the payment of hospital Part B inpatient services. All other information is unchanged.**

#### Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Claims Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

#### Provider Action Needed

This article is based on Change Request (CR) 8445 which provides details regarding the implementation of payment policies related to hospital Part B inpatient billing from the final regulation CMS-1599-F. Make sure that your billing staffs are aware of these changes.

#### Disclaimer

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## Background

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The Centers for Medicare & Medicaid Services (CMS) issued the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) /Long-Term Care Hospital (LTCH) Final Rule (CMS-1599-F; CMS-1455-F) on August 19, 2013, in which CMS finalized a policy to provide additional payment under Medicare Part B for hospital inpatient services when a hospital inpatient admission is determined not reasonable and necessary for payment under Medicare Part A, and the beneficiary should have been treated as a hospital outpatient. You can find the CMS “FY 2014 IPPS/LTCH Final Rule Home Page” at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html> on the CMS website.

Change Request (CR) 8445 provides claims processing guidance related to the implementation of this policy for all hospitals and critical access hospitals (CAHs). CR 8445 contains related revisions to the Medicare Claims Processing Manual (Pub. 100-04), and CMS will issue companion revisions to the Medicare Benefit Policy Manual (Pub. 100-02) in a separate release.

### **Payment of Part B Inpatient Services**

When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired. The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. In this document and in CR8445, the term “hospital” includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

This policy applies when a hospital 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 must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a “no pay” Part A claim indicating that the provider is liable under section 1879 of the Social Security Act for the cost of the Part A services. The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the

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beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

Those services that specifically require an outpatient status includes those that are, by definition, provided to hospital outpatients and not inpatients, including:

- Hospital outpatient visits (emergency department and clinic visits);
- Observation services;
- Diabetes Self-Management Training Services.

Hospitals may not bill for inpatient routine services in a hospital. Inpatient routine services generally are those services included by the provider in a daily service charge – sometimes referred to as the “room and board” charge.

Payable and non-payable services are further described in the update of the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital – Including Inpatient Hospital Part B and OPSS); Section 240 which is attached to CR8445.

Part B inpatient services are billed using the 12X TOB.

For Part B inpatient services furnished by the hospital that are not paid under the OPSS, but rather under some other Part B payment mechanism, Part B inpatient payment will 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. All hospitals billing Part A services are eligible to bill the Part B inpatient services, including

- Short-term acute-care hospitals paid under the 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 continue billing the OPSS for Part B inpatient services.

Hospitals that are excluded from payment under the OPSS in Title 42 of the Code of Federal Regulations (CFR) Section 419.20(b) are eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies. For more information regarding 42 CFR 419.20(b), refer to <http://www.ecfr.gov/cgi-bin/text->

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[idx?c=ecfr&SID=f0a3c4c0d051e60e0bf1fe559cc9dfdf&tpl=/ecfrbrowse/Title42/42cfr419\\_main\\_02.tpl](http://www.cms.gov/medicare/coverage/coverage-articles/2012/01/120101a.html) on the Internet.

### **Other Circumstances When Part A Payment Cannot Be Made**

CMS notes that there are no changes to the policies for billing Part B under other circumstances when Part A payment cannot be made. For example, 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 a limited set of ancillary Part B inpatient services. Some of these services are typically packaged for payment under the OPPI, and the primary service into which they are packaged is not payable. In these circumstances, CMS will provide separate payment for the ancillary Part B inpatient service. For example, hospitals should continue to use HCPCS code C9899 created by CMS to obtain separate payment under this provision for certain implantable prosthetic devices which replace all or part of an internal body organ and do not have pass-through payment status. However CMS revised the Medicare Claims Processing Manual Ch. 4 Sec. 240 to specify that this code should *not* be used when billing Part B following a reasonable and necessary Part A denial, because the primary service (the implantation surgery) is a payable Part B inpatient service and payment of the device is packaged with the surgery.

### **Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A**

Medicare continues the current policy allowing hospitals to bill Part B for services furnished by the hospital that were bundled into the original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission. CMS revised the manual to clarify that if these services were furnished by the hospital (including referred hospital lab tests), they may be billed to Part B. CMS is clarifying that both 13X (85x for CAH) and 14X TOB may be submitted for payment of these services, subject to the revised manual instructions.

### **Timely Filing and Supporting Documentation**

Timely filing restrictions will apply for the Part B services billed. Therefore, Part B claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid. Hospitals are required to maintain documentation to support the services billed on the Part B claim(s).

### **Provider and Beneficiary Liability**

A “no-pay” provider-liable Part A claim (110 TOB) must be present in the claims history before accepting the Part B claim(s) for payment. The no-pay Part A claim indicates that the provider and not the beneficiary is liable under the Social Security Act (Section 1879; see [http://www.socialsecurity.gov/OP\\_Home/ssact/title18/1879.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1879.htm)) for the cost of the Part A services. Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A. When a Medicare review contractor

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denies a Part A claim for medical necessity, the claims system converts the originally submitted 11X claim to a 110 TOB on behalf of the hospital. When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished. The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, "Beneficiary Determined to Be Without Liability" and 30.2.2, "Provider/Practitioner/Supplier is Determined to Be Liable" of the Medicare Claims Processing Manual).

If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the services they received, the beneficiary may face greater cost sharing.

#### **Summary of Business Requirements for CR 8445:**

- MACs will ensure that provider submitted medical necessity denial claims contain the Occurrence Span Code "M1" and dates on the inpatient claim.
  - Hospital part B Inpatient service claims that are billed after a Medical Necessity denial should contain the following data elements:
    - A treatment authorization code of A/B Rebilling submitted by a provider.
      - **NOTE: Providers submitting an 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~
        - **For DDE or paper Claims**, "A/B Rebilling" will be added in FL 63.
- A condition code "W2" attesting that this is a rebilling and no appeal is in process, and
  - The original denied inpatient claim (CCN/DCN/ICN) number, and
    - **NOTE: Providers submitting an 837I** will be instructed to place the DCN in the Billing Notes loop 2300/NTE in the format:  
NTE\*ADD\*ABREBILL12345678901234~

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- **For DDE or paper Claims**, Providers will be instructed to use the word “ABREBILL” plus the denied inpatient DCN/CCN/ICN will 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.

- MACs will Return to Provider a TOB 121 A/B Rebilling claim that does not have a medical denied 11x claim in history that matches the DCN in remarks.
- MACs will dismiss redetermination requests of Part A 11x claims if the provider has previously billed a 121 A/B rebilling claim. However, contractors will accept appeal requests of A/B rebilled 121 claims.
- Medicare will not allow observation services (Revenue Code 762), and outpatient visits (Revenue Codes 45x and 51x) to be billed on the A/B rebilling 121 TOB claim. (This includes G0738, G0739, 99201-99215, 99281-99285, G0380-G0384, and G0463.)
- Additionally, Medicare's claims processing systems will set edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed as follows:

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390		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.

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## Additional Information

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The official instruction, CR8445 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2877CP.pdf> on the CMS website.

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 can review the FY 2014 IPPS/LTCH Final Rule (CMS-1599-F; CMS-1455-F) displayed in the Federal Register Vol. 78, No. 160 dated August 19, 2013 at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> on the CMS website.

You may also want to review MLN Matters® Article SE1333, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1333.pdf> on the CMS website.

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