DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8277	Related Change Request (CR) #: CR 8277
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Related CR Transmittal #: R1247OTN	Implementation Date: July 1, 2013

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

Provider Types Affected

This MLN Matters® Article is intended for hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and Part A Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What you Need To Know

This article is based on Change Request (CR) 8277, which provides the instructions for implementing CMS Ruling 1455-R (the Ruling) until the operating instructions in CR 8185 are implemented. The Ruling permits you to bill for Part B services when an inpatient Part A claim is denied by a Medicare contractor for the reason that the inpatient admission was not reasonable and necessary. The Ruling provides an interim policy to address certain Part A appeal decisions by Administrative Law Judges (ALJs) and the Medicare Appeals Council, while CMS establishes permanent policy changes through notice and comment rulemaking under CMS-1455-P, issued concurrently with CMS-1455-R.

Background

- On March 13, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1455-R (the Ruling) which establishes an interim process for hospitals to bill Medicare for Part B inpatient and/or outpatient services following a denial of a Part A claim on the basis that an inpatient admission was not reasonable and necessary. (You can find this Ruling at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf on the CMS website).
- Subsequently, CMS issued CR 8185 – Administrative Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims, on March 22, 2013, which sets forth the requirements for Medicare contractors to implement the Ruling, effective for claims processed after July 1, 2013. (The associated MLN Matters® Article can be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8185.pdf on the CMS website).
- CR 8277, from which this article is taken, provides the instructions for implementing the Ruling until such time as the operating instructions in CR 8185 are implemented.

CMS Ruling 1455R

The Ruling established an interim process for hospitals to bill Medicare for Part B inpatient and/or outpatient services following a denial of a Part A inpatient admission claim as not being reasonable and necessary. As explained in the Ruling, in an increasing number of cases, hospitals that have appealed Part A inpatient claim denials to Administrative Law Judges (ALJs) and to the Medicare Appeals Council have received decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, but also 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. (Detailed information regarding the agency's previous policy is included for your reference in the Ruling and in CR 8277.) While decisions issued by the ALJs and the Medicare Appeals Council do not establish Medicare payment policy, Medicare is 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, and establishes a standard, interim policy for effectuating these decisions until CMS establishes a final policy on the issue through notice and comment rulemaking.

The policy announced in the Ruling: 1) became effective upon issuance; 2) supersedes any other statements of policy on the issues therein; and 3) remains in effect until the effective date of the final regulations for the currently issued proposed rule, CMS-1455-P, "Medicare Program; Part B Billing in Hospitals", issued concurrently with the Ruling. (You can find CMS-1455-P in the Federal Register / Vol. 78, No. 52 / Monday, March 18, 2013 / Proposed Rules at www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf on the Internet.

When Does This Ruling Apply?

CMS Ruling 1455-R only applies to denials of Part A hospital inpatient claims when the inpatient admission was determined to be not reasonable and necessary by a Medicare review contractor (provided payment was not made under the waiver of liability provision (Section 1879 of the Act), and repayment of any Part A overpayment was not waived (Section 1870 of the Act)).

In this situation, under the Ruling, you may submit a Part B inpatient claim for all Part B services that would have been payable to you had the beneficiary originally been treated as an a hospital outpatient rather than admitted as an a hospital inpatient, except when those services specifically require an outpatient status (for example, outpatient visits, emergency department visits, and observation services).

Note: The services requiring an outpatient status cannot be billed for the period of time that the beneficiary was an inpatient, and cannot be included on the Part B inpatient claim.

The Ruling applies to the claim denials described above 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 (March 13, 2013); or 3) prior to the effective date of the Ruling (March 13, 2013), but for which an appeal is pending. It does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal had expired prior to the Ruling's effective date, nor does it apply to inpatient admissions that the hospital, itself, deemed 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 provides you with notice of your right to submit Part B claims following the denial of a claim for a Part A hospital inpatient admission as described above, provided you withdraw 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, your Medicare contractor will continue processing all pending Part A appeals that are subject to the Ruling. Your withdrawal request must identify the claims being appealed and explain that the appeal request is being withdrawn so you may submit Part B claim(s) in accordance with the Ruling. **Medicare contractors will use the model language in the draft dismissal notice in Attachment 1 in CR 8277 when dismissing an appeal in response to a withdrawal request.**

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 is available to

appellants on the Office of Medicare Hearings and Appeal's (OMHA's) public website at http://www.hhs.gov/omha on the Internet.

If your Medicare contractor determines that you have 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 will be denied as a duplicate and the Part A appeal will continue. Once a Part B claim under the Ruling is submitted, 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 submission of a Part B claim under the Ruling, no additional payment will 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, you 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 you have submitted a claim, your 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 you submit an appeal of a determination that a Part A hospital inpatient admission was not reasonable and necessary, the only issue before an adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim, 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, you must 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, you 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/or 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 CR 8185 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 in CR 8277, restated in the section titled, "Claims Submission Instructions for Part B

Inpatient Claims", below. You will initially be paid the amount that would have been paid under the demonstration, i.e., at 90 percent of the net amount that would be payable (after subtracting deductibles and co-insurance) if you 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 percent 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.

Medicare contractors have been instructed to update the Provider File to allow you the ability to bill under these methods which were used for the A/B Rebilling Demonstration, and will remove any termination dates in the Rebill Code field. Additionally, contractors will bypass timely filing edits on Part B outpatient claims (Type of Bill 13x) when billed using the instructions in CR 8277. Medicare contractors will no longer accept claims with a treatment authorization code of "SPN66" indicating that the claim is being rebilled due to a hospital self-audit, because the provisions of the Ruling do not apply to hospital self-audit.

Time Period for Submitting Part B Bills

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). (You can find more information about the timing of such claims in the MLN Matters® Article MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months (released May 7, 2010), which you can find at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6960.pdf on the CMS website).

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

2. If you have a pending appeal for a Part A hospital inpatient claim denial subject to the Ruling, and you do not withdraw your appeal, you have 180 days from the date of receipt of the final or binding unfavorable appeal decision (or subsequent dismissal notice following a withdrawal) to submit your Part B claim(s). For example, you receive an unfavorable reconsideration decision but decide 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 you receive 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, you 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 your Part B claim(s).

   Note: 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.

As noted in the model language in CR 8277's Attachment 2 (Medicare Redetermination Notice (MRN) – MAC Decision), your FI or MAC will include additional language in the Medicare Redetermination Notice explaining your available options for submitting Part B claim(s), which are to either: 1) submit Part B inpatient and/or outpatient claims; or 2) continue to appeal your Part A claim under existing procedures in 42 CFR Part 405 Subpart I.

Some Additional Important Information Regarding Pending Appeals

- If your Medicare contractor determines that you have submitted a Part B inpatient and/or outpatient claim under the Ruling for the same beneficiary and the same dates of service, they will dismiss a request for redetermination for a Part A claim consistent with the provisions of the Ruling, using the model language in the dismissal notice provided in CR 8277's Attachment 3 -- Order of Dismissal Pursuant to CMS Ruling 1455-R: Invalid Part A Appeal Request When a Part B Claim Has Been Submitted.
- If you have submitted a Part B claim under the Ruling, and a party subsequently files a request for redetermination of the Part B inpatient claim, the contractor will process the appeal request in accordance with existing procedures in the "Medicare Claims Processing Manual", Chapter 29 (Appeals of Claims Decisions) available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf on the CMS website.
- If you have submitted a Part B claim under the Ruling without withdrawing a pending Part A appeal, your Medicare contractor will not issue any payment for the Part A inpatient admission in response to a fully favorable appeal decision or an effectuation notice regarding the admission. The Ruling requires that all Part A appeals must be withdrawn prior to the submission of a Part B claim.

Claims Submission Instructions for Part B Inpatient Claims

Until CR 8185 is implemented, for Part B claims:

1. Submit 121 TOB (Hospital, Inpatient (Medicare Part B only, Admit thru Discharge Claim)) claims with a demonstration code SPN No. 65 (Rebilled claims due to auditor denials).
2. Place the appropriate treatment authorization code into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*SPN65~

   For DDE or paper Claims, 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 will be included in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R.

3. For DDE or Paper Claims, include the original, denied Part A inpatient DCN/CCN/ICN, last adjudication date, and provider attestation of compliance with the Ruling CMS-1455-R to the Remarks Field (form locator #80) as follows: 12345678901234-99999999-CMS1455R.

   Note: The numeric string above (12345678901234) is 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.

Note: Your FI or MAC will manually review and bypass timely filing edits for claims in which the receipt date of the original 121 TOB is within the 180 days of the last adjudication date found in remarks (plus an additional five calendar days for mailing).

Claims Submission Instructions for Part B Outpatient Claims

Until CR 8185 is implemented, for claims for services rendered as part of the 3 day payment window:

1. Submit TOB 131 (Hospital, Outpatient, Admit thru Discharge Claim).

2. Include 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 in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R.

3. For DDE or Paper Claims, include the original, denied Part A inpatient DCN/CCN/ICN and provider attestation of compliance with the requirements of Ruling CMS-1455 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.

Additional Information

The official instruction, CR 8277 issued to your FI or MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1247OTN.pdf on the CMS website.

If you have any questions, please contact your FI or 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.