

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4259	Date: March 22, 2019
	Change Request 11181

SUBJECT: Billing for Hospital Part B Inpatient Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide billing instructions for hospital Part B inpatient services.

EFFECTIVE DATE: October 1, 2013

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 21, 2019

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
R	4/240.1/ Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
R	4/240.2/ Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A

III. FUNDING:

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 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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SUBJECT: Billing for Hospital Part B Inpatient Services

EFFECTIVE DATE: October 1, 2013

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I. GENERAL INFORMATION

A. Background: Medicare pays for hospital (including CAH) inpatient Part B services in the circumstances provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, § 10 (“Medical and Other Health Services Furnished to Inpatients of Participating Hospitals”). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in chapter 1, §70 of Medicare Claims Processing Manual.

B. Policy: No policy is being updated.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
11181.1	A/B MACs (Part A) should be aware of the policy regarding billing for hospital Part B inpatient service claims.	X									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E M A C	C E D I		
		A	B	H H H				
11181.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09	X						

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C M E D I
		A	B	H H H		
	Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

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): Fred Rooke, fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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: 0

240.1 - Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

(Rev. 4259, Issued: 03-22-19, Effective: 10-01-13, Implementation: 06-21-19)

When inpatient services are denied as not medically necessary or a provider submitted medical necessity denial utilizing occurrence span code “M1”, and the services are furnished by a participating hospital, Medicare pays under Part B for physician services and the non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.1, “Reasonable and Necessary Part A Hospital Inpatient Claim Denials.”

A hospital may also be paid for Part B inpatient services if it 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 would be required to adjust its Part A claim (to make the provider liable) prior to submitting a claim for payment of Part B inpatient services. Whether or not the hospital had submitted a claim to Part A for payment, we require the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

The claims processing system shall set edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

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.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: M28
MSN: 21.21

CWF shall edit to ensure that DSMT services are not billed on a 12x claim.

Hospitals are required to report HCPCS codes that identify the services rendered.

240.2 - Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A

(Rev. 4259, Issued: 03-22-19, Effective: 10-01-13, Implementation: 06-21-19)

When Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his

or her Part A benefits, or receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	0250
0251	0252	0253	0256	0257	0258	0259	0261
0269	0270	0273	0277	0279	028x	029x	0360
0362	0367	0369	0370	0374	0379	038x	039x
041x	045x	0470	0472	0479	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	056x	057x	058x	059x	060x
0620	0623	0624	0630	0631	0632	0633	0637
064x	065x	066x	067x	068x	069x	072x	0760
0762	079X	081x	082x	083x	084x	085x	088x
090x	091x	093x	094x	095x	0960	0961	0962
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.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
 CARC: 96
 RARC: M28
 MSN: 21.21

Hospitals are required to report HCPCS codes that identify the services rendered.