



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 12: Inpatient Utilization Review and Notices

I. Inpatient Utilization Review

A. The UR Committee

1. The *Conditions of Participation* require the UR committee consist of at least two Doctors of Medicine or osteopathy and other specified practitioners. <See 42 C.F.R. 482.30(b)>

Non-physician practitioners that may be on the UR committee, include:

- Doctor of Dental Surgery or dental medicine
- Doctors of podiatric medicine
- Doctor of Optometry
- Chiropractors
- Clinical psychologists

B. Four Requirements for Determinations by the UR Committee

1. The UR committee must offer the attending physician or NPP an opportunity to present their views prior to making a determination an admission is not medically necessary. <See 42 C.F.R 482.30(d)(2)>
2. One member of the UR committee may make the determination an admission is not medically necessary if the patient's attending physician or NPP concurs with the determination or does not present their views. <See 42 C.F.R. 482.30(d)(1)(i), see *MLN Matters Article SE0622, Background*>
3. Two members of the UR committee must make the determination an admission is not medically necessary if the patient's attending physician does not concur with the determination. <See 42 C.F.R. 482.30(d)(1)(ii), see *MLN Matters Article SE0622, Background*>

4. If the UR committee determines a patient's admission was not medically necessary, notice must be provided to the patient, the hospital, and the attending physician within 2 days of the determination. <See 42 C.F.R. 482.30(d)(3)>

C. Role of Non-physician Hospital Staff

1. CMS has clarified that case managers, who are not licensed practitioners authorized under state law to admit patients to the hospital, do not have the authority to make a determination an admission is not medically necessary or change a patient's status from inpatient to outpatient. <See *MLN Matters Article SE0622, Q.3*>

CMS encourages and expects hospitals to employ case managers to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in decision making processes.

D. Timing of UR Determination

1. Determination Prior to Discharge

- a. If the determination an admission is not medically necessary is made prior to the patient's discharge, the hospital may retroactively convert the patient to an outpatient if the following conditions are met:

- i. The change in status is made while the patient is still in the hospital to allow the hospital to provide notice of the determination to the patient prior to discharge. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; see *MLN Matters Article SE0622, Q.8*>

Although the UR CoP allows 2 days to provide notice to the patient, in order to retroactively change the patient's status to outpatient, notice must be provided before discharge.

- ii. The attending physician concurs with the UR committee's decision. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
- iii. The physician's concurrence is documented in the medical record. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

- b. If all conditions are met, the claim for the case should be submitted as an outpatient claim (bill type 13X) with condition code 44. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>

- i. When billing observation services following conversion to outpatient status with condition code 44, an order for observation is required prior to counting time for observation. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2 and 290.5.2>
 - ii. The hospital may include charges representing the cost of all resources utilized in the care of the patient during the encounter, including monitoring and nursing care prior to an order for observation. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
 - a) Hours of monitoring and nursing care prior to a written order for observation may be reported on a line with revenue code 0762 (Observation Hours) without a HCPCS code. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
2. Determination After Discharge
- a. If the determination an admission is not medically necessary is made by the UR committee after the patient's discharge (i.e., self-denial), the patient remains an inpatient and the case should be submitted as an inpatient Part B claim (bill type 12X) with condition code W2. <78 *Fed. Reg.* 50914; *MLN Matters Article SE1333*>

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

II. Inpatient Part B (TOB 012X) Payment

Medicare covers and makes payment under Part B for inpatient services in three separate circumstances:

- An inpatient admission denied as not reasonable and necessary by a contractor or through self-denial (UR determination)
- The patient has no entitlement to Part A or has exhausted their Part A benefits
- Preventative services only covered under Part B

A. Admission Denied as Not Reasonable and Necessary

1. Inpatient Part B payment is available if:

- a. The inpatient admission is denied as not reasonable and necessary through contractor or self-denial; and
- b. The services would have been reasonable and necessary as outpatient services; and
- c. The services meet all applicable Part B coverage and payment conditions. <See 42 CFR 414.5, 78 Fed. Reg. 50914, See Medicare Benefit Policy Manual, Chapter 6 § 10.1>

2. Payment is available for:

- a. Services payable under OPPS and certain ancillary services payable under other payment systems (e.g., therapy, DME, laboratory services). <See 42 CFR 414.5(a)(1), 78 Fed. Reg. 50914, see Medicare Benefit Policy Manual, Chapter 6 § 10.1, MLN Matters SE1333>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.1, attached, has a list of the ancillary services payable when the inpatient admission is denied as not reasonable and necessary.
 - ii. Exceptions:
 - a) Services that by their nature are outpatient services (e.g., ED visits and observation services). <See Medicare Benefit Policy Manual, Chapter 6 § 10.1; MLN Matters SE1333>

Tip: These services should be submitted on a standard outpatient (131) claim.

- b) Inpatient nursing services (e.g., infusions, injections, transfusions, and nebulizer treatments) that the hospital treats as routine (i.e., billed as part of their inpatient room rate). <See Medicare Claims Processing Manual, Chapter 4 § 240>

Note: Ancillary nursing services for which the provider customarily makes a separate charge to inpatients may be billed for inpatient Part B payment if all documentation and coverage requirements are met.

- 1) Routine services are services included in the provider's daily room and board charges and the provider does not separately charge for them. <Program Reimbursement Manual, Chapter 22 § 2202.6>
 - (a) The provider must follow all instructions in the Provider Reimbursement Manual and the principles of cost apportionment for Medicare to "recognize" their treatment of the services as routine or ancillary. <Medicare Claims Processing Manual, Chapter 4 § 240>

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>
- ii. The three-day payment window, which requires inclusion of certain outpatient services on a subsequent inpatient claim, does not apply when no Part A inpatient payment is made. <MLN SE1333; See Medicare Benefit Policy Manual, Chapter 6 § 10.1; See Medicare Claims Processing Manual, Chapter 4 § 10.12>

Tip: If significant surgical or emergency department services are provided before the admission order and billed on an outpatient 131 claim triggering C-APC payment, no inpatient Part B claim will be needed because the C-APC provides payment in full for the encounter.

b. Inpatient Part A Non-covered Claim

- i. To bill for inpatient Part B payment, the provider must first submit a Part A “provider liable” claim on a type of bill 110, unless the claim has already been denied by the contractor. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 § 240.6, Medicare Claims Processing Manual, Transmittal 2877>
 - a) The “provider liable” claim must process and the remittance advice must be issued prior to billing for inpatient Part B payment. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; Medicare Claims Processing Manual, Transmittal 2877>
 - b) The provider must report the Occurrence Span Code M1 to indicate the period of provider liability on the Part A claim. <MLN Matters SE1333, Medicare Claims Processing Manual, Transmittal 2877>
 - c) The provider must refund any inpatient deductible or copay to the patient. <See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; MLN Matters SE1333>

c. Inpatient Part B Claim

- i. After receiving the remittance advice for the “provider liable” claim, the provider may submit a claim on type of bill 12X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240; MLN Matters SE1333>
 - a) The provider must submit the following on the 12X claim:
 - 1) A treatment authorization code “A/B Rebilling”.
 - 2) Condition code W2 attesting that the claim is a rebill and no appeal is in process.
 - 3) A remark code with the document control number (DCN) of the denied inpatient Part A claim in the format ABREBILL followed by the DCN of the denied inpatient claim. <Medicare Claims Processing Manual, Transmittal 2877>
 - b) Medicare Claims Processing Manual, Chapter 6 § 240.1, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the inpatient stay was denied as not reasonable and necessary.

- c) Hospitals must report the HCPCS codes they would report on an outpatient Part B claim, including for implantable prosthetic devices. <See Medicare Claims Processing Manual, Chapter 4 § 240.1, 240.3>
- d) The claim for Part B inpatient payment must be submitted within 1 year of the date of service in compliance with normal timely filing requirements. <See 42 CFR 414.5 (c)>
- ii. The patient is liable for the normal Part B deductible and co-payment for services billed on an inpatient Part B claim. <See Medicare Claims Processing Manual, Chapter § 240.6>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e., there was no reasonable expectation of a two midnight stay) and would not be covered under Part A. On what bill type should the hospital submit the pacemaker procedure?

B. No Part A Entitlement or Exhaustion of Part A Benefits

1. Limited inpatient Part B payment is available if:
 - a. No Part A payment is made at all for the case because the patient had exhausted his or her benefit days *before* or during the admission, OR
 - b. The patient was otherwise not eligible for or entitled to coverage under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>
2. Payment is available for:
 - a. Specified services payable under OPPS or other payment systems, including diagnostic tests, therapy, radiation therapy, acute dialysis, specified screening tests and preventative services, specified covered drugs, specified DME, and ambulance services. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.2, attached, has a list of the services payable when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.

- ii. If one of these services is packaged under the OPPS and the service it would package to is not payable on the inpatient Part B claim, it is excluded from OPPS packaging and paid separately. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>

Example: An inpatient, who has exhausted their Part A benefits, has a surgical service and related lab tests. The lab tests would normally package and only the surgical service would pay, but on an inpatient Part B claim the surgical service is not payable and the lab test will be excluded from packaging and pay separately.

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B as noted above. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>

b. Inpatient Part B Claim

- i. The provider submits a claim with type of bill 012X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240>
 - a) Medicare Claims Processing Manual, Chapter 6 § 240.2, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.
 - b) Hospitals must report the HCPCS codes they would report on an outpatient Part B claim. <See Medicare Claims Processing Manual, Chapter 4 § 240.2>

1) Special instructions for implantable prosthetic devices

- (a) Hospitals should bill implantable prosthetic devices with HCPCS code C9899 ("Implantable prosthetic device, payable only for inpatients who do not have inpatient coverage"). <See Medicare Claims Processing Manual, Chapter 4 § 240.3>

- (b) The provider should report the HCPCS code for the device, if one exists, or a narrative description of the device in the remarks section. <Medicare Claims Processing Manual Transmittal 1628, IV. Supporting Information>
- (c) The MAC prices the device according to its pass-through amount, DME fee schedule amount or the device offset amount for packaged devices and the beneficiary co-insurance is set at 20% of the payment amount determined by the MAC. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>
- (d) This code should not be used on inpatient Part B claims for inpatient cases denied as not reasonable and necessary because the surgical service that includes payment for the device is payable. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>

C. Services Covered Only Under Part B

- 1. Inpatient Part B payment is available for a limited number of preventative services and vaccines only covered under Part B and not covered under Part A when provided to an inpatient directly or under arrangement by a hospital. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3>
 - a. Medicare Benefit Policy Manual, Chapter 15 § 250, attached, contains a list of the services only covered under Part B and not covered under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3 and Chapter 15 § 250>
- 2. Billing Requirements
 - a. The hospital submits a 12X claim for these services. <See Medicare Claims Processing Manual, Chapter 4 § 240>

III. Inpatient Patient Responsibility (i.e., Deductibles and Coinsurance)

A. Benefit Periods

- 1. The inpatient deductible and coinsurance are based on a “benefit period” concept.

- a. The benefit period begins to run when the patient is first admitted to a hospital or SNF for inpatient care. The benefit period ends when the patient has not been an inpatient of a hospital or SNF for 60 consecutive days. <42 CFR §§ 409.60(a), 409.60(b)>

A benefit period can be as short as 61 days and there can be multiple benefit periods in a calendar year, resulting in payment of the deductible multiples times in a single calendar year.

- i. SNF admissions and discharges affect the benefit period determination regardless of whether the beneficiary's SNF care qualified for Medicare coverage. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 § 10.4.3.2 (Example 3)>

B. Deductible and Coinsurance Amounts

1. The first 60 inpatient hospitalization days of a benefit period are considered full benefit days and the patient is only responsible for paying the inpatient deductible. <42 CFR § 409.61(a)(1)(i)>
 - a. For 2023, the inpatient deductible is \$1600 per benefit period. <87 Fed. Reg. 59096>
 - b. The deductible is based on the calendar year in which the benefit period began. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.3>
2. Inpatient hospitalization days 61 to 90 in a benefit period are considered coinsurance days and the patient pays a daily coinsurance. <42 CFR § 409.61(a)(1)(ii)>
 - a. For 2023, the daily coinsurance is \$400 (25% X \$1600) per day. <87 Fed. Reg. 59096>
3. Lifetime reserve days <42 CFR § 409.61(a)(2)>
 - a. Medicare beneficiaries have 60 "lifetime reserve days" that may be used after the full benefit and coinsurance days for a particular benefit period have been used.

Full benefit and coinsurance days are renewed each benefit period, but once the 60 lifetime reserve days are used, they are exhausted forever.

- b. For each lifetime reserve day, the patient is responsible for a daily coinsurance. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 §§ 10.2.1, 10.3>
 - i. For 2023, the lifetime reserve day coinsurance is \$800 (50% X \$1600) per day. <87 Fed. Reg. 59096>
- c. Use of Lifetime Reserve Days for Admissions with Exhaustion of Regular Benefits
 - i. If the beneficiary has at least one regular benefit day at the beginning of the stay and exhausts their benefits *during* the stay, the beneficiary will be deemed not to use their lifetime reserve days for the *non-outlier* portion of the stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1 (2)>
 - ii. If the admission reaches outlier status, the beneficiary may elect not to use their lifetime reserve days for the days after the outlier is reached. If the beneficiary elects not to use their lifetime reserve days, Medicare will not make an outlier payment to the hospital and the hospital may charge the beneficiary for the charges that would have been paid as outlier by Medicare. <Medicare Benefit Policy Manual, Chapter 5 § 30.4.2>
- d. Election Not to Use Lifetime Reserve Days
 - i. Hospitals are required to notify beneficiaries that they may elect not to use their lifetime reserve days for all or part of a stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - a) Ideally, the notice should be given when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - b) CMS provides model language for use by beneficiaries in making an election not to use lifetime reserve days. <Medicare Benefit Policy Manual, Chapter 5 § 40.1, MLN Matters Article SE0663>
 - c) A retroactive election not to use lifetime reserve days may be made if certain criteria are met. <Medicare Benefit Policy Manual, Chapter 5 § 30.3, MLN Matters Article SE0663>
 - ii. If the beneficiary elects not to use lifetime reserve days, then the hospital may bill the patient for any services provided after the beneficiary's full benefit days and coinsurance days are exhausted. <42 CFR §409.65(a)(4)>

Case Study 3

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2023.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

IV. Transfer Payment for Discharges

A discharge will be paid as a transfer if:

- The patient is admitted to another hospital on the day of discharge; OR
- The patient is discharged with a qualifying MS-DRG to a post-acute care setting

- A. CMS published *MLN Matters Article 21001*, available on the CMS website, with a review of Medicare's transfer policy, including post-acute care transfers.
- B. Patient admitted to another hospital on the day of discharge
 1. A case will be treated as a transfer for payment purposes if a patient is admitted on the day of discharge to another acute IPPS hospital, critical access hospital, or a hospital eligible to be paid under IPPS but does not have a participation agreement with Medicare. <42 CFR 412.4(b); *Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A) and (B)>
 - a. Exception: The case will be treated as a discharge rather than a transfer if the readmission is unrelated to the discharge. <*Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A)>

Example: A patient is discharged from one hospital and later that is in an auto accident and is admitted to another hospital.

- i. CMS has suggested that for the readmission to be considered unrelated “the hospital can present documentation showing that the patient’s care associated with the [first admission] was completed before discharge.” <68 Fed. Reg. 45405>
 - b. Patients who leave against medical advice and are admitted to another hospital on the same day are also treated as transfers. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(A)>
2. Patient readmitted on the day of discharge
 - a. If a patient is readmitted on the day of discharge for symptoms related to, the earlier stay’s medical condition, the hospital must combine the original and subsequent stay onto a single claim. <Medicare Claims Processing Manual, Chapter 3 § 40.2.5>
 - b. If a patient is readmitted on the day of discharge for symptoms unrelated to the earlier stay’s medical condition, the hospital should treat the readmission as a new admission and should report condition code “B4” on the claim for the second admission. <Medicare Claims Processing Manual, Chapter 3 § 40.2.5>

Case Study 4

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1’s claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

C. Post-Acute Care Transfers

A post-acute care transfer payment is triggered when:

- The case is assigned to a designated post-acute care transfer MS-DRG; and
- The patient is discharge to a specific post-acute care setting.

1. Post-Acute Care Transfer MS-DRGs

- a. For FY 2023, there are 280 designated post-acute care transfer MS-DRGs. The list of post-acute care transfer MS-DRGs is published in Table 5 of the IPPS Final Rule.
2. The post-acute care settings, as indicated by the Patient Discharge Status code (see below) in Field 17 of the UB-04, which trigger the “post-acute care transfer” rule are:

- a. A non-IPPS hospital or a distinct part non-IPPS unit on the day of discharge. *<Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>*
 - i. Inpatient rehabilitation facilities and units (Patient Discharge Status 62 or 90)
 - ii. Long-term care hospitals (Patient Discharge Status 63 or 91)
 - iii. Psychiatric hospitals and units (Patient Discharge Status 65 or 93)
 - iv. Children's hospitals and cancer hospitals (Patient Discharge Status 05 or 85)
- b. A Medicare certified skilled nursing facility or SNF unit within a hospital, (Patient Discharge Status 03 or 83) on the day of discharge. *<Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>*
 - i. A discharge to a SNF is considered a transfer under this policy if the patient is directly admitted to the SNF from the hospital. *<63 Fed. Reg. 40978>*
 - ii. Swing Beds (Patient Discharge Status 61 or 89)
 - a) A swing-bed is not a SNF for purposes of the post-acute care transfer provisions. *<63 Fed. Reg. 40977>*
 - iii. Non-covered SNF Admissions
 - a) A discharge to a SNF bed is still considered to be a post-acute care transfer (assuming a qualifying DRG), regardless of whether or not the SNF admission was covered or paid by Medicare, as long as the patient qualified for skilled nursing care. *<63 Fed. Reg. 40978, See MedLearn Matters Article MM4046>*
 - b) The following discharges to a SNF are not considered post-acute care transfers:
 - 1) A patient discharged at a non-skilled level of care,
 - 2) A patient discharged to a non-Medicare certified bed, and
 - 3) A patient discharged to a non-skilled bed within a SNF. *<See MLN Matters Article MM4046>*

- c. Home health care (Patient Discharge Status 06 or 86), beginning within 3 days of the discharge, including the resumption of home health services in place prior to the inpatient stay. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>
 - i. The hospital may add condition code 42 (“Continuing Care not Related to Inpatient Hospitalization”) to the claim if the patient’s continuing home health care is not related to the condition or diagnosis for which the patient received inpatient hospital services. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411; MLN Matters SE21001>
 - ii. The hospital may add condition code 43 (“Continuing Care not Provided Within Prescribed Post-Discharge Window”) to the claim if the patient’s continuing home health care is related, but no home health services are provided within 3 days of hospital discharge. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411; MLN Matters SE21001>
 - iii. If Patient Discharge Status code 06 or 86 is reported with condition code 42 or 43, full DRG payment is made, rather than post-acute care transfer payment. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411>
 - d. Hospice care provided by a hospice program (Patient Discharge Status 50 – Discharged/Transferred to Hospice – Routine or Continuous Home Care; or Patient Discharge Status 51 – Discharged/Transferred to Hospice – General Inpatient Care or Inpatient Respite). <83 Fed. Reg. 41393-392; Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>
3. If a hospital submits a claim indicating the patient was discharged to home or another setting not included in the post-acute-care transfer policy and subsequently learns the patient went to a setting included in the post-acute-care transfer policy (e.g., home health), the hospital should submit an adjusted claim. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE20025>

D. Transfer Payment

- 1. Payment to the transferring hospital:
 - a. A “per diem” rate is determined by dividing the full payment for the discharge DRG by the geometric mean length of stay (“GMLOS”) for the discharge DRG.
 - i. The GMLOS for each DRG is listed in Table 5 of the IPPS final rule.

- b. The first day of the admission is paid at twice the per diem rate in recognition of the extra expenses incurred on the day of admission.
- c. All subsequent days are paid at the per diem, up to the full DRG amount.

Case Study 5

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

- 2. For FY2023, special payment rules apply to 42 post-acute care transfer MS-DRGs identified on Table 5 of the IPPS Final Rule. <42 CFR 412.4(f)(6)>
 - a. The “special payment rules” only apply to post-acute care transfers and do not apply to other transfers. <42 CFR 412.4(f)(6)>
 - b. A “special pay” post-acute care transfer is paid:
 - i. 50% of the full DRG payment plus 50% of the calculated per diem for the first day.
 - ii. 50% of the calculated per diem for each subsequent day up to the full DRG payment.
- 3. The final discharging hospital” (i.e., the hospital to which the patient is considered to have been transferred) is paid at the full payment rate based on the final discharge DRG. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(A)>

Case Study 6

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

Analysis: No, in order to bill with condition code 44 the UR committee determination must be made prior to the patient's discharge and notice provided to the patient. The stay may be billed to Medicare as a self-denial for inpatient Part B payment. <Medicare Claims Processing Manual, Chapter 1 § 50.3; MLN Matters Article SE1333; 42 C.F.R 414.5>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e. there was no reasonable expectation of a two midnight stay) and would not be covered under Part A. On what bill type should the hospital submit the pacemaker procedure?

Analysis: The hospital should submit the pacemaker on a 13X (outpatient) bill type because the surgery was an outpatient service provided prior to a non-covered inpatient stay. The three-day window is inapplicable when the inpatient stay is non-covered. Note that full payment for the encounter will be made under the C-APC for the pacemaker procedure on the 131 claim and no inpatient Part B claim will be necessary in this case. <Medicare Claims Processing Manual, Chapter 4 § 10.12>

Case Study 3

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2023.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Analysis: For Admission #1, the patient would pay the deductible of \$1,600 on day one of the stay and it covers all 58 days of the admission. For Admission #2, the patient would pay \$400 for day three and four, for a total of \$800. Note that day one and two of Admission #2 are paid for with the deductible paid during Admission #1. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.1 and 10.3>

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

Analysis: For Admission #3, the patient would pay the deductible of \$1,600. The patient began a new benefit period with the 60-day break between Admission # 2 and #3. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.1 and 10.3>

Case Study 4

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1's claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

Analysis: The claim should be treated as a discharge rather than a transfer if Hospital #2's admission was unrelated to the discharge from Hospital #1. Regardless of whether Hospital #1 claim is paid as a discharge or transfer, Hospital #2 will be paid the full payment rate based on the patient's final discharge MS-DRG. <42 CFR 412.4(b); *Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A)>

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Case Study 5

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$4000 for day one, and \$2000 for days 2, 3 and 4 for a total of \$10,000. In this case, transfer payment was not less than the full discharge payment. <42 CFR 412.4(f)(1)>

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Case Study 6

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$6000 for day one (\$5000 + \$1000), and \$1000 for days 2, 3 and 4 for a total of \$9,000. <42 C.F.R.412.4(f)(6)>

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This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter G - Standards and Certification

Part 482 - Conditions of Participation for Hospitals

Subpart C - Basic Hospital Functions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr, unless otherwise noted.

Source: 51 FR 22042, June 17, 1986, unless otherwise noted.

§ 482.30 Condition of participation: Utilization review.

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

- (a) **Applicability.** The provisions of this section apply except in either of the following circumstances:
 - (1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.
 - (2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.
- (b) **Standard: Composition of utilization review committee.** A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).
 - (1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:
 - (i) A staff committee of the institution;
 - (ii) A group outside the institution -
 - (A) Established by the local medical society and some or all of the hospitals in the locality; or
 - (B) Established in a manner approved by CMS.
 - (2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.
 - (3) The committee's or group's reviews may not be conducted by any individual who -
 - (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or
 - (ii) Was professionally involved in the care of the patient whose case is being reviewed.
- (c) **Standard: Scope and frequency of review.**

- (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -
 - (i) Admissions to the institution;
 - (ii) The duration of stays; and
 - (iii) Professional services furnished, including drugs and biologicals.
- (2) Review of admissions may be performed before, at, or after hospital admission.
- (3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.
- (4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:
 - (i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in § 412.80(a)(1)(i) of this chapter; and
 - (ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in § 412.80(a)(1)(ii) of this chapter.
- (d) **Standard: Determination regarding admissions or continued stays.**
 - (1) The determination that an admission or continued stay is not medically necessary -
 - (i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
 - (ii) Must be made by at least two members of the UR committee in all other cases.
 - (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
 - (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);
- (e) **Standard: Extended stay review.**
 - (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may -
 - (i) Be the same for all cases; or
 - (ii) Differ for different classes of cases.

- (2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.
- (3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.
- (f) **Standard: Review of professional services.** The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 414 - Payment for Part B Medical and Other Health Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

Source: 55 FR 23441, June 8, 1990, unless otherwise noted.

Editorial Note: Nomenclature changes to part 414 appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

- (a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:
- (1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.
 - (2) Physical therapy services, speech-language pathology services, and occupational therapy services.
 - (3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.
 - (4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.
 - (5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.
 - (6) Clinical diagnostic laboratory services.
 - (7)
 - (i) Effective December 8, 2003, screening mammography services; and
 - (ii) Effective January 1, 2005, diagnostic mammography services.
 - (8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

- (b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).
- (c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 414 - Payment for Part B Medical and Other Health Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

Source: 55 FR 23441, June 8, 1990, unless otherwise noted.

Editorial Note: Nomenclature changes to part 414 appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

- (a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:
- (1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.
 - (2) Physical therapy services, speech-language pathology services, and occupational therapy services.
 - (3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.
 - (4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.
 - (5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.
 - (6) Clinical diagnostic laboratory services.
 - (7)
 - (i) Effective December 8, 2003, screening mammography services; and
 - (ii) Effective January 1, 2005, diagnostic mammography services.
 - (8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

- (b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).
- (c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

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Excerpt from Medicare Benefit Policy Manual, Chapter 6**10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals****(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

Payment may be made under Part B for physician services and for the nonphysician medical and other health services as provided in this section when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. This 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 section, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements (see chapter 16, §170 of this manual, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider"). A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

10.1 - Reasonable and Necessary Part A Hospital Inpatient Claim Denials**(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, and if waiver of liability payment is not made, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

- 1) Part B services paid under the outpatient prospective payment system (OPPS), excluding observation services and hospital outpatient visits that require an outpatient status. Hospitals that are excluded from payment under the OPPS are instead paid under their alternative payment methodology (e.g., reasonable cost, all inclusive rate, or Maryland waiver) for the services that are otherwise payable under the OPPS.
- 2) The following services excluded from OPPS payment, that are instead paid under the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients:

- a. Physical therapy services, speech-language pathology services, and occupational therapy services (see chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services,”).
- b. Ambulance services.
- c. Prosthetic devices, prosthetic supplies, and orthotic devices paid under the DMEPOS fee schedule (excludes implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) and replacement of such devices).
- d. Durable medical equipment supplied by the hospital for the patient to take home, except durable medical equipment that is implantable.
- e. Certain clinical diagnostic laboratory services.
- f. Screening and diagnostic mammography services.
- g. Annual wellness visit providing personalized prevention plan services.

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.2 - Other Circumstances in Which Payment Cannot Be Made Under Part A

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

Part B payment could be made to a hospital for the medical and other health services listed in this section for inpatients enrolled in Part B if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before or during the admission; or
- The patient was not otherwise eligible for or entitled to coverage under Part A (see chapter 16, §180 of this manual for services received as a result of non-covered services).

Beginning in 2014, for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

The following inpatient services are payable under the OPPS:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Acute dialysis of a hospital inpatient with or without end stage renal disease (ESRD). The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §200.2, "Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)."
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Prostate screening;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;

- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO) that is not covered under the ESRD benefit.

The following inpatient services are payable under the non-OPPS Part B fee schedules or prospectively determined rates listed:

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the applicable rate under Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §240.3, “Inpatient Part B Hospital Services - Implantable Prosthetic Devices”);
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient’s physical condition (DMEPOS fee schedule);
- Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services”) (applicable rate based on the Medicare Physician Fee Schedule);
- Ambulance services (ambulance fee schedule); and
- Screening mammography services (Medicare Physician Fee Schedule).

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for these services must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70, “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.3 - Hospital Inpatient Services Paid Only Under Part B (Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The services listed in Chapter 15, §250 of this manual, “Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities,” when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

In all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

20 - Outpatient Hospital Services (Rev. 157, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The rules in this section pertaining to the coverage of outpatient hospital services are not applicable to the following services.

- Physical therapy, speech-language pathology or occupational therapy services when they are furnished “as therapy” meaning under a therapy plan of care. See chapter 15, sections 220 and 230 of this manual, for coverage and payment rules for these services, which are paid at the applicable amount under the physician fee schedule.
- Services that are covered and paid under the End Stage Renal Disease Prospective Payment System. See Chapter 11, “End Stage Renal Disease (ESRD)” of this manual, for rules on the coverage of these services.

Excerpt from Medicare Benefit Policy Manual, Chapter 15

fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an “intensive care” concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

There are several services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are:

Physicians' services (including the services of residents and interns in unapproved teaching programs);

Physician assistant services, furnished after December 31, 1990;

Certified nurse-midwife services, as described in §180, furnished after December 31, 1990; and

Qualified clinical psychologist services, as defined in §160, furnished after December 31, 1990;

Screening mammography services;

Screening pap smears and pelvic exams;

Screening glaucoma services;

Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations;

Colorectal screening;

Bone mass measurements; and

Prostate screening;

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient. The other

services listed are not subject to bundling but, because they are excluded from the statutory definition of inpatient hospital services, may be covered only under Part B.

Payment may be made under Part B to a hospital (or critical access hospital) for certain medical and other health services furnished to its inpatients as provided in Chapter 6, §10 of this manual, “Medical and Other Health Services Furnished to Inpatients of Participating Hospitals.”

Payment may be made under Part B for certain medical and other health services if the beneficiary is an inpatient of a skilled nursing facility (SNF) as provided in chapter 8, §§ 70ff of this manual.

260 - Ambulatory Surgical Center Services

(Rev. 77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and change requests. The ASC must accept Medicare’s payment for such procedures as payment in full with respect to those services defined as ASC facility services.

Where services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services; however, the “professional” rate is then adjusted since the ASC incurs the facility costs.

260.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 104; Issued: 03-13-09; Effective Date: 04-01-09; Implementation Date: 04-06-09)

An ASC for purposes of this benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, a facility elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise. This provision is intended to prohibit such an entity from switching from one payment method to another to maximize its revenues (47 FR 34082, 34099, Aug. 5, 1982). For other general conditions and requirements, see 42 CFR 416.25-416.49. If the hospital based surgery center is certified as an ASC it is considered an ASC and is subject to rules for ASCs. Related survey requirements are published in the State Operations Manual, Pub. 100-07, Appendix L. Claims processing and payment requirements for ASCs are published in Pub. 100-04, the Medicare Claims Processing Manual, chapter 14.

Excerpt from Medicare Claims Processing Manual, Chapter 4

furnished. See Pub. 100-04, chapter 3, §90.3.1 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

Effective January 1, 2017, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0815 (Other Organ Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same claim as the transplant procedure in order to be appropriately packaged for payment purposes. Revenue code 0815 charges for allogeneic stem cell acquisition costs are reported on Worksheet D Part V, column 2, line 77, cost center 0077 of the hospital Medicare cost report (Form CMS-2552-10).

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by A/B MACs (A) under the OPPS is available at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>

240 - Inpatient Part B Hospital Services

(Rev. 3106, Issued: 11-06-14, Effective: 10-01-13, Implementation: 02-10-15)

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 this manual.

Inpatient Part B services include inpatient ancillary services that do not require an outpatient status and are not strictly provided in an outpatient setting. Services that require an outpatient status and are provided only in an outpatient setting are not payable inpatient Part B services, including Clinic Visits, Emergency Department Visits, and Observation Services (this is not a complete listing).

Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some provider's customary charging practice has established separate charges for these services following the PRM-1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS in order to separately bill.

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

(Rev.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)

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.

A hospital part B inpatient services claim billed when a reasonable and necessary part A hospital inpatient was denied must be billed with:

- A condition code “W2” attesting that this is a rebilling and no appeal is in process,
- “A/B REBILLING” in the treatment authorization field, and
- The original, denied inpatient claim (CCN/DCN/ICN) number.

NOTE: Providers submitting an 837I are 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.

NOTE: Providers submitting an 837I are instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~ For DDE or paper Claims, Providers are instructed to use the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234". (The numeric string (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.)

Not Allowed Revenue Codes

The claims processing system shall set edits to prevent payment on Type of Bill 012x 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	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 012x claim.

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

ort 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.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)

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 012x for claims containing the revenue codes listed in the table below with exceptions as noted. For the exceptions noted, contractors shall ensure that only the exceptions identified are allowed to process with the revenue code.

Not Allowed Revenue Codes

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	026x	0270
0271	0272	0273	0277	0279	028x	029x	036x
0370	0374	0379	038x	039x	041x	045x	0470
0472	0479	0480	0481	0489	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	056x	057x	058x	059x	060x
0620	0624	063x	064x	065x	066x	067x	068x
069x	070x	071x	072x	075x	076x	079X	081x
082x	083x	084x	085x	087x	088x	089x	090x
091x	093x	0940	0941	0942*	0943	0944	0945
0946	0947	0948	0949	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.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

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.

Allowed Revenue Codes

0240	0274	0275	0276	0278	030x	031x	032x
0333	034x	035x,	040x,	042x	043x	044x	046x
0471	0482	0483	054x	061x	0623	073x	074x
0771	078x*	080x	086x	092x	0942*	0964*	

*Billed prior to admission or on the day of discharge.

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

Additional Allowed services that are identified by HCPCS, not identified by Revenue Codes

Other Diagnostic services: (A MAC maintained)

Preventive services:

COVID-19, Influenza, pneumococcal pneumonia, and hepatitis B vaccines

Colorectal screening

Screening glaucoma services

Bone mass measurements

Prostate screening

Covered drugs:

Hemophilia clotting factors

Immunosuppressive drugs

Oral anti-cancer drugs

Oral anti-emetic

Non-ESRD Epoetin Alfa (EPO)

240.3 - Implantable Prosthetic Devices

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

Under 42 CFR 419.2(b)(11), implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices, are paid under the OPPS, and are therefore packaged with the surgical implantation procedure unless the device has pass-through payment status. This payment provision applies when such a device is billed as a Part B outpatient service, or as a Part B inpatient service when the inpatient admission is determined not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.1). In these circumstances, hospitals should submit the usual HCPCS code for Part B payment of the device.

In the other circumstances in which a beneficiary does not have Part A coverage of inpatient services on the date that such a device is implanted (that is, when furnished by a participating hospital to an inpatient 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), hospitals paid under the OPPS should report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, that is effective for services furnished on or after January 1, 2009. This code allows an alternative Part B inpatient payment methodology for the device as discussed in this section, and may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage under Part A because he or she is not entitled to Part A benefits, has exhausted his or her Part A benefits, or receives services not covered under Part A. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting C9899, the hospital is reporting that the item is eligible for separate OPPS payment because the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”).

If C9899 is a separately payable Part B inpatient service, the contractor shall determine the payment amount as follows. If the device has pass through status under the OPPS, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS

fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPTS webpage, select “Device, Radiolabeled Product, and Procedure Edits” from the list on the left side of the page. Open the file “Procedure to Device edits” to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPTS webpage and open the file “FB/FC Modifier Procedures and Devices”. Select the applicable year’s file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy”). Select the “Full offset reduction amount” that pertains to the APC that is most applicable to the device described by C9899. It would be reasonable to set this amount as payment for the device.

For example, if C9899 is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in “remarks”) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single chamber pacemaker to \$4881.77. In this case the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or

the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

When a hospital that is not paid under the OPPTS furnishes an implantable prosthetic device other than dental), which replaces all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such a device, to an inpatient who has coverage under Part B but does not have Part A coverage, and the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”), payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

240.4 - Indian Health Service/Tribal Hospital Inpatient Social Admissions

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

There may be situations when an American Indian/Alaskan Native (AI/AN) beneficiary is admitted to an IHS/Tribal facility for social reasons. These social admissions are for patient and family convenience and are not billable to Medicare. There are also occasions where IHS/Tribal hospitals elect to admit patients prior to a scheduled day of surgery, or place a patient in a room after an inpatient discharge. These services are also considered to be social admissions as well.

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 Common Working File (CWF) returns an A/B crossover edit and creates an unsolicited response (IUR) in this situation.

The CWF also creates an IUR when a line item date of service on TOB 12X is equal to or one day following the discharge date on TOB 11X for the same provider.

The CWF bypasses both of these edits when the beneficiary is not entitled to Medicare Part A at the time the services on TOB 12X are rendered.

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

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10 (“Medical and Other Health Services Furnished to Inpatients of Participating Hospitals”) and Pub 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12 (“Payment Window for Outpatient Services Treated as Inpatient Services”) regarding services bundled into the

original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission, that may be billed to Part B when Part A payment cannot be made. Hospitals should use the following type of bill to report these services:

- 13X TOB (85X for a CAH)- Hospital outpatient services included in the payment window for outpatient services treated as inpatient services
- 14X TOB- Laboratory tests that are paid under the clinical laboratory fee schedule (see chapter 16, §40.3 of this manual), and included in the payment window for outpatient services treated as inpatient services

240.6 - Submitting Provider-Liable “No-Pay” Part A Claims and Beneficiary Liability

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

When Part A payment cannot be made for a hospital inpatient admission and the hospital, not the beneficiary, is liable under section 1879 of the Act for the cost of the Part A items and services, the hospital must submit a provider-liable “no pay” Part A claim (110 TOB) (see chapter 3 §40.2.2, “Charges to Beneficiaries for Part A Services” of this manual). 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 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 this manual).

Medicare beneficiaries are liable for their usual Part B financial liability for services covered under Part B when Part A payment cannot be made, including Part B copayments for each payable Part B inpatient or Part B outpatient service. The beneficiary is also liable for the cost of services not covered under Part B.

250 - Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in §250.1. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee