DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

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- "The Basics of Medicare Enrollment for Institutional Providers," Fact Sheet, ICN 903783, Downloadable only.

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CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8185, which implements the Centers for Medicare & Medicaid Services (CMS) Administrator's Ruling CMS-1455-R, issued March 13, 2013. This ruling permits you to bill under Part B, certain services when an inpatient Part A claim is denied by a Medicare contractor for the reason that the inpatient admission was not reasonable and necessary. CR8185 includes specific guidance for contractors to accept such Part B claims. Make sure that your billing staffs are aware of these changes. The Ruling provides an interim policy to address certain Part A appeal decisions by Administrative Law Judges (ALJs) and the Medicare Appeals Council, while

CMS establishes permanent policy changes through notice and comment rulemaking under CMS-1455-P, issued concurrently with CMS-1455-R.

Background

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner may admit the beneficiary for inpatient care or treat him or her as an outpatient. In some cases, when the physician admits the beneficiary and the hospital provides inpatient care, a Medicare review contractor such as a Medicare Administrative Contractor (MAC), Recovery Auditor, or the Comprehensive Error Rate Testing Contractor determines that inpatient care was not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act and denies the associated Part A claim for payment. To date under the Medicare program, in these cases hospitals may bill a subsequent Part B inpatient claim for a limited set of medical and other health services referred to as "Part B Inpatient" or "Part B Only" services, specified in the "Medicare Benefit Policy Manual (MBPM)," Chapter 6, Section 10, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf on the CMS website. Prior to CT8185, these Part B claims were considered new claims that are subject to the timely filing restrictions.

In an increasing number of cases, hospitals that have appealed these Part A inpatient claim denials to ALJs and the Medicare Appeals Council have received decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, but effectively requiring Medicare to issue payment for all Part B services that would have been payable had the beneficiary been treated as a hospital outpatient (rather than an inpatient), instead of limiting payment to only the set of Part B inpatient services that are designated in the MBPM. Moreover, the decisions have required payment regardless of whether the subsequent hospital claim for payment under Part B is submitted within the otherwise applicable time limit for filing Part B claims. While these Medicare Appeals Council and ALJ decisions are contrary to CMS' longstanding policies, CMS is bound to effectuate each individual decision, which has created numerous operational difficulties. The Administrator's Ruling establishes a standard process for effectuating these decisions and handling pending claims and appeals in the interim while CMS finalizes policy changes going forward. The Administrator's Ruling also addresses the scope of administrative review in these and other, similar cases.

The Administrator's Ruling establishes that, when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit Part B claims for services that would have been payable to the hospital had the beneficiary originally been treated as a hospital outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status.

- Specifically, the hospital may bill for more Part B services than just those listed in the Manual section noted above, including all Part B services that would have been payable to the hospital had the beneficiary originally been treated as a hospital outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, for example,

outpatient visits, emergency department visits, and observation services. Such services that require an outpatient status cannot be billed for the time period the beneficiary spent in the hospital as an inpatient and cannot be included on the Part B inpatient claim.

- Hospitals may also bill separately for outpatient services provided in the three-day payment window (one day for hospital not subject to the Inpatient Prospective Payment System or IPPS) prior to the inpatient admission as the outpatient services that they were on an outpatient Part B claim (see the "Medicare Claims Processing Manual," Chapter 4, Section 10.12, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf), including services that require an outpatient status.

Hospitals may only submit claims for Part B inpatient and Part B outpatient services that are reasonable and necessary in accordance with Medicare coverage and payment rules and must maintain documentation to support the services for which they are billing.

For claims filed under the Administrator's Ruling, the beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital. CMS notes that because the beneficiary's patient status remains inpatient, rebilling under the Ruling does not impact Skilled Nursing Facility (SNF) eligibility.

The policy in the Administrator's Ruling's supersedes any other statements of policy on the issues therein and remains in effect until the effective date of the regulations that finalize CMS's proposed rule titled, "Medicare Program; Part B Inpatient Billing in Hospitals" (CMS-1455-P), which was issued concurrently with the Administrator Ruling and will establish a final policy that will apply prospectively from the effective date of the finalized regulations for CMS-1455-P.

Applicability

This interim policy applies to Part A hospital inpatient claims denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, as long as the denial is/was made:

(1) While the Administrator's Ruling is in effect;

(2) Prior to the effective date of the Administrator's Ruling, but for which the timeframe to file an appeal has not expired; or

(3) Prior to the effective date of the Administrator's Ruling, but for which an appeal is pending.

The Ruling does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired prior to the effective date of the Ruling (March 13, 2013). In addition, the Ruling does not apply to other instances in which CMS currently provides for limited Part B inpatient billing when a beneficiary has no Part A coverage for an inpatient hospital stay (e.g., exhausted Part A benefit days). Finally, the Ruling applies only to claim denials by a Medicare review contractor and not to hospital self-audits.

Treatment of Pending Appeals and Denials and Submitting Part B Claims Under the Ruling

The Ruling provides hospitals with notice of their right to either submit Part B claims following denial of a Part A inpatient admission as described above, or continue to pursue an appeal of the Part A denial. In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service. Thus, if a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, consistent with the Ruling, the hospital cannot also maintain its request for payment for the same services on the Part A claim. In this situation, the hospital must withdraw any pending appeal request on the Part A claim before submitting a Part B claim. If a contractor determines that a hospital has submitted a Part B claim for payment while a Part A appeal is pending (i.e., the request has not been withdrawn and a decision on the request has not been issued), the Part B claim for payment shall be denied as a duplicate and the Part A appeal will continue. Once the hospital submits a Part B claim, parties will no longer be able to request further appeals of the Part A claim. Rather, parties will be able to exercise their appeal rights for the subsequent Part B claim under existing procedures in 42 CFR part 405 Subpart I. If a Part A appeal is mistakenly processed after a hospital submits a Part B claim, no additional payment shall be made with respect to the Part A claim in effectuating the Part A decision.

Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending. Until and unless an appeal is withdrawn by the appellant, contractors will continue processing all pending Part A appeals that are subject to the Ruling. The Ruling also established a policy for handling appeals remanded from the ALJ level to the QIC level. Remanded cases will be returned to the ALJ level for adjudication of the Part A claim appeal. Information regarding requests for withdrawal will be available to appellants on the Office of Medicare Hearing and Appeals public website at http://www.hhs.gov/omha on the Internet.

Coding and Submission of Part B Claims

To receive payment under Part B, the hospital shall submit the Part B claims that are required under current policy, i.e., a Part B inpatient 12X Type of Bill (TOB) for services furnished during the inpatient admission and an 11X inpatient Provider Liable TOB. On the 12X TOB, the hospital must code the reasonable and necessary Part B services furnished during the inpatient admission, and must, when available, provide the Healthcare Common Procedure Coding System (HCPCS) code(s), Current Procedure Terminology (CPT) code(s) and revenue code(s) that describe the reasonable and necessary services that were ordered and rendered in accordance with Medicare rules and regulations, and that are documented in the medical record. Also the hospital shall submit a 13X Part B outpatient TOB to receive payment for all reasonable and necessary Part B services furnished in the three-day payment window (one day for non-IPPS hospitals) prior to the inpatient admission.

Hospitals submitting Part B inpatient claims subject to this interim policy shall include condition code “W2” on the claim. By using the "W2" condition code on the Part B claim(s), the hospital acknowledges that the Part B claim is a duplicate of the previously denied Part A claim, that no payment shall be made with respect to the items or services included on the Part A claim, and that any amounts collected from the beneficiary with respect to the Part A claim will be refunded to the

beneficiary. By using the "W2" condition code, the hospital attests that there is no pending appeal with respect to a previously submitted Part A claim, and that any previous appeal of the Part A claim is final or binding or has been dismissed, and that no further appeals shall be filed on the Part A claim.

Hospitals shall include the appropriate Part B billing treatment authorization code on the 121 or 131 TOB. The treatment authorization code is “A/B Rebilling”. Once CR8185 is implemented, hospitals billing a 837I claim shall place this appropriate Prior Authorization code into Loop 2300 REF02 (REF = G1) as follows: REF*G1*A/B Rebilling~

For Direct Data Entry (DDE) or paper claims, hospitals are instructed, upon implementation of CR8185, to use Field 5/MAP1715 (for DDE) or Treatment Authorization Field #63 (for paper).

Additionally, hospitals shall also include in remarks on the 121 or 131 TOB:

- The original, denied inpatient claim (CCN/DCN/ICN) number, and
- The last adjudication date.

Once CR8185 is implemented, providers billing a 837I claim shall place the DCN and last adjudication date shall be included in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234-99999999~

On both claim submission types, the word "ABREBILL," the original, denied inpatient DCN/CCN/ICN and last adjudication date shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234-99999999," where the "12345678901234” is meant to represent the original claim DCN/ICN numbers from the inpatient denial and the second number string (99999999) is meant to represent the most recent adjudication date in mmddyyyy format.

Scope of Review of Pending Appeals

As explained in the Ruling, hospitals are solely responsible for both submitting claims for items and services furnished to beneficiaries and determining whether submission of a Part A or Part B claim is appropriate. Once a hospital submits a claim, the Medicare contractor can make an initial determination and determine any payable amount. Accordingly, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and appeals adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination. If a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim the provider has not yet submitted.

Additional Information

The official instruction, CR8185, issued to your FI and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1203OTN.pdf on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.