| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 4394** | **Date: September 13, 2019** |
| | **Change Request 11413** |

**SUBJECT: Billing for Hospital Part B Inpatient Services**

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

**EFFECTIVE DATE: October 1, 2013**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 15, 2019**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 4/240.1/ Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials |
| R | 4/240.2/ Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 4394 | Date: September 13, 2019 | Change Request: 11413 |
|---|---|---|---|

**SUBJECT: Billing for Hospital Part B Inpatient Services**

**EFFECTIVE DATE: October 1, 2013**
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## I. GENERAL INFORMATION

**A. Background:** Medicare pays for hospital (including CAH) inpatient Part B services in the circumstances provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, § 10 ("Medical and Other Health Services Furnished to Inpatients of Participating Hospitals"). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in chapter 1, §70 of Medicare Claims Processing Manual. Revenue code 0240 was inadvertently added to the listing of services not allowed and needs to be removed. Additional billing clarifications have been added, where appropriate.

**B. Policy:** No policy is being updated.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 11413.1 | A/B MACs (Part A) should be aware of the policy regarding billing for hospital Part B inpatient service claims, including the allowance of Revenue Code 0240 on 012x Type of Bills (TOB). | X | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 11413.2 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. | X | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Fred Rooke, fred.rooke@cms.hhs.gov

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

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

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

**(Rev.4394, Issued: 09-13-19, Effective: 10-01-13, Implementation: 10-15-19)**

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

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to adjust its Part A claim (to make the provider liable) prior to submitting a claim for payment of Part B inpatient services. Whether or not the hospital had submitted a claim to Part A for payment, we require the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

*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.

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

**(Rev.4394, Issued: 09-13-19, Effective: 10-01-13, Implementation: 10-15-19)**

When Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 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 | 0261 | 0269 |
| 0270 | 0273 | 0277 | 0279 | 028x | 029x | 0360 | 0362 |
| 0367 | 0369 | 0370 | 0374 | 0379 | 038x | 039x | 041x |
| 045x | 0470 | 0472 | 0479 | 049x | 050x | 051x | 052x |
| 053x | 0541 | 0542 | 0543 | 0544 | 0546 | 0547 | 0548 |
| 0549 | 055x | 056x | 057x | 058x | 059x | 060x | 0620 |
| 0623 | 0624 | 0630 | 0631 | 0632 | 0633 | 0637 | 064x |
| 065x | 066x | 067x | 068x | 069x | 072x | 0760 | 0762 |
| 079X | 081x | 082x | 083x | 084x | 085x | 088x | 090x |
| 091x | 093x | 0940 | 0941 | 0942* | 0943 | 0944 | 0945 |
| 0946 | 0947 | 0948 | 0949 | 095x | 0960 | 0961 | 0962 |
| 0964* | 0969 | 097x | 098x | 099x | 100x | 210x | 310x |
| | | | | | | | |

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