CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12887	**Date: October 10, 2024**
	Change Request 13810

SUBJECT: Correction to Editing for Inpatient Part B Ancillary 12X Claims When Part A Benefits Exhaust and Manual Updates for Billing of Inpatient Pre-Entitlement Days

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to correct the editing for inpatient Part B ancillary 12X claims for non-physician outpatient services provided within an Inpatient Prospective Payment System (IPPS) hospital admission when Part A benefits exhaust during the inlier portion of the inpatient stay that has exceeded a cost outlier threshold. This CR also includes updates to the Internet Only Manual (IOM) 100-04 Medicare Claims Processing Manual; Chapter 3 Inpatient Hospital Billing for instructions on billing pre-entitlement days.

EFFECTIVE DATE: April 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

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	3/Table of Contents
N	3/40/40.2/40.2.7/Billing Procedures for Pre-Entitlement Days

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: 12887	Date: October 10, 2024	Change Request: 13810

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EFFECTIVE DATE: April 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to correct the editing for inpatient Part B ancillary 12X claims for non-physician outpatient services provided within an Inpatient Prospective Payment System (IPPS) hospital admission when Part A benefits exhaust during the inlier portion of the inpatient stay that has exceeded a cost outlier threshold. This CR also includes updates to the Internet Only Manual (IOM) 100-04 Medicare Claims Processing Manual; Chapter 3 Inpatient Hospital Billing for instructions on billing pre-entitlement days.

II. GENERAL INFORMATION

A. Background: All items and non-physician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to the prospective payment system (PPS). 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).

Currently, the Common Working File (CWF) performs editing to detect and prevent duplicate billing of non-physician outpatient services considered included in an inpatient hospital admission in the same facility or in another facility. A bypass of this editing is allowed for inpatient Part B ancillary services billed on the 12X claim for dates of service after the beneficiary has their exhausted Part A benefits, when the inpatient claim received a cost outlier payment. This CR corrects the editing to ensure that a bypass is allowed for the Part B ancillary 12X claim, for situations where the beneficiary has exhausted their Part A benefits during the inpatient confinement, a cost outlier threshold is exceeded on the inpatient claim, and the beneficiary has no lifetime reserve (LTR) days available. Service dates outside the inlier portion of the stay, as reported with occurrence span code 70, shall be allowed to process for payment consideration.

B. Policy: This CR does not include new policy. CMS is correcting editing in the Common Working File (CWF) that detects duplicate billing of non-physician outpatient services considered included in an inpatient hospital admission in the same facility or in another facility.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13810.1	CWF shall update the bypass logic for A/B crossover edits to allow an incoming outpatient claim ('12x'): • The line-item service dates are ***after*** the occurrence span code 70 days reported on an IPPS, Long Term Care Hospital (LTCH) or Inpatient Rehabilitation Facility (IRF) history claim (excluding the discharge date) and, • Part A benefits exhaust date is present (Occurrence code A3, B3 or C3) on the history inpatient claim and, • The history inpatient claim does not indicate outlier payment, but has exceeded a cost outlier threshold (occurrence Code 47 is present indicating the first full day of cost outlier status). Note: All other existing bypass criteria shall remain the same.								X	
13810.1.1	CWF shall update any applicable informational unsolicited response (IUR) edit logic to include the updated bypass criteria.								X	
13810.2	Medicare contractors shall adjust inpatient Part B ancillary claims meeting the updated bypass criteria, when brought to their attention.	X								
13810.3	Medicare contractors shall be aware of updates to the Internet Only Manual (IOM) 100-04: Medicare Claims Processing	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Manual, Chapter 3: Inpatient Hospital Billing; Section 40.2.7 Billing Procedures for Pre-Entitlement Days.									

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
211439.1	Contractors should review CWF edits 7050, 7070 and Alert 7545 which may be impacted.

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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 12887; Issued: 10-10-24)

40.2.7 – Billing Procedures for Pre-Entitlement Days

(Rev. 12887; Issued:10-10-24; Effective: 04-01-25; Implementation: 04-07-25)

Providers submit a bill that contains charges for pre-entitlement days when a beneficiary is admitted to an acute care hospital prior to the beneficiary's Medicare Part A entitlement effective date. Providers may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

- *Report the original admission date form locator (FL 12).*
- *Enter the statement covered period from date (FL 06) equal to the effective date of Medicare coverage (Part A Entitlement Effective Date).*
- *Enter the statement covered period through date (FL 06) equal to the end date of the stay.*
- *Report the room & board (R&B) (FL 42) revenue codes (010X – 016X).* ***Note:*** *Only include R&B charges for the days that the beneficiary was entitled to Medicare Part A.*
- *Report the covered days with value code 80 (FL 39-41) equal to the from and through date span.*
- *Include all ICD-9/10 CM diagnosis codes (FL 66) since the admission date.*
- *Include all ICD-9-CM, or ICD-10-PCS Surgical Procedures (FL 74, 74a-e) performed since the admission date.*
- *Include all charges since admission date excluding room and board prior to the effective date of Medicare.*
- *Enter the date of the beneficiary's entitlement to Medicare Part A in the billing notes/remarks field of the claim form.*

NOTE: *Claims with a discharge date equal to the Medicare Part A effective date cannot be billed as pre-entitlement claims. These guidelines apply to bills for discharges and interim billing.*