CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2388	**January 20, 2012**
	Change Request 7706

SUBJECT: Update to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing

I. SUMMARY OF CHANGES: CMS is clarifying billing instructions to Pub 100-04, Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing, Section 40, Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals when life time reserve (LTR) days exhaust during the nonoutlier portion of an Inpatient Prospective Payment System (IPPS) stay.

EFFECTIVE DATE: April 22, 2012
IMPLEMENTATION DATE: April 22, 2012
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	3/40/Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2388	Date: January 20, 2012	Change Request: 7706

SUBJECT: Update to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing

EFFECTIVE DATE: April 22, 2012
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I. GENERAL INFORMATION

A. Background: CMS is clarifying billing instructions to Pub 100-04, Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing, Section 40, Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals when life time reserve (LTR) days exhaust during the nonoutlier portion of an Inpatient Prospective Payment System (IPPS) stay.

B. Policy: There are no policy changes with this instruction.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7706.1	Contractors shall be aware of the revisions to Pub. 100-04, Chapter 3, Section 40, Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7706.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov (FI Billing)

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: 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.

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

(Rev.2388, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)

A. General

Days of utilization are charged based upon actual days of coverage including grace and waiver days. The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. The hospital collects the coinsurance, if applicable, for only the number of days charged against the beneficiary's utilization record maintained by CMS. For example, if the mean length of stay for a DRG is 10 days and the beneficiary is discharged after 3, only 3 days of utilization is charged. In a like situation, if the DRG mean length of stay is 10 days and the beneficiary is discharged after 15, the 15 days are charged against the utilization record.

NOTE: There are some exceptions to this rule under LTCH PPS. See §150.4.

Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the DRG payment. Days after benefits are exhausted are not charged against the beneficiary's utilization even though the hospital may receive the full DRG payment.

The basic prospective payment amount will be paid if:

- There is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium).

- There is at least l day for which payment may be made under the guarantee of payment. (If benefits are exhausted prior to admission and no payment may be made under guarantee of payment, only Part B benefits are available.)

- The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Utilization is not counted for any days treated as noncovered, except as described below:

- Utilization is not counted for any nonentitlement days, or days after benefits are exhausted (including guarantee of payment days), even if those days are treated as covered for outlier calculation or treated as Medicare patient days for the cost report.

- The length of stay exceeds the day*/cost* outlier threshold (Day outliers were discontinued at the end of FY 1997), utilization is counted for medically unnecessary days which are noncovered but for which the hospital may not charge the beneficiary because the requirements of §40.2 were not met. See §40.2.2 for identification of these days.

- If the adjusted cost of the stay exceeds the cost outlier threshold, utilization is counted for any medically unnecessary days on which all Part A services are treated as noncovered under §40.2.B and for which the hospital may not charge the beneficiary. (Where only ancillary services are denied, all days are counted as covered.)

Lifetime reserve days *(LTR)* for an inpatient hospital stay for which prospective payment may be made is subject to the following:

If the beneficiary had one or more regular benefit days *(full or coinsurance days)* remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the nonoutlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. IPPS uses Occurrence Span code 70 for the covered non-utilization period after regular benefit days are exhausted *or when only LTR days are exhausted*. For example:

EXAMPLE 1: No Cost Outlier, only LTR Days available and Exhaust prior to discharge

Dates of Service:	*01/05 – 01/16*
Medically necessary days	*11*
Benefit days available VC 83:	*1 LTR*
Covered days VC 80:	*1*
Noncovered days VC 81	*10*
Cost report days:	*11*
OC A3:	*01/15(includes covered non-utilization period)*
OSC 70:	*01/06 – 01/15*
Room & Board revenue code	*11 Total & Covered units*
Medicare approved revenue codes	*Charges in covered*
Reimbursement:	*Full DRG payment, no cost outlier*
Beneficiary Liability:	*LTR copayment amount*

EXAMPLE 2: No Cost Outlier, Coinsurance Days available and Exhaust prior to discharge

Dates of Service:	*01/05 – 01/16*
Medically necessary days	*11*
Benefit days available VC 82:	*3 Coinsurance*
Covered days VC 80:	*3*
Noncovered days VC 81	*8*
Cost report days:	*11*
OSC 70:	*01/08 – 01/15*
Room & Board revenue code	*11 Total & Covered units*
Medicare approved revenue codes	*Charges in covered*
Reimbursement:	*Full DRG payment, no cost outlier*
Beneficiary Liability:	*Coinsurance copayment amount*

After regular benefits have been exhausted, lifetime reserve days will be used automatically for outlier days unless the beneficiary elects not to use them, or the average daily charges for outlier days to be reimbursed as lifetime reserve days do not exceed the lifetime reserve day coinsurance amount. (In the latter case the beneficiary is deemed to have elected not to use lifetime reserve

days for outlier days.) An election not to use lifetime reserve for outlier days applies to all outlier days in an admission.

- If the beneficiary had no regular benefit days remaining when admitted, available lifetime reserve days are used automatically for each day of the stay. Exceptions exist if the beneficiary elects not to use lifetime reserve days, or the charges for which the beneficiary is liable, if electing not use lifetime reserve days, do not exceed the charges for which the beneficiary would be liable if the lifetime reserve days were used. Using lifetime reserve days, the beneficiary would be responsible for the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days are available. (In the latter case the beneficiary will be deemed to have elected not to use any lifetime reserve days.)

An election by the beneficiary not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay. A deemed election not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay unless payment may be made under the guarantee of payment.

The number of days for which utilization is charged may be different from the number used in Pricer to compute outlier status or the number of Medicare patient days shown on the cost report.