CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2877	**Date: February 07, 2014**
	Change Request 8445

Transmittal 2812, dated November 7, 2013, is being rescinded and replaced by Transmittal 2877, February 07, 2014 to: (1) remove the sensitive/controversial label, (2) revise the subject of this CR to clearly reflect the content of the CR, (3) clarifying and technical edits have been made to the Transmittal. In addition, sections I and II of the Business Requirements (specifically, BR 8445.1, BR 8445.4.1, and 8445.7) and the Table of Contents and the Manual instructions have been revised. All other information remains the same.

SUBJECT: Implementing the Part B Inpatient Payment Policies from CMS-1599-F

I. SUMMARY OF CHANGES: Implementing the revised policies related to payment of Part B inpatient services from the Fiscal Year 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule, CMS-1599-F.

EFFECTIVE DATE: For Admissions occurring on or after October 1, 2013
IMPLEMENTATION DATE: April 7, 2014

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	4/10.12 – Payment Window for Outpatient Services Treated as Inpatient Services
R	4/240 – Inpatient Part B Hospital Services
R	4/240.1 – Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
N	4/240.2 – Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A
N	4/240.3 – Implantable Prosthetic Devices
N	4/240.4 – Indian Health Service/Tribal Hospital Inpatient Social Admits
N	4/240.5 – Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services when Part A Payment Cannot Be Made

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	4/240.6 – Submitting Provider-Liable “No-Pay” Inpatient Claims and Beneficiary Liability

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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: 2877	Date: February 07, 2014	Change Request: 8445

Transmittal 2812, dated November 7, 2013, is being rescinded and replaced by Transmittal 2877, February 07, 2014 to: (1) remove the sensitive/controversial label, (2) revise the subject of this CR to clearly reflect the content of the CR, (3) clarifying and technical edits have been made to the Transmittal. In addition, sections I and II of the Business Requirements (specifically, BR 8445.1, BR 8445.4.1, and 8445.7) and the Table of Contents and the Manual instructions have been revised. All other information remains the same.

SUBJECT: Implementing the Part B Inpatient Payment Policies from CMS-1599-F

EFFECTIVE DATE: For Admissions occurring on or after October 1, 2013
IMPLEMENTATION DATE: April 7, 2014

I. GENERAL INFORMATION

A. Background: When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired. The 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 hospitals services furnished by nonparticipating hospitals. In this document, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

B. Policy: When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients. Part B payment may only be made if the beneficiary is enrolled in Part B and waiver of liability payment is not made.

This policy applies when a hospital 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 must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a "no pay" 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 may 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.

For Part B inpatient services furnished by the hospital that are not paid under the OPPS, but rather under some other Part B payment mechanism, Part B inpatient payment is made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

When payment cannot be made under Medicare Part A, Medicare continues to pay for Part B services included in the 3-day (1-day for hospitals not paid under the Inpatient Prospective Payment System (IPPS)) payment window preceding the inpatient admission, including services requiring an outpatient status (see Pub. 100-04, Medicare Claims Processing Manual, chapter 3 § 40.3).

The Part B coverage and payment rules for individual services apply. Hospitals are required to maintain documentation to support the Part B services rendered and billed.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the IPPS, hospitals paid under the OPPS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, CAHs, children's hospitals, cancer hospitals, Maryland waiver hospitals and other facilities as provided by CMS. Hospitals paid under the OPPS must continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the services they received, the beneficiary may face greater cost sharing.

Timely filing restrictions apply for the Part B services billed. Claims that are filed beyond 1 calendar year from the date of service will be rejected as untimely and will not be paid.

CMS notes that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of ancillary Part B inpatient services specified in the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 6, Section 10.2).

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8445.1	Contractors shall be aware of all polices outlined in the policy section above and in Pub. 100-04, chapter 4.	X											AdQIC, CERT, QIC, RACs,

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
													ZPICs
8445.2	For claims received on or after April 1, 2014, FISS shall no longer process 13x or 12x claims under the Administrator's Ruling CMS-1455-R that have an admission date on or after the effective date of CMS-1599-Final Rule. FISS shall disable any editing that looks to the Rebilling Termination Date from the Provider File and use the effective date of this rule instead. However, FISS shall continue to accept claims that have a treatment authorization of "A/B Rebilling" effective with claims that have an admission date on or after the effective date of this transmittal.	X							X				
8445.3	FISS shall recognize and process both 837I, DDE and Paper 12x TOB claims with: 1. a treatment authorization code of A/B Rebilling submitted by a provider. **NOTE:Providers submitting an 837I** will be 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. 2. a condition code "W2" attesting that this is a rebilling and no appeal is in process, and 3. the original, denied inpatient claim (CCN/DCN/ICN) number. **NOTE: Providers submitting an 837I** will be instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234 ~ **For DDE or paper Claims**, Providers will be 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". **NOTE:**	X							X				

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.												
8445.4	FISS shall validate the existence of an 11x medical necessity denial claim (either provider submitted medical necessity denial or contractor review medical necessity denial) based on the DCN in remarks.	X							X				
8445.4.1	FISS shall update and include OIG and ZPIC claim adjustments in the search for 11x medical necessity denials and update reports as necessary to reflect all changes.	X							X				
8445.4.2	If the claim is offline, FISS shall have the Part B Rebill claim systematically moved to a pending location so that the system can retrieve the offline claim. Once the 11x claim is back online, then the Part B Rebill claim needs to be systematically released so that it can then go thru the edits, which will then determine if the information in remarks has a valid DCN and correct formatting.								X				
8445.4.3	Contractors shall ensure that provider submitted medical necessity denial claims that qualify under this final rule only contain the Occurrence Span Code (OSC) "M1" and dates on the inpatient claim. Provider submitted denial claims that contain OSC "77" and dates on the inpatient claim do not qualify under this final rule.	X							X				
8445.5	If an 11x medical necessity denial claim does not exist based on the DCN submitted on the claim, then FISS shall create/modify a reason code that will be used to RTP the claim to the Provider.	X							X				
8445.6	Contractors shall Return to Provider a TOB 12x A/B Rebilling claim that does not have a medical denied 11x claim in history that matches the DCN in remarks.	X											

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8445.7	FISS shall not allow observation services (Revenue Code 762), and hospital outpatient visits (Revenue Code 45x and 51x) to be billed on the A/B Rebilling 12x TOB claim. This line level edit shall be bypassable. **NOTE:** This includes G0378 and G0379, 99201-99215, 99281-99285, G0380-G0384 and **G0463**.								X				
8445.8	FISS shall not allow services not covered under Part B (e.g., Room and Board Revenue Codes 0100 - 0239) to be billed on the Part B inpatient rebilling. This line level edit shall not be bypassable.								X				
8445.9	FISS shall bypass edits that only allow certain revenue codes to be covered on 12X type of bill (TOB), including edits tied to the revenue code file with exceptions noted in above requirements.								X				
8445.10	FISS shall permit providers to rebill for all of the services that would have been payable if the claim was originally ordered and submitted as an outpatient claim for payment (except for services that by definition could not be provided to a hospital inpatient, see requirements #7 and #8).								X				
8445.11	FISS shall pay the rebilled claim as if the provider had originally submitted the claim for services as an outpatient claim for payment based on the OPPS Pricer amount, lab fee amount, or other applicable payment methodology with applicable deductible and coinsurance amounts. **NOTE:** Beneficiaries will not be held harmless from any out of pocket expenses due to the change in payment, but are entitled to refunds of any amount already paid to the hospital consistent with IOM 100-4, Ch. 30 §§30.1.2, 30.2.2.								X				
8445.12	Contractors shall dismiss redetermination requests of Part A 11x claims if the provider has previously billed a 12x A/B rebilling claim.	X											

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8445.12.1	However, Contractors shall accept appeal requests of A/B rebilled 12x claims.	X											
8445.13	FISS shall revise Reason Code 39015 logic to no longer apply to both 13x and 12x A/B Rebilling claims with claims that have an Admission date on or after the effective date of this rule. FISS shall ensure that Reason Codes 39011 and 39012 apply to both 13x and 12x A/B Rebilling claims that have an admission date on or after the effective date of this rule.								X				
8445.14	CWF shall create an edit for claims that have a from date of October 1, 2013 and forward, that contain DSMT services. With this edit, CWF shall not allow these services as covered on the Type of Bills (TOBs) 12x and 22x.											X	
8445.14.1	FISS shall ensure that the CWF edit created above is mapped to a FISS Reason Code and set to RTP in FISS.	X							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8445.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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	X							

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	this article, on their Web sites and include information about it 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 the contractor's 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: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Ann Marshall, 410-786-3059 or ann.marshall@cms.hhs.gov (for policy questions), Fred Rooke, 404-562-7205 or fred.rooke@cms.hhs.gov (for institutional claims questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) 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; Contractors activities are to be carried out with 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 do 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.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev 2877., Issued: 02-07-14)

10.12 – Payment Window for Outpatient Services Treated as Inpatient Services

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

The policy for the payment window for outpatient services treated as inpatient services is discussed in chapter 3 *§ 40.3* of *this manual.* The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the *Medicare Part A* payment for the beneficiary's inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services *(including non-patient laboratory tests)* and non-diagnostic services (i.e., therapeutic) that are related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

All diagnostic services *(including non-patient laboratory tests)* provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital) on the date of the beneficiary's inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission are required to be included on the *Part A* bill for the inpatient stay.

Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the *Part A* billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission. In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed *to Part A* with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed *to Part A* with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission). Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010 effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

In the event that there is no Part A coverage for the inpatient stay, *the hospital may bill Part B for the* services provided to the beneficiary prior to the point of *inpatient* admission (i.e., *the time of formal admission pursuant to* the *inpatient* admission order) *that would otherwise be included in the payment window for Part A payment, including services requiring an outpatient status. Certain Part B inpatient services provided to the beneficiary after the point of inpatient admission (i.e., the time of formal admission pursuant to the inpatient admission order) may also be billed to Part B when Part A payment cannot be made. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10 "Medical and Other Health Services Furnished to Inpatients of Participating Hospital" for a full description of this policy.*

A hospital may attest to specific non-diagnostic services as being unrelated to the hospital *Part A* claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April 1, 2011, will need to be adjusted by the provider if they were

rejected by FISS or CWF.

As stated in §180.7 of this chapter, “inpatient-only” procedures that are provided to a patient in the outpatient setting during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS. Providers should bill for these services on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same outpatient encounter as the non-covered inpatient-only procedure (see the two exceptions listed in §180.7), providers are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,
- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.

240 – Inpatient Part B Hospital Services

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

*Medicare pays for hospital (including CAH) i*npatient 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. These services are never outpatient services, and therefore are not separately billable Inpatient Part B ancillary services. They include routine nursing services that are captured in the Room and Board rate (such as IV infusions and injections, blood administration, and nebulizer treatments), which are not separately billable Inpatient Part B ancillary services.

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

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

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.” The claims processing system* shall set edits to prevent payment on Type of Bill 12x 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*	*024x*	*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.*

CWF shall edit to ensure that DSMT services are not billed on a 12x claim.

When denying lines containing the above revenue codes on TOB 12x, the A/B MAC shall use MSN message 21.21– This service was denied because Medicare only covers this service under certain circumstances.

The A/B MAC or FI shall place reason code M28 on the remittance advice when denying services reported under the specified revenue codes.

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

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 12x 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	024x	0250
0251	0252	0253	0256	0257	0258	0259	0261
0269	0270	0273	0277	0279	029x	0339	0360
0370	0374	038x	039x	041x	045x	0472	0479
049x	050x	051x	052x	053x	0541	0542	0543
0544	0546	0547	0548	0549	055x	057x	058x
059x	060x	0630	0631	0632	0633	0637	064x
065x	066x	067x	068x	072x	0762	078x	079X
082x	083x	084x	085x	088x	0905	0906	0907
0912	0913	093x	0940	0941	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.*

When denying lines containing the above revenue codes on TOB 12x, the A/B MAC shall use MSN message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.

The A/B MAC shall place reason code M28 on the remittance advice when denying services reported under the specified revenue codes.

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

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 OPPS 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 OPPS 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 OPPS 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

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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

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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.