national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Inpatient Rehabilitation Facilities: Preparing and Submitting Compliant Claims to Medicare

6/26/2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

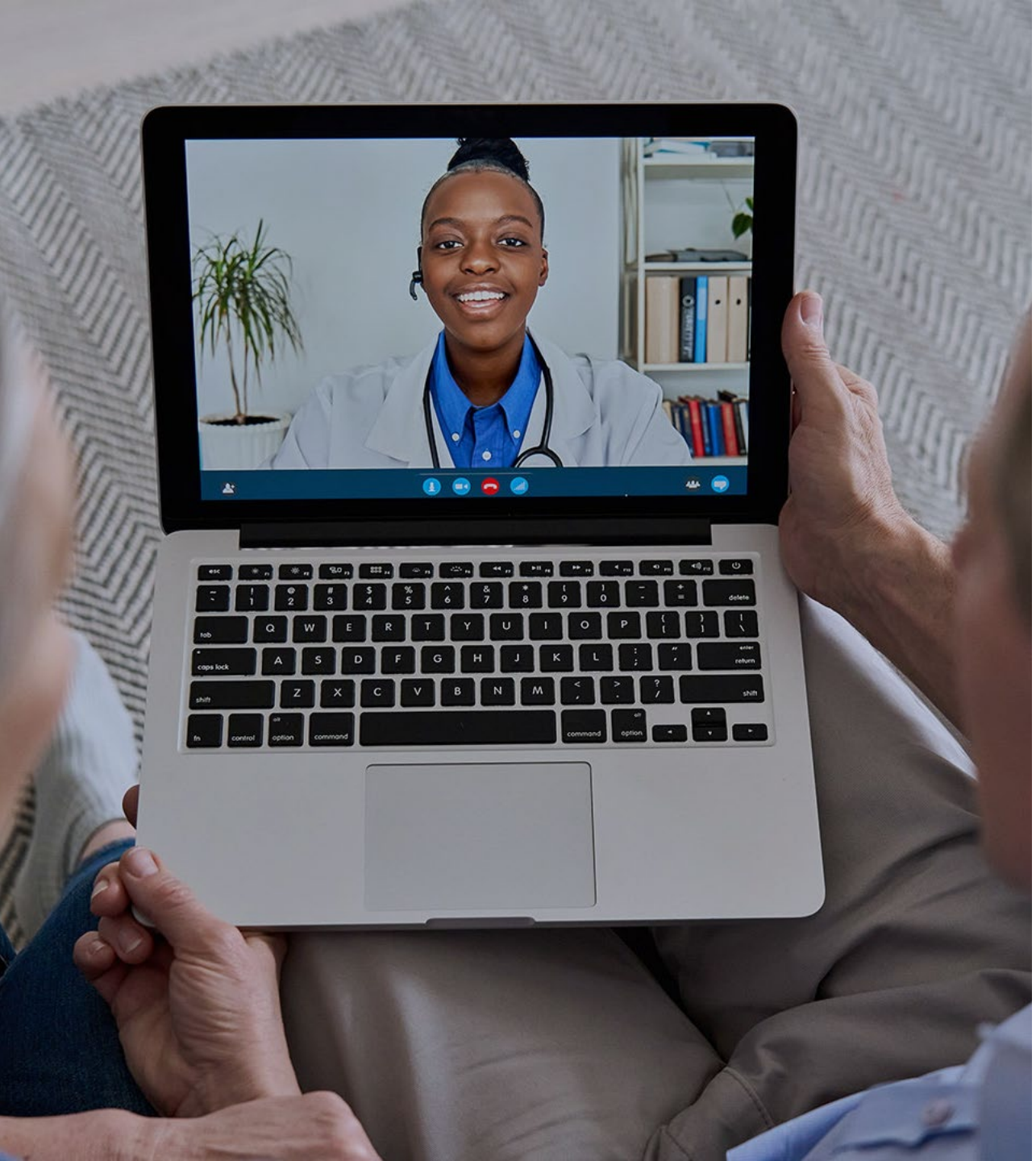
NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2758_062625

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.



Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events. **This includes the use of AI-assistant recording tools.**

Objective

Assist IRFs in understanding how to prepare and submit compliant claims to Medicare so fewer of your claims RTP or reject for billing errors

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

- Billing and Claim Resources
- Basic IRF Billing Requirements
- Frequency of Billing and TOBs
- Application of Benefit Days and BE During Stay
- One-Day Payment Window Policy
- Miscellaneous IP Situations
- References and Resources
- Questions

Billing and Claim Resources

Billing Resources

- Complete IRF claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Section 140

Claim Resources

- Claim form
  - UB-04/CMS-1450
  - Electronic equivalent: 837I claim
  - Claim entry via FISS DDE
- Claim FLs (of UB-04/CMS-1450)
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
    - FL names and descriptions but no codes
- Claim codes
  - National Uniform Billing Committee (NUBC) members access billing codes from NUBC's *UB-04 Data Specifications Manual*

FLs for Provider Identification

- FL 1 = Billing provider name, address, telephone number
- FL 5 = Federal tax number
- FL 56 = Billing provider NPI
- FL 76 = Attending provider name and identifiers
- FL 77 = Operating provider name and identifiers
- FLs 78 and 79 = Other provider name and identifiers

FLs for Patient Identification

- FL 3a = Patient control number
- FL 3b = Medical/health record number (situational)
- FL 8 = Patient's name and identifier
- FL 9 = Patient's address
- FL 10 = Patient's birth date
- FL 11 = Patient's sex

FLs for Insurance Identification

- FL 50A = Medicare when Medicare primary
  - All additional entries across line A (FLs 51-55) supply information needed by payer named in 50A
- FL 58A = Insured's name
- FL 59A = Patient's relationship to insured (self)
- FL 60A = Insured's Unique ID (Certificate/Social Security Number/MBI)
- For FLs to complete for MSP claims, refer to Prepare and Submit a Medicare Secondary Payer Claim

Other FLs

- FL 4 = TOB
- FL 6 = Statement covers period (from and through dates)
- FL 12 = Date of admission
- FL 14 = Priority (type) of admission
- FL 15 = Point of origin for admission
- FL 17 = PSC as of statement covers period through date (FL 6)
- FLs 18-28 = CCs
- FLs 31-34 = OCs and dates
- FLs 35-36 = OSCs with from/through dates
- FLs 39-41 = VCs and amounts
- FL 42 = Revenue code

Other FLs (continued)

- FL 44 = HCPCS/Rates/HIPPS rate codes (accommodation rate)
- FL 46 = Unit(s) of service
- FL 47 = Total charges (not for electronic billing)
- FL 48 = Noncovered charges
- FL 64 = DCN
- FL 67 = Principal diagnosis code
- FLs 67 A-Q = Other diagnosis codes
- FL 69 = Admitting diagnosis code
- FL 74 = Principal procedure code and date
- FLs 74 A-E = Other procedure codes and dates
- FL 80 = Remarks

Before Submitting Claims to Medicare

- Check with internal departments to ensure all services reported on claim
- Verify all required data elements entered accurately and completely
- Check if claim already submitted
- Remember our one-year timely filing requirement
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

Submitting Claims to Medicare – Options

- UB-04/CMS-1450 hardcopy claim form
  - Must have approved ASCA waiver
  - ASCA Requirements for Paper Claim Submission
- FISS DDE claim entry or through clearinghouse
- 837I claim
  - EDI and How it Works

Claims Status/Locations in FISS

- When claim submitted for processing, it receives a S/LOC
  - Basic S/LOCs include
    - P B9997 – Claim processed
    - S XXXXX – Claim suspended
    - R B9997 – Claim rejected
    - T B9997 – Claim RTP
    - D B9997 – Claim denied

Claim Status and Provider Action

- If claim RTP (S/LOC = T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
    - Select PF9 to resubmit claim
- If claim rejected (S/LOC = R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim denied (S/LOC = D B9997)
  - Determine if appeal needed
  - Documentation must support services rendered

Basic IRF Billing Requirements

Billing and Payment Responsibilities

- IRF
  - Performs patient assessments
  - Transmits IRF PAI data to CMS via software which generates HIPPS rate code
  - Reports this HIPPS rate code on Medicare claim
    - One exception
- Medicare
  - If claim payable, generates CMG payment to IRF via PRICER
    - Subject to
      - Case-level adjustments
      - Facility-level adjustments
      - IP hospital deductible and coinsurance

Revenue Code 0024, HIPPS Rate Code and IRF PAI Transmission Date

- On claim, report
  - **Revenue codes** for procedures and services rendered with
    - Number of units and charges
  - **Revenue code 0024** and one valid **HIPPS rate code** with
    - One unit of service and no charges
    - HIPPS rate code = AXXYY–DXXYY
      - First two digits = A, B, C or D = based on comorbidity tier
      - XX = RIC
      - YY = Sequential numbering system within RIC
  - **OC 50 and date** IRF PAI data transmitted to CMS

Special HIPPS Rate Codes

- CMG paid based on HIPPS rate code IRF reported on claim
  - Unless PRICER changes HIPPS rate code to special HIPPS rate code
    - If so, we place RARC on RA to explain change
- Five special HIPPS codes if beneficiary expires (PSC = 20)
  - A5001 = Expires or discharged within three days of admission
    - Considered short stay
  - A5101 = Orthopedic patient, LOS 13 days or fewer
  - A5102 = Orthopedic patient, LOS 14 days or more
  - A5103 = Non-orthopedic patient, LOS 15 days or fewer
  - A5104 = Non-orthopedic patient, LOS 15 days or more

Reporting Special HIPPS Rate Codes

- IRFs never report special HIPPS rate code unless A5001 applies:
  - Beneficiary's thorough preadmission screening shows he/she an appropriate candidate for IRF care
  - Something unexpected happens between preadmission screening and IRF admission such that beneficiary no longer appropriate candidate for IRF care on admission and
  - Day count greater than three
- IRF receives short stay payment
  - Whether or not IRF discharges beneficiary to another setting of care within three days

Frequency of Billing and TOBs

Frequency of Billing Guidelines for IRFs

- Submit claims through final discharge or death
  - Admission to discharge claims or
  - Interim claims every 60 days
- Continue to submit claims even if
  - Benefits exhaust or
  - Care becomes noncovered

TOBs for IRF Claims

- "One claim per stay" concept
  - 111 = Admission to discharge claim
  - 112 = First interim claim
  - 117 = Subsequent interim claim and adjustment claim
  - 118 = Cancel claim
  - 110 = No-payment claim
  - 12X = IP ancillary claim

TOB 111

- IP claim from admission to final discharge/death
  - Admission date = actual admission date
  - Statement from date = admission date
    - If payment window policy applies, report earliest OP DOS added to IP claim
  - Statement through date = discharge/death date
    - Report PSC that accurately represents beneficiary's status as of this date
- Submit
  - At final discharge/death

TOBs 112 and 117 for Interim Billing

- IP interim claims
  - You may submit if stay greater than 60 days
    - TOB 112 = First 60-day interim claim
    - TOB 117 = Subsequent 60-day interim claims
    - Each contains original stay(s) plus each subsequent 60-day periods
    - TOB 117 may contain less than 60 days if beneficiary discharges, transfers or dies

Interim Claim Coding

- TOB = 112 (first interim claim) or 117 (subsequent interim claim)
- Admission date = actual admission date
- Statement from date = admission date
  - If payment window applies, report earliest OP DOS added to claim
- Statement through date = 60th day, discharge/transfer/death
- PSC = 30 (still a patient) or appropriate PSC (if final claim)
- Claim change reason code = D3 (on TOB 117)
- Revenue code 0024 with lowest level HIPPS rate code from admission assessment until final discharge

TOB 117 for Adjustments

- IP adjustment claim
  - Submit to change or correct original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires one claim change reason code (reason for adjustment)
  - FISS Claim Change/Condition Reason Codes
    - Changes to HIPPS rate code (CC D4)
      - 60-day time limit for submitting when change results in higher paying CMG
  - How to Adjust a Claim
    - Reference original claim DCN in FL 64

TOB 118

- IP cancel claim
  - Submit to cancel original claim
  - Requires one claim change reason code (reason for cancel)
  - FISS Claim Change/Condition Reason Codes
  - How to Cancel a Claim
    - Reference original claim DCN in FL 64

TOB 110

- IP no-payment claim
  - Submit when no payment expected from Medicare
- You must submit
  - For all noncovered IP stays
    - Except when beneficiary not enrolled in Medicare Part A (enrolled in Part B only)
  - At final discharge/death
- Tip
  - Do not include OP services rendered in one-day payment window

When to Submit TOB 110

- Medicare IP hospital benefit days exhausted at admission
- Beneficiary at noncovered LOC at admission and for entire stay
  - Claim coding for admission denials (not R&N)
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.2 letter E
  - If care becomes covered during stay, cancel TOB 110s, submit corrected claims
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.1

TOB 12X

- IP ancillary claim for services to inpatients submitted under Part B when Part A can't pay for IP stay
  - Report revenue codes, units, charges, LIDOS (FL 45), CPT/HCPCS codes
  - Billable services depend on reason Part A can't pay for IP stay
    - No Part A or IP hospital benefit days exhausted
      - Bill services per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2
      - Do not bill revenue codes in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2
    - IP stay denied not R&N
      - Bill services per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1
      - Do not bill revenue codes in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.1

Did You Know

- There are several services which, when provided to a hospital inpatient, are covered under Part B, even though the beneficiary has Part A coverage for the hospital stay.
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 250

TOB 12X for Vaccines and Administration

- You may submit TOB 12X for vaccines and administration provided to inpatients
  - Influenza, PPV, and hepatitis B
  - For DOS, use discharge date or BE date
- Reference
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2

Application of Benefit Days and BE During Stay

Payment Under IRF PPS

- CMG payment = Payment of IP IRF services
  - Beneficiary must have at least one IP hospital benefit day
- HCO payment = Additional payment for cases with extraordinarily high costs
  - Beneficiary must have IP hospital benefit day for each medically necessary day in HCO period
    - HCO period begins day after accumulated covered charges reach HCO threshold amount (amount exceeded)
      - HCO threshold amount = CMG + fixed loss amount
        - OC 47 and date HCO threshold exceeded may be needed on claim

Medicare IP Hospital Benefit Days

- 90 renewable days per benefit period (regular days)
  - Renewed when new benefit period starts
    - First 60 days = full days; inpatient deductible applied
    - Next 30 days = coinsurance days; daily coinsurance applied
- 60 nonrenewable days to use after 90 regular days (LTR days)
  - Not renewed when new benefit period starts
    - LTR days; daily coinsurance applied
    - Patient can elect not to use
      - Provider must inform beneficiary of this right
      - Beneficiary responsible for cost resulting from not using LTR days

Medicare's Application of IP Hospital Benefit Days Under IRF PPS

- We use unique method to apply IP hospital benefit days
  - We don't apply
    - IP hospital benefit days on a "day by day" basis
    - Regular benefit days and LTR days to same claim
      - Unless LTR days needed for **HCO period**
        - In this case, we apply LTR days in HCO period only
  - We do apply
    - LTR days if they are all that remain at admission

Medicare's Application of IP Hospital Benefit Days Under IRF PPS (continued)

- If **no HCO period** on claim, we apply
  - Regular IP hospital benefit days only, even if LTR days available
  - LTR days if only LTR days available
- If **HCO period** on claim, we apply
  - Regular IP hospital benefit days only in inlier period, even if LTR days available
  - LTR days in inlier period if only LTR days available
  - LTR days in HCO period only if needed

Inlier Days, Inlier Period and OSC 70

- If beneficiary has at least one IP hospital benefit day
  - We pay CMG up to any HCO period
    - Even if IP hospital benefit days exhaust before HCO period
  - We may pay for days beneficiary doesn't have (inlier) by adding OSC 70 and from/through dates to claim
    - Inlier days
      - If no HCO = days after last available IP hospital benefit day to end of stay
      - If HCO = days after last available IP hospital benefit day up to HCO
    - Inlier period
      - If no HCO = period between last available IP hospital benefit day and end of stay
      - If HCO = period between last available IP hospital benefit day and HCO period

Benefits Exhaust During Stay – IRF

- IRF can choose to report or not report BE date
  - BE date = last date on which IP hospital benefit day available
    - Report OC A3 and BE date, but also report
      - Covered and noncovered days/services per benefit day availability
    - Do not report OC A3 and BE date, but report
      - Up to 150 medically necessary days as covered regardless of benefit day availability
      - Medically necessary days over 150 as noncovered but associated charges as covered

Benefits Exhaust During Stay – Medicare

- Medicare
  - Determines availability of benefit days
  - Applies available benefit days
  - Corrects submitted OC A3 date or adds OC A3 date
  - Adds OSC 70 and from/through dates of inlier period, if applicable

HCO and OC 47 Date

- If claim qualifies for HCO, we determine if
  - Claim's covered charges exceed HCO threshold amount
  - Beneficiary has enough benefit days for each medically necessary day in HCO period
    - If yes, we pay claim accordingly
    - If no, we RTP claim with HCO threshold amount requesting OC 47 and date
      - IRF receives this RTP if beneficiary does not have enough regular benefit days or LTR days (when he/she has only LTR days) to cover all medically necessary days

RTP Reason Codes for HCO Claims

- **37036** = Not enough IP hospital benefit days for each medically necessary day and covered charges exceed HCO threshold amount
- **37045** = LTR days can only be present with IP hospital regular benefit days when OC 47 and date are present

RTP Reason Codes 37036 and 37045

- Provider action
  - Add OC 47 and date = day after date HCO threshold amount reached
    - View HCO threshold amount on MAP1716 (page 6 in FISS DDE)
    - Add claim's daily covered charges
      - Start with day one
      - Continue each day until your charges reach HCO threshold amount
      - Exclude charges occurring on days in noncovered OSCs
      - Notate date daily covered charges reach HCO threshold amount
    - Add/correct OC 47 and date
      - OC 47 date = day HCO threshold amount exceeded (day after date HCO threshold amount reached); cannot be equal to or during noncovered OSCs
    - Correct units/charges for noncovered services if BE occurs

Processing Claim With OC 47 and Date

- Upon receipt of OC 47 and date
  - We determine if beneficiary has enough or has correct combination of IP hospital benefit days for each medically necessary day in HCO period
    - If BE, date depends on number and type of benefit days available
- Reference
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 20.7.4

BE With No HCO

- Beneficiary
  - Has regular benefit days but they exhaust before claim's end
  - May/may not have LTR days
- We
  - Apply OSC 70
    - From = last regular benefit day
    - Through = end of claim
  - Do not add OC A3 and date
    - Benefits do not exhaust
  - Pay CMG

- Beneficiary
  - Does not have regular benefit days
  - Has LTR days but they exhaust before claim's end
- We
  - Apply OSC 70
    - From = last LTR day
    - Through = end of claim
  - Add OC A3 and date
    - Day before discharge date
  - Pay CMG

BE With HCO

- Beneficiary
  - Has regular benefit days but they exhaust before HCO
  - **Has no LTR days/elects not to use**
- We
  - Apply OSC 70
    - From = last regular benefit day
    - Through = day before OC 47 date
  - Add OC A3 date
    - **Day before OC 47 date**
  - Pay CMG but not HCO

- Beneficiary
  - Has regular benefit days but they exhaust before HCO
  - **Has LTR days**
- We
  - Apply OSC 70
    - From = last benefit day
    - Through = day before OC 47 date
  - Add OC A3 date
    - **Last LTR day**
  - Pay CMG and some or all of HCO

One-Day Payment Window Policy

Policy Overview

- Applies when payment can be made on Part A claim
  - **Admitting IRF** reports on its IP claim
    - OP **diagnostic** services it rendered on
      - IRF admission date and/or
      - Day prior to IRF admission date
    - OP **nondiagnostic** services it rendered on
      - IRF admission date
      - Day prior to IRF admission date unless IRF determines **not related** to IRF stay
        - If not related to IRF stay, you may submit separate OP claim with **CC 51**

Admitting Hospital

- Admitting IRF includes any entity that is either
  - Wholly-owned or wholly-operated by IRF or
  - Under arrangement with IRF to provide services to beneficiary
- References
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 12, Sections 90 and 90.7.1

OP Diagnostic Services

- Defined by revenue and CPT/HCPCS codes on CMS' diagnostic services list
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.3

OP Nondiagnostic Services

- Defined by revenue and CPT/HCPCS codes not on CMS' diagnostic services list
- Submit separately from IP claim on OP claim if
  - Rendered on day prior to IRF admission date and
  - IRF attests **not related** to IRF stay by reporting CC 51
    - **CC 51 = Services clinically distinct or independent from reason for IP admission**
      - You must have documentation to support decision
      - Claim may be subject to subsequent review
      - Claim subject to Medicare's one-year timely filing guideline

Reporting OP Services on IP Claim

- When you report applicable OP services on IP claim, include
  - Revenue code(s) and charges
  - Procedure(s) and associated date(s)
  - Diagnosis code(s)
  - Actual IP admission date and
  - Statement from date = earliest OP DOS added to claim

Payment Window Does Not Apply to CAHs

- OP diagnostic services
  - Rendered by CAH or entity wholly-owned or wholly-operated by CAH, during payment window, not subject to payment window policy
    - Admitting hospital should not report these services on IP stay claim
  - Rendered at CAH wholly-owned or wholly-operated by non-CAH hospital, during payment window, subject to payment window policy
    - Admitting hospital should report these services on IP stay claim

Miscellaneous IP Situations

Did You Know

- All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangement.
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 10.4

Services to Inpatients Under Arrangement

- General rule for all hospitals; hospital
  - Admits beneficiary as IP but he/she needs services it could not provide
  - Sends IP beneficiary to another facility for those services
    - Other facility renders services as OP; beneficiary returns to hospital same day
  - Reimburses other facility for OP services
    - Other facility submits their claim to hospital; not to Medicare
  - Submits IP claim with
    - Revenue codes for services it rendered and charges
    - Revenue codes for services other facilities rendered under arrangement and cost
    - Includes transportation cost with cost for arranged service and does not report revenue code 0540

Under Arrangement Example

- IRF example
  - Beneficiary in IRF but requires MRI IRF cannot provide
  - IRF sent beneficiary to ACH for MRI on 5/15/2025 at 8 a.m. by ambulance
  - Beneficiary returns to IRF same day 5/15/2025 at 1 p.m.
- IRF action
  - Pay ACH for MRI
  - Pay transportation provider for ambulance
  - On IP claim, report revenue code for MRI with total cost for MRI and transportation
- **Note:** This is also an example of IRF one-day interruption

Three-Day or Less Interruptions From IRF

- If you missed our webinar “Inpatient Rehabilitation Facilities: Three-Day or Less Interruptions” on 1/21/2025, you may review the materials on the Past Events page of our website.

Beneficiary Admitted to IRF Prior to Part A Medicare Entitlement Date

- Per Inpatient Admission Prior to Medicare Entitlement Job Aid:
  - Admission date = actual admission date
  - Statement covers period = Part A effective date to discharge date
  - Covered days (VC 80) = days in statement covered period
  - Accommodation days/units (R&B revenue codes) = VC 80 days
  - Revenue codes = admission to discharge
  - Charges = admission to discharge except R&B prior to Part A
  - Diagnosis codes = admission to discharge
  - Procedure codes = admission to discharge
  - Remarks to indicate beneficiary's Part A effective date

Beneficiary in IRF One Day in Between Two IP Stays at Same ACH

- Beneficiary incurs one-day IRF stay in between ACH stays
  - IP in ACH
  - Transferred to IRF on same day
  - Readmitted to same ACH by midnight on same day
- Contact ACH to identify who to bill for one IRF day
  - ACH determines – Are two ACH stays related to each other?
    - If yes, IRF bills ACH for one-day stay and ACH pays IRF under arrangement
    - If no, IRF bills Medicare directly for one-day stay
      - CR3389, Revision of CWF Editing for Same-Day, Same-Provider Acute Care Readmissions

Beneficiary in IRF One Day and Transferred to Another IP Facility on Same Day

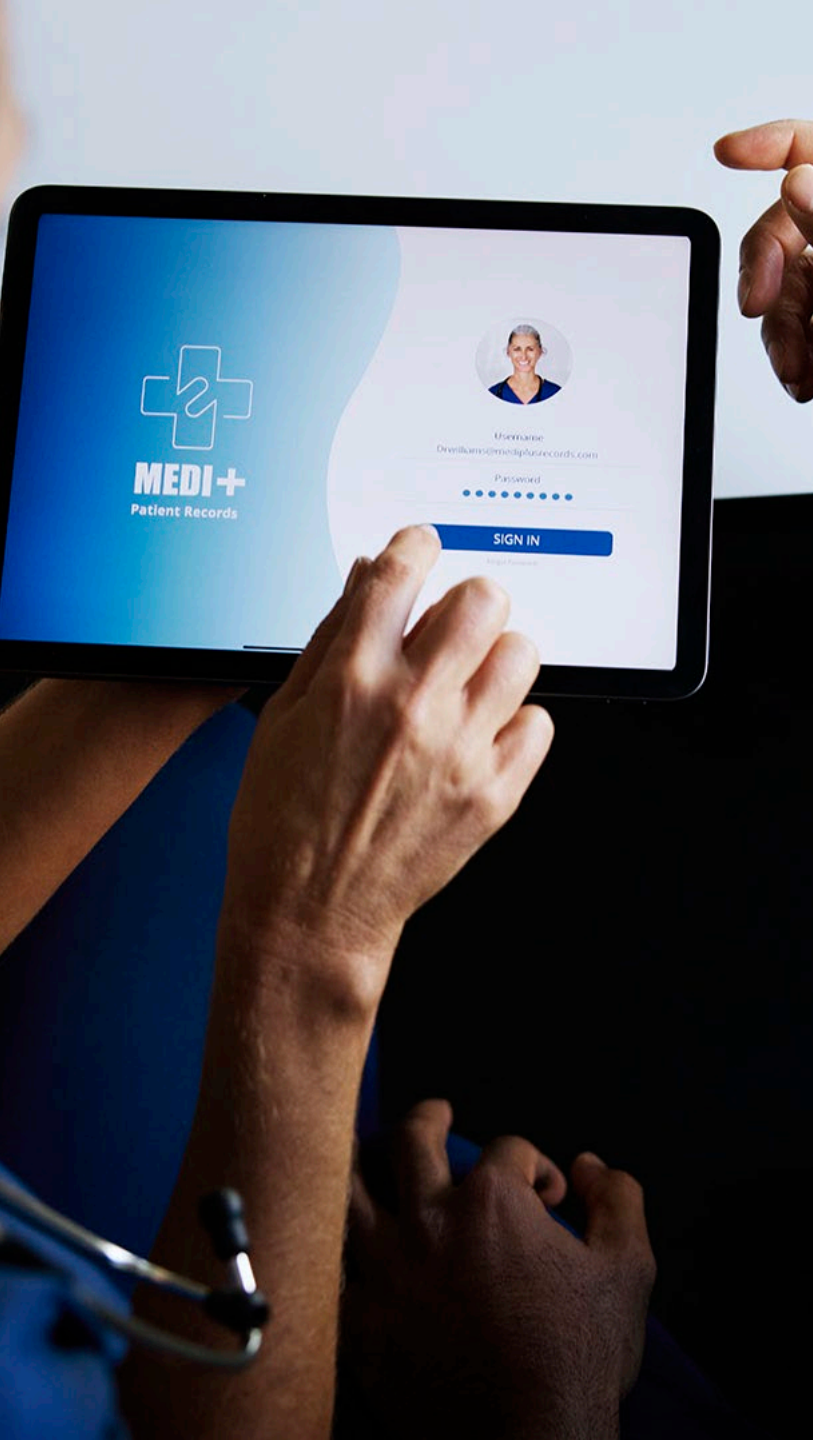
- If beneficiary incurs one-day IRF stay
  - Admitted to IRF but transferred to another IP facility on same day before midnight
  - Not same situation as indicated on prior slide
- Submit claim and report
  - Same admission, from, and through date
  - CC 40 (same-day transfer)
  - Report day as noncovered but services/charges as covered

Beneficiary Received Noncovered Care During IRF Stay

- All IP claims must include claim coding for any periods of time during which beneficiary at noncovered LOC
  - OC 31 and date
    - Date provider notified beneficiary
  - VC 31 and amount
    - Amount of charges provider may bill beneficiary for hospitalization not medically R&N
  - OSC 76 with from/through dates
    - Beneficiary liability
    - Period of noncovered care for which you may charge beneficiary
      - You notified beneficiary in writing prior to “from” date of this period

Beneficiary Received Noncovered Care During IRF Stay (continued)

- OSC 77 and from/through dates
  - Provider liability; utilization
  - Period of noncovered care for which you are liable (other than for lack of medical necessity or custodial care)
  - Beneficiary's record charged with utilization
    - You may collect deductible and/or coinsurance
- OSC M1 and from/through dates
  - Provider liability; no utilization
  - Period of noncovered care for which you are liable (denied due to lack of medical necessity or as custodial care)
  - Beneficiary's record not charged with utilization
    - You may not collect deductible and/or coinsurance



Patient Is MAO Plan Enrollee for Only a Portion of Billing Period

- Plan effective at admission responsible for entire IP stay
  - Traditional Medicare responsible
    - If patient enrolled in traditional Medicare at admission
  - MAO plan responsible
    - If patient enrolled in MAO plan at admission

Non-Teaching IRF Bills Traditional Medicare for MAO Plan Enrollee

- Submit IP informational claims to us to capture days for LIP adjustment
  - After billing MAO plan, submit IP claim to us and report
    - Covered TOB 11X
    - Covered days/charges
    - CC 04
    - Medicare as first payer (obtain MBI from patient); not as MSP claim
    - All other required claim elements for IRF claim
- We processes claims with reason code 3719C and capture days for LIP adjustment purposes

Teaching IRF Bills Traditional Medicare for MAO Plan Enrollee

- Submit IP informational claims to us to receive payment for DGME or N&AH via cost report
  - After billing MAO plan, submit IP informational claim to us and report
    - Covered TOB 11X (unless N&AH only; submit TOB 110)
    - Covered days/charges (unless N&AH only; submit noncovered days/charges)
    - CCs 04 and 69
    - Medicare as first payer (obtain MBI from patient); not as MSP claim
    - All other required claim elements for IRF claim
- We reject claims with
  - Reason code 37574 and pay DGME via cost report
  - Reason code 39934 and pay N&AH via cost report

What You Should Do Now

- Review references and resources
- Share information with staff
- Follow instructions for submitting IRF claims
- Develop and implement policies that ensure claims correctly submitted to Medicare
- Attend future education for IRFs

References and Resources

National Government Services

- Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
- FISS Claim Change/Condition Reason Codes
- How to Cancel a Claim
- How to Adjust a Claim
- Inpatient Admission Prior to Medicare Entitlement Job Aid

CMS IOM Publications

- 100-02, *Medicare Benefit Policy Manual*
  - Chapter 1, Section 110, Inpatient Rehabilitation Facility Services
  - Chapter 6
    - Section 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
    - Section 10.2, Other Circumstances in Which Payment Cannot Be Made Under Part A
  - Chapter 15, Section 250, Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities
- 100-04, *Medicare Claims Processing Manual*
  - Chapter 1
    - Section 50.2.1, Inpatient Billing From Hospitals and SNFs
    - Section 70, Time Limitations for Filing Part A and Part B Claims
    - Section 90, Patient is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
  - Chapter 3
    - Section 10.4, Patient of Nonphysician Services for Inpatients
    - Section 20.7.4, Cost Outlier Bills With Benefits Exhausted
    - Section 40.2.1, Noncovered Admission Followed by Covered Level of Care

CMS IOM Publications (continued)

- 100-04, *Medicare Claims Processing Manual*
  - Chapter 3
    - Section 40.2.2, E Charges to Beneficiaries For Part A Services (Admission Denied)
    - Section 40.3, Outpatient Services Treated as Inpatient Services
    - Section 140, Inpatient Rehabilitation Facility Prospective Payment System
    - Section 140.2.5.3, Low-Income Patient Adjustment
  - Chapter 4, Section 10.12, Payment Window for Outpatient Services Treated as Inpatient Services
  - Chapter 12, Section 90.7.1, Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)
  - Chapter 18, Section 10.2.2.1, Payment for Pneumococcal Pneumonia Virus, Influenza Virus, Hepatitis B Virus and COVID-19 Vaccines and Their Administration on Institutional Claims
  - Chapter 25, Section 75, General Instructions for Completion of Form CMS-1450 for Billing

Information for IRFs on CMS' Website

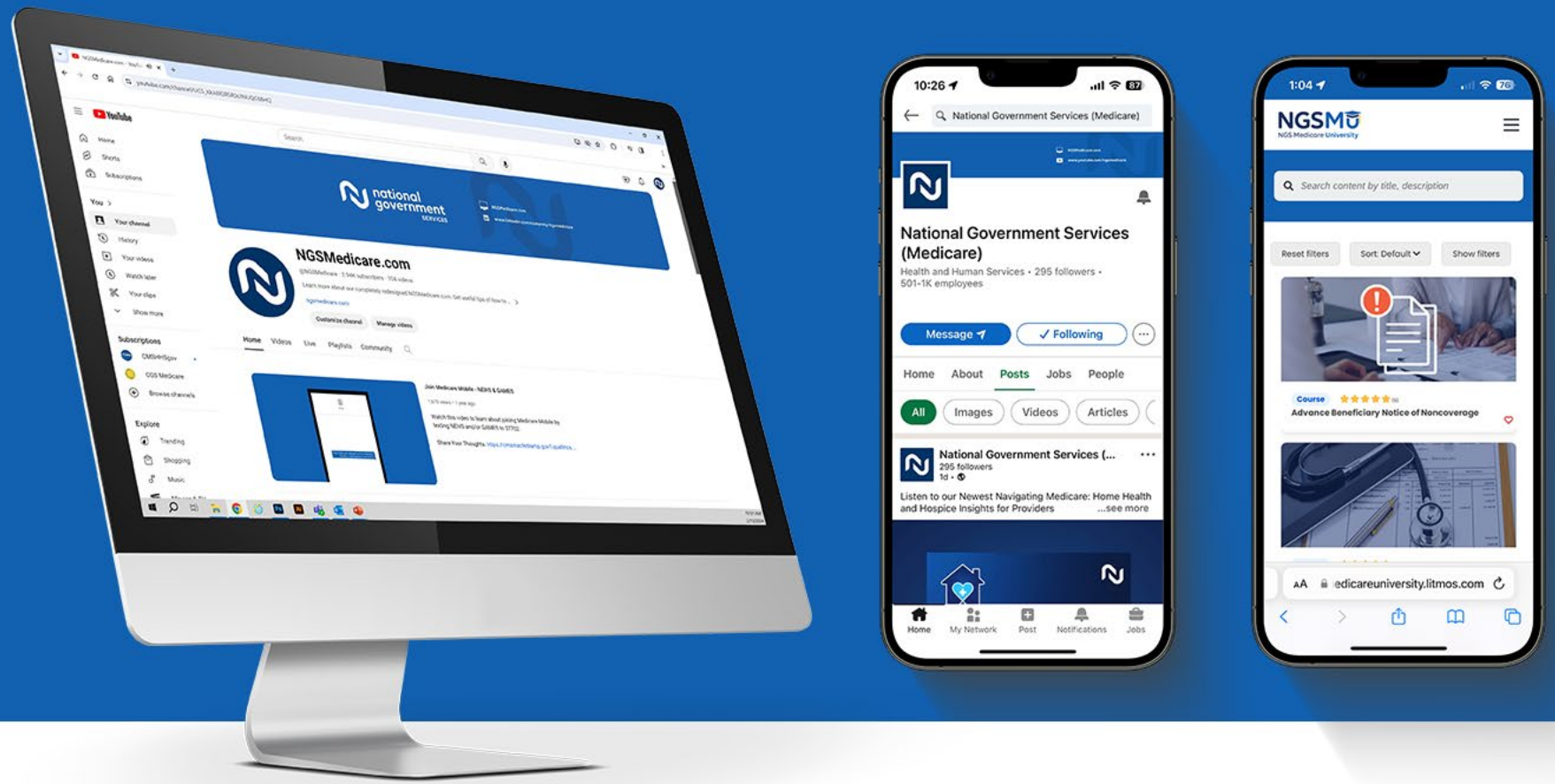
- IRF PPS
  - Contact Information
  - Coverage Information
  - Data Files
  - HIPPS Codes
  - IRF rules and Related Files
  - IRF-PAI
  - SSI Data

Information for IRFs on CMS' Website (continued)

- Inpatient Rehabilitation Facility Prospective Payment System
- Inpatient Rehabilitation Facility PPS Web Pricer
- IRF Grouper
- IRF Quality Reporting Program (QRP)
- Medicare Provider Compliance Tips - Inpatient Rehabilitation Hospitals & Inpatient Rehabilitation Units
- QIES Technical Support Office

Questions?

Thank you!



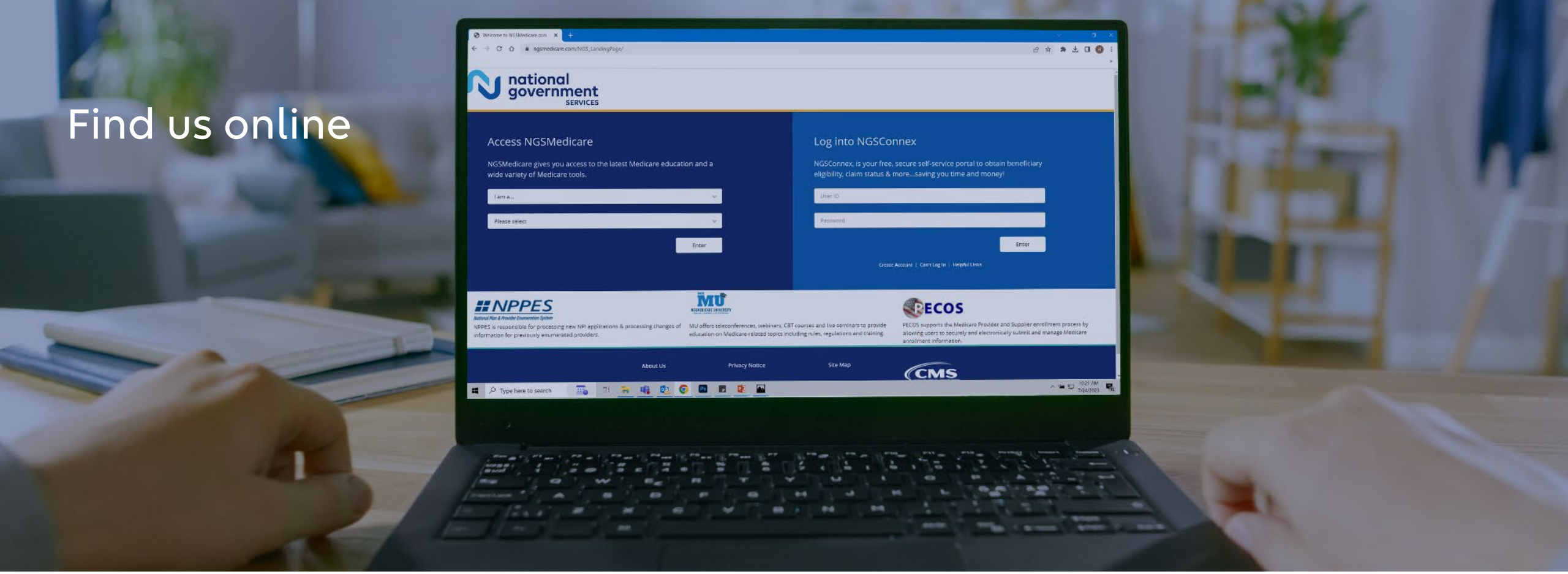
Connect with us on social media

[YouTube Channel](#)
Educational Videos

[Medicare University](#)
Self-paced online learning

[LinkedIn](#)
Educational Content

Find us online



www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news