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National Government Services

2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Preparing Acute Care Hospital Inpatient Claims – Ready, Set, Go!

5/12/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objective

- Assist ACHs in understanding how to complete IP claims for Medicare in a variety of IP billing situations

Agenda

- General claim information
- TOBs for IP claims and frequency of billing
- OP services rendered within payment window
- OP under arrangement services for inpatients
- LOAs and same-day readmissions
- BE during stay, HCOs, and how Medicare applies IP hospital benefit days
- IP claims for MAO plan enrollees
- Resources

Billing Instructions

- Complete claims in accordance with
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 1, Section 50.2.1, Frequency of Billing
    - Chapter 3, Inpatient Hospital Billing
    - Chapter 25, Section 75, Billing Code Fields
      - FLs 1 to 81
        - » Each states required, not required or situational
        - » Situational = CMS requires, if applicable

Claim Form, Fields and Codes

- Claim form = UB-04/CMS-1450
  - MLN® Booklet *Medicare Billing: Form CMS-1450 and the 837 Institutional* (ICN MLN006926)
- Complete claim fields for IP hospital services
  - Some are self-explanatory, others require an explanation
- Claim codes – For all options, refer to NUBC's Official UB-04 Data Specifications Manual on National Uniform Billing Committee (NUBC) website
  - Manual has mapping from UB-04 to 837I claim

Submitting Claims to Medicare

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

TOBs for IP ACH Claims and Frequency of Billing

IP ACH Claims

- One claim-per-stay concept
  - Submit “one claim” through discharge or death even if
    - BE (OC A3 and date) or care becomes noncovered
      - Coding for noncovered care includes but is not limited to
        - » OCs 31, 32 and date
        - » OSCs 76, 77, M1 and from/through dates
        - » VC 3l and amount
        - » Noncovered days/charges

TOBs for IP Hospital Claims

- TOB 111 = Admission to discharge claims
- TOB 112 = First 60-day interim claim
- TOB 117 = Adjustments & 60-day interim claims
- TOB 118 = Cancel claims
- TOB 110 = No-payment claims
- TOB 12X = IP ancillary claims

TOBs 112 and 117 for Interim Claims

- May be submitted if stay > 60 days
  - TOB 112 = First 60-day interim claim
    - Can be for > 60 days
    - Can be for < 60 days if noncovered LOC
  - TOB 117 = Subsequent 60-day interim claims
    - Original stay plus each subsequent 60 days
    - Becomes new claim by replacing original claim
    - Can be for > 60 days
    - Can be for < 60 days due to discharge, death, BE, noncovered LOC

TOBs 112 and 117 for Interim Claims – Claim Coding

Field	Instruction
Admission date	Original date of admission
Statement from date	Original date of admission (unless payment window applies)
Statement through date	60th day, date of final discharge/death, BE date (OC A3), date LOC falls to noncovered (OC 31)
Patient discharge status code	30 if still a patient or code for final claim
Claim change reason code (CC)	D3 (Subsequent PPS claim) on all TOB 117
Diagnosis and procedure codes	All that apply from admission to through date
Reference	CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 50.2.1

TOB 117 for Adjustments

- Adjustment claim
  - Changes or corrects way original claim was processed
  - Replaces original claim (debit/credit)
  - Complete FL 64 (DCN)
  - Use one CC (D0 to E0) to represent adjustment reason
    - FISS Claim Change/Condition Reason Codes
- Tip: If you resubmit a new claim when an adjustment is needed, it will reject as a duplicate

TOB 118 for Cancels

- Cancel claim
  - Cancels original claim
  - Complete FL 64 (DCN)
  - Complete one CC to represent cancel reason
    - FISS Claim Change/Condition Reason Codes
    - CC D5 or D6
      - D5 - Cancel-only to correct a beneficiary or provider ID number
      - D6 - Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on IP bill)

TOB 110 for IP No Payment Claims

- Submit for all IP stays when no payment is expected from Medicare
  - Except when beneficiary is enrolled in Part B only
- Situations include, but not limited to
  - BE at admission
  - Entire stay is noncovered (beneficiary liable, provider liable, combination, etc.)
    - Admission denial, hospital denial (self-audit), MAC or MRC denial
  - Noncovered procedure during IP stay

Noncovered Procedure During IP Stay

- If a noncovered procedure and a covered procedure are provided during IP stay
  - Submit payable TOB 11X with covered procedure codes/charges
  - If a Medicare denial is needed, submit noncovered TOB 110 with noncovered procedure codes/charges
    - Report same statement covers period (from and through date) as payable TOB 11X (CC 20 or demand or CC 21 for insurance denial)
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 60.2.1

Did You Know

- If a no payment bill for noncovered care is processed but beneficiary's care becomes covered, cancel or adjust original bill and submit corrected bill

Noncovered Admission Followed by Covered Level of Care

- Admission deemed to be when covered services became medically needed and rendered
  - Coding
    - Admission date (not the deemed date)
    - OC 31 and date
    - OSC 76 and from/through dates
    - VC 31 and amount
    - Noncovered days/charges
    - Principal diagnosis that caused covered LOC
    - Only procedures performed during covered LOC

TOB 12X for IP Ancillary Claims

- Submit for certain services if Part A cannot pay for stay or for a certain portion of stay (CR7849)
  - Payment under Part B if patient has Part B, code as such
    - Beneficiary has no Part A or BE, may bill per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 6, Section 10.2
      - Do not bill services in CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 240.2
    - If IP stay is denied not R&N, may bill per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 6, Section 10.1
      - Do not bill for services in CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 240.1

Three-Day Payment Window Policy Overview

Other Names For Three-Day Payment Window

- Preadmission services window
- DRG window
- Payment rule
- Payment window
- 72-hour rule
- 72-hour window
- Three-day rule
- Bundled/bundling
- OP services treated as IP

Three-Day Payment Window Policy General Rule

- When policy is applicable, admitting ACH
  - Adds certain OP diagnostic services and/or nondiagnostic services rendered to beneficiary to IP claim when
    - Beneficiary is admitted to ACH as IP and
    - Admitting ACH rendered such OP services on and/or within three days prior to beneficiary's IP ACH admission date
  - Does not submit such OP services separate from IP claim
    - Such OP services are deemed to be IP services
    - Considered paid for within DRG

Three-Day Payment Window Policy General Rule

- Policy is applicable when Medicare Part A can pay for IP ACH claim
  - Part A can pay for IP ACH claim when
    - Beneficiary is entitled to Part A
    - Beneficiary has IP hospital benefit days under Part A available
    - Beneficiary's IP stay is covered by Part A (medically R&N)

Three-Day Payment Window Policy – Report OP Services on IP Claim

- To add OP services to IP claim; report
  - OP services revenue codes and charges
  - OP services procedure codes and date(s)
  - OP services diagnosis codes
  - Admission date = date beneficiary formally admitted as IP
  - From date = earliest OP DOS added
- Could result in DRG change

Admitting Hospital

- Hospital that formally admits beneficiary as IP
  - Includes entities wholly-owned or wholly-operated (per 42 CFR, Section 412.2) by and under arrangement with admitting hospital
- Must
  - Consider OP services rendered by its provider-based departments/clinics, physician's offices/other Part B entities within payment window
  - Add technical portion of applicable OP services to IP claim

Three-Day Payment Window – Day Count

- Three-day policy but four days to consider
  - OP services rendered on IP admission date and within three days prior to IP admission date
- How to count days – Example
  - If IP admission date is 4/15/2022, review for OP services
    - 4/15/2022 (IP admission date)
    - 4/14/2022 (one day prior to IP admission date)
    - 4/13/2022 (two days prior to IP admission date)
    - 4/12/2022 (three days prior to IP admission date)

OP Diagnostic Services

- Certain revenue codes on OP claim
  - List in CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 3, Section 40.3
  - Admitting ACH must add to IP claim when rendered on and/or within three days prior to IP admission date
    - Regardless of relationship to IP stay
      - Example: Beneficiary receives OP service for revenue code 032X at ACH on 4/12, 4/13, 4/14, and/or 4/15 and is admitted as IP to same ACH on 4/15
        - » ACH adds OP service for revenue code 032X to IP claim

OP Nondiagnostic Services

- Revenue codes not on CMS' diagnostic list
  - Admitting ACH must add to IP claim when rendered
    - On IP admission date regardless of relationship to IP stay
      - Example: Beneficiary receives OP service for revenue code 045X at ACH on 4/15, is admitted as IP to same ACH on 4/15
        - » ACH adds OP service for 045X to IP claim
    - Within three days prior to IP admission date and related to IP stay
      - Example: Beneficiary receives OP service for revenue code 045X at ACH on 4/12, 4/13 and/or 4/14, is admitted as IP to same ACH on 4/15 for related services
        - » ACH adds OP service for revenue code 045X to IP claim

OP Nondiagnostic Services

- Admitting ACH may submit a TOB 13X, if **not related** to IP stay, when rendered
  - Within three days prior to IP admission date
    - Add CC 51 = Attestation that services are clinically distinct or independent from reason for IP admission (clinical decision)
    - Claim is subject to review; must have documentation
      - Example: Beneficiary receives OP service for revenue code 045X at ACH on 4/12, 4/13 and/or 4/14, is admitted to same ACH as IP on 4/15
        - » ACH submits OP TOB 13X for 045X with CC 51

Policy Does Not Apply To

- Certain provider types
  - Part A services by SNFs, HHAs, and hospices
  - OP services in RHC or FQHC all-inclusive rate
  - CAHs unless wholly-owned/wholly-operated by non-CAH
- Certain OP services
  - Ambulance services (revenue code 0540)
  - Maintenance dialysis services (CR7142)
  - OP nondiagnostic services not payable under Part B
    - Per CR8041, e.g., oral medications (self-administered drugs)
    - Exception is IP-only procedure in OP setting (CR7443 and CR9097)

Policy Does Not Apply To

- OP services rendered more than three days prior to IP admission date
  - Even when rendered during a single, continuous OP encounter and spans multiple dates (observation or ER)
    - If observation began outside payment window (should be rare)
      - Submit revenue code 0762 on TOB 13X with all hours of entire observation period on single line with LIDOS = date observation began
    - If beneficiary entered ER outside payment window
      - Submit revenue code 0450 on TOB 13X with LIDOS = date beneficiary entered ER

Three-Day Payment Window Policy Does Not Apply When…

- Medicare Part A cannot pay for IP claim
  - Part A cannot pay for IP claim when
    - Beneficiary is not entitled to Part A
    - Beneficiary exhausted IP hospital benefit days
    - IP stay is not covered by Medicare (i.e., not medically R&N) per a decision made by MAC or MRC
    - IP stay is not covered by Medicare (i.e., not medically R&N) per hospital self-audit

Billing of Payment Window Services When IP ACH Stay Is Not Covered

- If not covered for no Part A or BE at admission
  - Submit TOB 13X or 14X for OP payment window services, TOB 12X for billable IP services and a TOB 110 for IP stay
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 6, Section 10.2 and CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 240.5
- If not covered per self-audit, MAC or MRC
  - May appeal IP denied claim or submit Part A to B claims if rebilling criteria is met (CR8445 and CR8666)

Three-Day Payment Window Rejection Reason Codes

- Incoming claims reject if not in compliance
  - OP claims
    - Diagnostic services reject C7109; nondiagnostic services reject C7114 (bypassed if has CC 51 and DOS does not = admission date)
      - Adjust IP claim (TOB XX7) and add applicable OP services
  - IP claims
    - Diagnostic services reject C7113; nondiagnostic services reject C7115 (bypassed if has CC 51 and DOS does not = admission date)
      - Cancel OP claim and resubmit IP claim with applicable OP services

Billing Services Rendered Under Arrangement

Services Furnished to Your Inpatients

- All items and nonphysician services furnished to your hospital inpatients
  - Must be furnished directly by your hospital or billed through your hospital **under arrangement**
  - Are considered covered under IP DRG
    - Including transportation to and from another hospital or freestanding facility to receive specialized services that are not available at your hospital

Under Arrangement Policy – Defined

- What is meant by under arrangement?
  - ACH that admitted beneficiary as IP
    - May not be able to provide certain ancillary services during stay
    - Arranges for beneficiary to receive such services at another facility
      - Typically OP and beneficiary returns to ACH by midnight on same day
    - Pays other facility for such services and any transportation
    - Reports its costs for such services and transportation on its IP claim

Under Arrangement Policy – Billing

- Reporting arranged services, transportation and costs on IP claim
  - Admitting ACH
    - Report
      - Revenue code for ancillary service provided by other facility and
      - All associated costs including transportation costs
        - » Costs = amount you paid other facility/entities
    - Do not report
      - Revenue code for transportation (0540)

Under Arrangement Policy – Billing Example

- Hospital A
  - Admits beneficiary as IP who later needs MRI they cannot provide
  - Arranges for beneficiary to receive OP MRI at hospital B and transportation to/from each hospital
  - Submits IP claim including revenue code 0612 with cost of MRI and transportation (total paid)
- Hospital B charges hospital A for OP MRI
- Ambulance charges hospital A for transportation

LOAs

LOA

- Should take place when IP beneficiary
  - Leaves ACH
  - Is expected to return to same ACH as IP for related care and
  - Does not require hospital level of care in interim
- Time period between when beneficiary leaves and returns to ACH as IP

LOA Situations

- Include but are not limited to
  - Surgery could not be scheduled immediately
  - Specific surgical team is not available
  - Bilateral surgery was planned
  - Further treatment is needed after tests but cannot begin immediately

LOA – Claim Instructions

- Submit one claim from beneficiary's original admission through final discharge
  - Report LOA days as follows
    - OSC 74
      - From date = date beneficiary is placed on LOA
      - Through date = last date beneficiary is not in ACH at midnight
    - Noncovered days
    - Revenue code 0180 and number of units

LOA – When Beneficiary Does Not Return

- If your ACH places beneficiary on LOA but he/she does not return
  - Communicate with beneficiary/representative to determine status
  - May submit discharge claim with through date = date LOA began
    - CMS has not set certain amount of time that must pass before ACH can submit discharge claim

LOA – Payment and Services Rendered During LOAs

- When LOA occurs, Medicare
  - Pays one DRG for both IP stays (billed as one claim)
  - Will not pay separately for any OP hospital/facility services rendered during LOA
    - If your ACH rendered OP services to beneficiary during LOA from your ACH
      - Report services on your IP ACH claim; do not bill Medicare
    - If your ACH rendered OP services to beneficiary during LOA from another ACH
      - Bill that ACH under arrangement; do not submit OP claim to us

Same Day Readmissions

Same Day Readmissions

- Readmission should take place when beneficiary is
  - Formally discharged from IP hospital
  - Readmitted to same IP hospital unexpectedly
- Same day readmission
  - Beneficiary is discharged/transferred from ACH and readmitted as IP to same ACH on same day by midnight

Same Day Readmissions

- Your billing staff needs to know if initial stay and readmission will be billed as one or two claims
  - If two claims, readmission claim requires CC B4
    - CC B4 – Symptoms are unrelated to, and/or not for evaluation and management of, prior stay's medical condition
- Your utilization review staff
  - Determines if CC B4 can be reported on readmission
    - Is readmission for symptoms related to, or for evaluation and management of, prior stay's medical condition?
  - Let billing staff know answer – yes or no?

Same Day Readmissions

- Answer determines billing **one or two claims**
  - If **yes**, (readmission related to prior stay), submit **one**
    - From initial admission through final discharge
      - If services rendered at another facility in between, they bill your ACH under arrangement
  - If **no**, (readmission not related to prior stay) submit **two**
    - One from initial admission through first discharge
    - One from readmission through final discharge with **CC B4**
      - If services rendered at another facility in between, they bill Medicare

Same Day Readmissions – Claim Editing

- Initial stay billed first, then readmission
  - Readmission rejected reason code C7270 if no CC B4
    - If related to initial stay, adjust initial stay to add readmission
    - If not related to initial stay, submit new readmission with CC B4
- Readmission billed first, then initial stay
  - Initial stay rejected reason code C7271
    - If related to readmission, adjust readmission to add initial stay
    - If not related to readmission, adjust readmission to add CC B4 and submit a new initial stay

Benefits Exhaust During Stay, High Cost Outliers and How Medicare Applies IP Hospital Benefit Days

Payment Under IPPS

- Payment of IP ACH services made via DRG
  - Beneficiary must have at least one IP hospital benefit day
- HCO payment is 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 ACH's accumulated covered charges reach HCO threshold amount (amount is exceeded)
      - HCO threshold amount = DRG + fixed loss amount
        - » OC 47 and date HCO threshold is exceeded MAY be needed on claim

IP Hospital Medicare Benefit Days

- Up to 150 IP hospital benefit days under Part A
  - 90 regular days (renewable per benefit period)
    - 60 full days and 30 coinsurance days
  - 60 LTR coinsurance days (not renewable)
    - Beneficiary may use as necessary but can elect not to use
      - If elects not to use, document medical record (CC 67)
      - We apply when only LTR days remain at admission or in any HCO period when all regular days are exhausted
- Benefit period – Tracks use of benefit days

Medicare's Application of IP Hospital Benefit Days Under IPPS

- Medicare uses a unique methodology when applying IP hospital benefit days to IP claim
  - We do **not apply**
    - IP benefit days on a "day by day" basis
    - Regular benefit days and LTR days to same claim unless LTR days are needed for HCO period
      - If so, Medicare applies 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 IPPS

- If there is not a HCO period on claim
  - Medicare applies
    - Regular benefit days only, even if LTR days are available
    - LTR days if only LTR days are available
- If there is a HCO period on claim
  - Medicare applies
    - Regular 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

Benefits Exhaust

- If a beneficiary has at least one benefit day
  - Medicare pays DRG up to any HCO period
    - Even if benefit days exhaust before HCO period
- If all benefit days exhaust during IP stay
  - Report OC A3 with BE date on claim **or**
    - If date is incorrect, we will correct it
  - Let Medicare determine BE date (preferred)
    - We determine per IPPS benefit day application and add OC A3 with BE date on claim

Inlier Days, Inlier Period and OSC 70

- Since Medicare will pay DRG (up to any HCO) if beneficiary has at least one benefit day available
  - We may pay for days beneficiary does not have; we code to claim with OSC 70 and from/through dates
    - Inlier days
      - If no HCO = days after last available benefit day to end of stay
      - If HCO = days after last available benefit day up to HCO
    - Inlier period
      - If no HCO = period between last available benefit day and end of stay
      - If HCO = period between last available benefit day and HCO period

Preparing IP ACH Claims

- Submit
  - Admission to discharge claim (TOB 111) or
  - Interim claims (TOBs 112/117) every 60 days
- Report
  - Up to 150 medically necessary days as covered
    - Regardless of days available in CWF
  - Medically necessary days above 150 days as noncovered
    - But with associated charges as covered

Claim RTP for OC 47 and Date

- If claim qualifies for HCO, it may RTP for OC 47 and date if
  - Claim's covered charges exceed HCO threshold and
  - Beneficiary does not have enough regular benefit days to cover all medically necessary days or has only LTR days but not enough to cover all medically necessary days
- Common RTP reason codes = 37036 and 37045
  - Request provider adds OC 47 and date
    - Day after date on which HCO threshold amount is exceeded

RTP Reason Codes 37036 and 37045 for Cost Outlier Claims

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

RTP Reason Codes 37036 and 37045 for Cost Outlier Claims

- ACH action
  - View HCO threshold on MAP1716, PG 6 in FISS DDE
  - Total claim's daily covered charges
    - From day one until HCO threshold amount is reached; notate that date
      - Exclude days and charges during noncovered spans
  - Add/correct OC 47 date
    - Day after date on which HCO threshold amount is reached
      - Cannot be equal to or during noncovered spans
  - Correct units/charges for noncovered services if BE occurs

Processing Claim With OC 47 and Date

- Upon receipt of OC 47 and date
  - Medicare determines if beneficiary has enough or correct combination of IP hospital benefit days for each medically necessary day in HCO period
    - If BE, BE date depends on number and type of benefit days available

Benefits Exhaust Without HCO

- Beneficiary
  - Has regular benefit days that exhaust prior to end of claim
  - May/may not have LTR days
- Medicare
  - Applies OSC 70 from last available regular benefit day to end of claim
    - Benefits do not exhaust with this claim so a BE date is not needed
  - Pays full DRG

Benefits Exhaust Without HCO

- Beneficiary
  - Does not have any regular benefit days
  - Has only LTR days that exhaust prior to end of claim
- Medicare
  - Applies OSC 70 from last available LTR day to end of claim
    - BE date (OC A3 and date) = Day before discharge date
  - Pays full DRG

Benefits Exhaust With HCO

- Beneficiary
  - Has regular benefit days that exhaust prior to HCO
  - Does not have LTR days (or elects not to use them)
- Medicare
  - Applies OSC 70 from last available regular benefit day through day before HCO threshold is exceeded (OC 47 date)
  - BE date (OC A3 and date) = day before OC 47 date
  - Pays full DRG but not HCO

Benefits Exhaust With HCO

- Beneficiary
  - Has regular benefit days that exhaust prior to HCO
  - Has LTR days
- Medicare
  - Applies OSC 70 from last available benefit day through day before HCO threshold is exceeded (OC 47 date)
    - BE date (OC A3 and date) = last available LTR day
    - Full DRG is paid; some or all of HCO is paid

Billing for MAO Plan Enrollees

Beneficiary Enrolled in Option Code C MAO Plan for Entire or a Portion of IP Stay

- If enrolled for entire IP stay
  - Bill MAO plan for stay and submit informational claim to FFS Medicare
- If enrolled for portion of IP stay
  - Patient's status at admission determines liability
    - If in MAO plan, bill them for stay even if any disenrollment takes effect during stay and submit informational claim to FFS Medicare
    - If in FFS Medicare, bill us for stay even if any enrollment in MAO plan takes effect during stay

IP Informational Claims – Billing Tips

- Be aware of billing instructions on next slides
- Review CC definitions
  - CC 04 (zero 4) = MAO plan enrollee
  - CC 69 = Billing for medical education (IME and/or N&AH)
- Adhere to one-year timely filing limitation
- Code claims as Medicare primary, not as MSP
  - Report Medicare information (MBI), not MAO plan

IP Informational Claims – Teaching ACHs (Except N&AH Program Only)

- Submit IP informational claim to FFS Medicare
  - Covered TOB (not 110)
  - Covered days/charges
  - CCs 04 and 69
  - All required claim elements
- Medicare processes claim
  - As paid with reason code 37210
  - Pays for IME via claim per Program Memorandum A-98-21

IP Informational Claims – Teaching ACHs (N&AH Program Only)

- Submit IP informational claim to FFS Medicare
  - Noncovered TOB (110)
  - Noncovered days/charges
  - CCs 04 and 69
  - All required claim elements
- Medicare processes claim
  - As rejected with reason code 79995
  - Handles N&AH through cost report

IP Informational Claims – Non-Teaching ACHs

- Submit IP informational claim to FFS Medicare
  - Covered TOB (not 110)
  - Covered days/charges
  - CC 04
  - All required claim elements
- Medicare processes claim
  - With reason code 3719C (TOB remains 111)
  - No claim payment due; captures days in DSH per CR5647

What You Should Do Now

- Share information with other staff members
- Follow instructions for submitting IP claims
- Develop and implement policies that ensure that claims are correctly submitted to Medicare
- Be familiar with resources for ACHs
- Check our Events calendar
- Sign up for our Email Updates

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Resources

NGS Resources

- Article on adjustment and cancel reasons
  - FISS Claim Change/Condition Reason Codes
- ASCA Requirements for Paper Claim Submission
- CBT modules in Medicare University
- Contact Us (Connex, IVR, PCC)
- EDI information
- Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide
- Top Claim Errors

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CMS Resources

- Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Proposed Rule (CMS-1752-P)
- Acute Inpatient PPS
- Beneficiary Notices Initiative (BNI)
- Frequently Asked Questions CR 7502: (Bundling of Payments for Services Provided to Outpatients Who Later are Admitted as Inpatients: 3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices)
- FSS & MA IM: Important Message from Medicare (IM) - CMS-10065
- Web Pricers

CMS Resources

- MLN® Educational Tool: *Medicare Payment Systems*
- Memorandum: Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window
- MLN Connects® Newsletter
- MLN Matters® Articles
- MLN Publications & Multimedia
- MLN Web-Based Training
- Open Door Forums
- Transmittals/CRs

CMS IOM Publications

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 10.4, Benefit Period
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 3, Sections 10, Benefit Period & 20, Inpatient Benefit Days

CMS IOM Publications

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Sections
  - 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
  - 10.2, Other Circumstances in Which Payment Cannot Be Made Under Part A
  - 10.3, Hospital Inpatient Services Paid Only Under Part B

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Sections
  - 50.2.1, Frequency of Billing
  - 60.2.1, Billing for Noncovered Procedures in an Inpatient Stay
  - 90, Patient Is a Member of a MA Organization for Only a Portion of the Billing Period

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Sections
  - 10.4, Payment of Nonphysician Services for Inpatients
  - 10.5, Hospital Inpatient Bundling
  - 20.3, Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients
  - 20.7.4, Cost Outlier Bills With Benefits Exhaust
  - 40.1.1, Noncovered Admission Followed by a Covered Level of Care

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Sections
  - 40.2.1, 40.2.1 - Noncovered Admission Followed by Covered Level of Care
  - 40.2.2, Charges to Beneficiaries for Part A Services
  - 40.2.5, Repeat Admissions
  - 40.2.6, Leaves of Absence
  - 40.3, OP Services Treated as IP Services
  - 50.2, Claim Change Reason Codes

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Sections
  - 10.12, Payment Window for OP Services Treated as IP Services
  - 180.6, Emergency Room Services That Span Multiple Service Dates
  - 180.7, Inpatient-Only Services
  - 240.1, Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Sections
  - 240.2, Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made Under Part A
  - 240.5, Payment of Part B Services in Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A
  - 240.6, Submitting Provider-Liable Part A No-Pay Claims
  - 290.2.2, Reporting Hours of Observation

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Sections
  - 90.7, Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (Physician Practices and Clinics): 3-Day Payment Window
  - 90.7.1, Payment Methodology 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (Physician Practices and Clinics)"

CMS IOM Publications

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75, Billing Code Fields
- CMS IOM Publication 100-16, *Medicare Managed Care Manual*

CMS MLN Matters® Articles

- *MM3389: Revision of Common Working File (CWF) Editing for Same-Day, Same- Provider Acute Care Readmissions*
- *MM11312: Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services*
- *MM11559 Revised: Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy*

CMS MLN Matters® Articles

- *SE0663 Revised: Notifying Medicare Patients about Lifetime Reserve Days (LRDs)*
- *SE20024: FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients*
- *SE17033 Revised: Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities*

CMS Transmittals

- CR5647 Capturing Days on Which Medicare Beneficiaries are Entitled to Medicare Advantage (MA) in the Medicare/Supplemental Security Income (SSI) Fraction
- CR7142 Clarification of Payment Window for Outpatient Services Treated as Inpatient Services
- CR7443 July 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CR7502 Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices
- CR7672 January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

CMS Transmittals

- CR7849 Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission
- CR8041 Fiscal Year (FY) 2013 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes
- CR8046 Modification of Payment Window Edit in the Common Working File (CWF) to Modify Diagnostic Service List
- CR8185 CMS Administrators Ruling: Part A to B Rebilling of Denied Hospital Inpatient Claims
- CR8445 Implementing the Part B Inpatient Payment Policies from CMS-1599-F
- CR8666 Implementing the Part B Inpatient Payment Policies from CMS-1599-F

CMS Transmittals

- CR9097 April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CR11312 Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services
- CR11559 Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent With Current Policy

OIG Resources

- OIG reports
  - A-01-15-00511, June 2017, Medicare Paid New England Providers Twice for Nonphysician OP Services Provided Shortly Before or During IP Stays
  - A-09-16-02026, September 2017, Medicare Inappropriately Paid ACHs for OP Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities

Other Resources

- NUBC's website

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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