



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 15: Inpatient Utilization Review and Notices

I. Inpatient Utilization Review

A. The UR Committee

1. The *Conditions of Participation* require the UR committee consist of at least two Doctors of Medicine or osteopathy and other specified practitioners. <See 42 C.F.R. 482.30(b)>

Non-physician practitioners that may be on the UR committee, include:

- Doctor of Dental Surgery or dental medicine
- Doctors of podiatric medicine
- Doctor of Optometry
- Chiropractors
- Clinical psychologists

B. Four Requirements for Determinations by the UR Committee

1. The UR committee must offer the attending physician or NPP an opportunity to present their views prior to making a determination an admission is not medically necessary. <See 42 C.F.R 482.30(d)(2)>
2. One member of the UR committee may make the determination an admission is not medically necessary if the patient's attending physician or NPP concurs with the determination or does not present their views. <See 42 C.F.R. 482.30(d)(1)(i); *MLN Matters Article SE0622, Background*>
3. Two members of the UR committee must make the determination an admission is not medically necessary if the patient's attending physician does not concur with the determination. <See 42 C.F.R. 482.30(d)(1)(ii), *MLN Matters Article SE0622, Background*>

4. If the UR committee determines a patient's admission was not medically necessary, notice must be provided to the patient, the hospital, and the attending physician within 2 days of the determination. <See 42 C.F.R. 482.30(d)(3)>

C. Role of Non-physician Hospital Staff

1. CMS has clarified that case managers, who are not licensed practitioners authorized under state law to admit patients to the hospital, do not have the authority to make a determination an admission is not medically necessary or change a patient's status from inpatient to outpatient. <MLN Matters Article SE0622, Q.3>

CMS encourages and expects hospitals to employ case managers to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in decision making processes.

D. Timing of UR Determination

1. Determination Prior to Discharge

- a. If the determination an admission is not medically necessary is made prior to the patient's discharge, the hospital may retroactively convert the patient to an outpatient if the following conditions are met:

- i. The change in status is made while the patient is still in the hospital to allow the hospital to provide notice of the determination to the patient prior to discharge. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2; MLN Matters Article SE0622, Q.8>

Although the UR CoP allows 2 days to provide notice to the patient, in order to retroactively change the patient's status to outpatient, notice must be provided before discharge.

- ii. The attending physician concurs with the UR committee's decision. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2>

- iii. The physician's concurrence is documented in the medical record. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2>

- b. If all conditions are met, the claim for the case should be submitted as an outpatient claim (bill type 13X) with condition code 44. <Medicare Claims Processing Manual, Chapter 1 § 50.3.1>

- i. When billing observation services following conversion to outpatient status with condition code 44, an order for observation is required prior to counting time for observation. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2; Medicare Claims Processing Manual, Chapter 4 § 290.2.2 and 290.5.2>
 - ii. The hospital may include charges representing the cost of all resources utilized in the care of the patient during the encounter, including monitoring and nursing care prior to an order for observation. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2>
 - a) Hours of monitoring and nursing care prior to a written order for observation may be reported on a line with revenue code 0762 (Observation Hours) without a HCPCS code. <Medicare Claims Processing Manual, Chapter 1 § 50.3.2>
2. Determination After Discharge
- a. If the determination an admission is not medically necessary is made by the UR committee after the patient's discharge (i.e., self-denial), the patient remains an inpatient and the case should be submitted as an inpatient Part B claim (bill type 12X) with condition code W2. <78 Fed. Reg. 50914; MLN Matters Article SE1333

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

II. Inpatient Part B (TOB 012X) Payment

Medicare covers and makes payment under Part B for inpatient services in three separate circumstances:

- An inpatient admission denied as not reasonable and necessary by a contractor or through self-denial (UR determination)
- The patient has no entitlement to Part A or has exhausted their Part A benefits
- Preventative services only covered under Part B

A. Admission Denied as Not Reasonable and Necessary

1. Inpatient Part B payment is available if:

- a. The inpatient admission is denied as not reasonable and necessary through contractor or self-denial; and
- b. The services would have been reasonable and necessary as outpatient services; and
- c. The services meet all applicable Part B coverage and payment conditions. <See 42 CFR 414.5, 78 Fed. Reg. 50914, See Medicare Benefit Policy Manual, Chapter 6 § 10.1>

2. Payment is available for:

- a. Services payable under OPPS and certain ancillary services payable under other payment systems (e.g., therapy, DME, laboratory services). <See 42 CFR 414.5(a)(1), 78 Fed. Reg. 50914, see Medicare Benefit Policy Manual, Chapter 6 § 10.1, MLN Matters SE1333>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.1, attached, has a list of the ancillary services payable when the inpatient admission is denied as not reasonable and necessary.
 - ii. Exceptions:
 - a) Services that by their nature are outpatient services (e.g., ED visits and observation services). <See Medicare Benefit Policy Manual, Chapter 6 § 10.1; MLN Matters SE1333>

Tip: These services should be submitted on a standard outpatient (131) claim.

- b) Inpatient nursing services (e.g., infusions, injections, transfusions, and nebulizer treatments) that the hospital treats as routine (i.e., billed as part of their inpatient room rate). <See Medicare Claims Processing Manual, Chapter 4 § 240>

Note: Ancillary nursing services for which the provider customarily makes a separate charge to inpatients may be billed for inpatient Part B payment if all documentation and coverage requirements are met.

- 1) Routine services are services included in the provider's daily room and board charges and the provider does not separately charge for them. <Program Reimbursement Manual, Chapter 22 § 2202.6>
 - (a) The provider must follow all instructions in the Provider Reimbursement Manual and the principles of cost apportionment for Medicare to "recognize" their treatment of the services as routine or ancillary. <Medicare Claims Processing Manual, Chapter 4 § 240>

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>
- ii. The three-day payment window, which requires inclusion of certain outpatient services on a subsequent inpatient claim, does not apply when no Part A inpatient payment is made. <MLN SE1333; See Medicare Benefit Policy Manual, Chapter 6 § 10.1; See Medicare Claims Processing Manual, Chapter 4 § 10.12>

Tip: If significant surgical or emergency department services are provided before the admission order and billed on an outpatient 131 claim triggering C-APC payment, no inpatient Part B claim will be needed because the C-APC provides payment in full for the encounter.

b. Inpatient Part A Non-covered Claim

- i. To bill for inpatient Part B payment, the provider must first submit a Part A “provider liable” claim on a type of bill 110, unless the claim has already been denied by the contractor. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 § 240.6, Medicare Claims Processing Manual, Transmittal 2877>
 - a) The “provider liable” claim must process and the remittance advice must be issued prior to billing for inpatient Part B payment. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; Medicare Claims Processing Manual, Transmittal 2877>
 - b) The provider must report the Occurrence Span Code M1 to indicate the period of provider liability on the Part A claim. <MLN Matters SE1333, Medicare Claims Processing Manual, Transmittal 2877>
 - c) The provider must refund any inpatient deductible or copay to the patient. <See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; MLN Matters SE1333>

c. Inpatient Part B Claim

- i. After receiving the remittance advice for the “provider liable” claim, the provider may submit a claim on type of bill 12X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240; MLN Matters SE1333>
 - a) The provider must submit the following on the 12X claim:
 - 1) A treatment authorization code “A/B Rebilling”.
 - 2) Condition code W2 attesting that the claim is a rebill and no appeal is in process.
 - 3) A remark code with the document control number (DCN) of the denied inpatient Part A claim in the format ABREBILL followed by the DCN of the denied inpatient claim. <Medicare Claims Processing Manual, Transmittal 2877>
 - b) Medicare Claims Processing Manual, Chapter 6 § 240.1, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the inpatient stay was denied as not reasonable and necessary.

- c) Hospitals must report the HCPCS codes they would report on an outpatient Part B claim, including for implantable prosthetic devices. <See Medicare Claims Processing Manual, Chapter 4 § 240.1, 240.3>
- d) The claim for Part B inpatient payment must be submitted within 1 year of the date of service in compliance with normal timely filing requirements. <See 42 CFR 414.5 (c)>
- ii. The patient is liable for the normal Part B deductible and co-payment for services billed on an inpatient Part B claim. <See Medicare Claims Processing Manual, Chapter 4 § 240.6>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e., there was no reasonable expectation of a two midnight stay) and would not be covered under Part A.

A. On what bill type should the hospital submit the pacemaker procedure?

B. No Part A Entitlement or Exhaustion of Part A Benefits

1. Limited inpatient Part B payment is available if:
 - a. No Part A payment is made at all for the case because the patient had exhausted his or her benefit days *before* or during the admission, OR
 - b. The patient was otherwise not eligible for or entitled to coverage under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>
2. Payment is available for:
 - a. Specified services payable under OPPS or other payment systems, including diagnostic tests, therapy, radiation therapy, acute dialysis, specified screening tests and preventative services, specified covered drugs, specified DME, and ambulance services. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.2, attached, has a list of the services payable when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.

- ii. If one of these services is packaged under the OPPS and the service it would package to is not payable on the inpatient Part B claim, it is excluded from OPPS packaging and paid separately. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>

Example: An inpatient, who has exhausted their Part A benefits, has a surgical service and related lab tests. The lab tests would normally package and only the surgical service would pay, but on an inpatient Part B claim the surgical service is not payable and the lab test will be excluded from packaging and pay separately.

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B as noted above. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>

b. Inpatient Part B Claim

- i. The provider submits a claim with type of bill 012X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240>
- ii. Medicare Claims Processing Manual, Chapter 6 § 240.2, attached, contains a list of revenue codes and services allowed to be reported on a 12X claim for inpatient Part B services when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.
 - a) If a line is reported on a 12X claim without an allowed revenue code or HCPCS code, the line is rejected. The list of allowed revenue and HCPCS codes is available in the IOCE Quarterly Data Files, Report-Table folder, Data_Revenue, Column K, "PART_B_BILLABLE" and Data_HCPCS, Column DR, "PART_B_BILLABLE", and included in the materials behind the outline. <See *IOCE Specifications*, Section 6.2.3, and Section 8.2, Edit 127>
 - 1) Edit 127 is not applied to 12X claims with condition code W2 for inpatient Part B services when the inpatient stay was denied as not reasonable and necessary. <See *IOCE Specifications*, Section 6.2.3 and Section 8.2, Edit 127>
 - b) Special instructions for implantable prosthetic devices

- 1) Hospitals should bill implantable prosthetic devices with HCPCS code C9899 (“Implantable prosthetic device, payable only for inpatients who do not have inpatient coverage”). <See Medicare Claims Processing Manual, Chapter 4 § 240.3>
- 2) The provider should report the HCPCS code for the device, if one exists, or a narrative description of the device in the remarks section. <Medicare Claims Processing Manual Transmittal 1628, IV. Supporting Information>
- 3) The MAC prices the device according to its pass-through amount, DME fee schedule amount or the device offset amount for packaged devices and the beneficiary co-insurance is set at 20% of the payment amount determined by the MAC. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>
- 4) This code should not be used on inpatient Part B claims for inpatient cases denied as not reasonable and necessary because the surgical service that includes payment for the device is payable. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>

C. Services Covered Only Under Part B

1. Inpatient Part B payment is available for a limited number of preventative services and vaccines only covered under Part B and not covered under Part A when provided to an inpatient directly or under arrangement by a hospital. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3>
 - a. Medicare Benefit Policy Manual, Chapter 15 § 250, attached, contains a list of the services only covered under Part B and not covered under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3 and Chapter 15 § 250>
2. Billing Requirements
 - a. The hospital submits a 12X claim for these services. <See Medicare Claims Processing Manual, Chapter 4 § 240>

III. Important Message from Medicare (“IM”)

A. General Rule

1. Medicare beneficiaries have a right to an expedited review of their discharge when the hospital and their physician determine inpatient care is no longer necessary. <Medicare Claims Processing Manual, Chapter 30 § 200.2>

2. Hospitals are responsible for notifying beneficiaries of their right to an expedited determination through a standard form (the Important Message from Medicare). *<Medicare Claims Processing Manual, Chapter 30 § 200.2, 200.3.3>*

B. Scope of Requirement

1. All hospitals must comply, including PPS and non-PPS hospitals (e.g., CAHs). *<Medicare Claims Processing Manual, Chapter 30 § 200.1; 42 C.F.R. 405.1205(a)(1)>*
2. The IM must be delivered to all beneficiaries covered by Medicare, including Medicare as a primary or secondary payer and beneficiaries with a Medicare Advantage plan. *<Medicare Claims Processing Manual, Chapter 30 § 200.2, 42 C.F.R. 422.620>*
 - a. The IM is delivered even if the beneficiary agrees with the hospital discharge. *<Medicare Claims Processing Manual, Chapter 30 § 200.3.3>*
3. The IM is not delivered if the beneficiary is not entitled to an expedited determination, and hospitals should not provide an IM “just in case” or routinely to all beneficiaries. Situations in which the beneficiary is not entitled to an expedited determination include:
 - a. The beneficiary is not in a Medicare covered inpatient hospital stay.
 - b. The beneficiary transfers to another hospital at an inpatient level of care;
 - c. The beneficiary exhausts their benefits, including lifetime reserve days, prior to or while in the hospital;
 - d. The beneficiary ends care on their own initiative (e.g., elects hospice);
 - e. The hospital changes the beneficiary’s status under procedures for condition code 44;
 - f. The physician does not concur with the discharge. *<Medicare Claims Processing Manual, Chapter 30 §§ 200.2 and 200.2.1>*

C. The Required Form

1. The IM is the required form for providing beneficiaries notice of their discharge appeal rights and is available in English, Spanish, and large print versions. Handout 21 is the current IM.

- a. The latest IM form has an expiration date of 12/31/25 and can be downloaded from the Beneficiary Notice Initiative (BNI) page. <cms.gov website, “Beneficiary Notice Initiative (BNI) page, “FFS & MA IM” page>

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

The IM must be provided within two specific timeframes related to:

- The date of admission (“First IM”); and
- The date of discharge (“Follow-up Copy”).

D. Timing of the IM Notice

1. First IM Notice

- a. The First IM is delivered at or near admission, but in all cases:
 - i. No more than seven calendar days before admission, as part of pre-admission protocols; and
 - ii. No later than two calendar days after admission. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.1>

2. Follow-up IM Notice

- a. The follow-up IM must be delivered within two calendar days of discharge and at least four hours before discharge. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2>
 - i. The IM can be delivered once the discharge is planned. A discharge order is not required before giving the IM. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.1>
 - ii. The follow-up IM applies when the beneficiary is physically discharged from the hospital or discharged to a lower level of care in the same hospital such as swing bed or custodial care. <Medicare Claims Processing Manual, Chapter 30 § 200.2>

- iii. The same notice may function as the First IM and the follow-up IM as long as it meets both specified timeframes. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2>

Example: Patient is admitted on Monday. The IM is provided on Wednesday. Patient is discharged on Friday. No additional notice is required because the IM on Wednesday occurred within two calendar days of discharge.

- b. The follow-up IM can be provided in two ways:

- i. Deliver a new copy of the IM and have the beneficiary sign and date the form again; or
- ii. Deliver a copy of the signed First IM and have the beneficiary initial and date in the “Additional Information” section. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2, 200.3.8>

E. Delivery of the IM Notice

1. The IM is a standardized two page form and may not be altered except as allowed. Allowed alterations include:
 - a. Adding a hospital logo, provided it does not shift text to the second page;
 - b. Filling in the beneficiary’s name and hospital issued number, which may not be the patient’s Social Security Number, HICN, or Medicare Beneficiary Identifier (MBI);
 - c. Filling in the contact information for the QIO for the state;
 - d. Adding information in the “Additional Information” section relevant to the beneficiary’s situation or delivery of the form. <Medicare Claims Processing Manual, Chapter 30 § 200.3.1, 200.3.2>
2. The hospital may provide the IM through electronic delivery (i.e., viewed on an electronic screen), including a digitally captured signature, but the beneficiary must have the option of requesting paper delivery and must be provided a paper copy of the completed, signed IM. <Medicare Claims Processing Manual, Chapter § 200.3.3>

3. Beneficiary Comprehension

- a. If the beneficiary cannot read the contents of the IM or comprehend the oral explanation, the hospital must use translators, interpreters, or assistive technology to ensure comprehension of the notice. <Medicare Claims Processing Manual, Chapter § 200.3.6>

4. Provision to a Beneficiary's Representative

- a. The IM may be delivered to a beneficiary's appointed representative, authorized representative, or a person representing the patient if there is no appointed or authorized representative. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - i. An appointed representative is an individual designated by the beneficiary to act on their behalf via an "Appointment of Representative" form (CMS-1696). For more information, see *Medicare Claims Processing Manual*, Chapter 29 § 270. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - ii. An authorized representative is an individual who may make health care decisions on a beneficiary's behalf under State or other applicable law (e.g., a legal guardian or someone named in a durable power of attorney). <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
- b. If the beneficiary is incapacitated and has no appointed or authorized representative, a person the hospital has determined could reasonably represent the beneficiary may receive the IM on their behalf. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - i. The person acting on the beneficiary's behalf should act in their best interests, in manner protective of their interests and have no relevant conflict of interest. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - ii. When notice is provided to a person acting on the beneficiary's behalf, the hospital should document the name of the staff person initiating contact, the name of the person contacted and the date, time and method of contact (e.g., in person, telephone). <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
- c. Delivery to off-site representatives

- i. If the beneficiary's representative or the person acting on their behalf is not physically present, the hospital may deliver the IM by telephone. The date of the telephone call is considered the date of receipt. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - ii. When the hospital provides an IM by telephone they should:
 - a) Verbally convey all contents of the IM;
 - b) Document in the "Additional Information" section that the information was verbally communicated to the representative, along with the name of the staff person, the name of the representative, the date and time of the telephone contact and the telephone number called; and
 - c) Provide the representative with a copy of the IM by:
 - 1) Mailing a copy to the representative the same day as the telephone contact by certified, return receipt or other method with signed verification of receipt;
 - 2) Emailing or faxing a copy via HIPAA compliant secure fax or email if the representative agrees. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
5. Beneficiary or Representative Signature
- a. The beneficiary or their representative must sign and date the IM confirming their receipt and understanding. <Medicare Claims Processing Manual, Chapter 30 § 200.3.3>
 - b. If the beneficiary refuses to sign the form, the hospital should annotate the form indicating the date of refusal of the notice, which is considered the date of receipt of the notice. <Medicare Claims Processing Manual, Chapter 30 § 200.3.5>

Case Study 3

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

IV. Beneficiary Request for Expedited Review

- A. A beneficiary who disagrees with their discharge from the hospital may request an expedited review by contacting the QIO at the contact information provided in the IM. <Medicare Claims Processing Manual, Chapter 30 § 200.4.1.1>
 1. A beneficiary's request is considered timely if it is made before midnight on the day of discharge and the beneficiary has not left the hospital. <Medicare Claims Processing Manual, Chapter 30 § 200.4.1.1>
 - a. For a timely request, and the QIO agrees with the hospital, the patient's liability begins at noon on the day after the QIO notifies the beneficiary of their decision. <Medicare Claims Processing Manual, Chapter 30 § 200.4.2>
 - b. For a timely request, and the QIO agrees with the beneficiary, the hospital should issue a new follow-up IM when a new discharge date is determined. <Medicare Claims Processing Manual, Chapter 30 § 200.4.2>
 2. The QIO must make its determination and notify the beneficiary and hospital no later than one calendar day after it receives all requested information. <Medicare Claims Processing Manual, Chapter 30 § 200.5.6>
 - a. The QIO must also notify the beneficiary of their right to an expedited reconsideration by the QIO and provide them with information regarding how to request a reconsideration. <Medicare Claims Processing Manual, Chapter 30 § 200.5.6>
 - b. If the QIO does not receive requested information from the hospital, the QIO may make their decision based on the information available or delay a decision until the information is provided, but the hospital will be financially liable for services during the delay. <Medicare Claims Processing Manual, Chapter 30 § 200.5.6>
 3. A beneficiary may make an untimely request for an expedited review while still in the hospital or up to 30 days after discharge. <Medicare Claims Processing Manual, Chapter 30 § 200.4.3>

- a. For an untimely request, and the patient remains in the hospital, the QIO is required to notify the beneficiary and hospital of their determination within 2 calendar days and the patient is not protected from liability while the QIO makes their determination. <Medicare Claims Processing Manual, Chapter 30 § 200.4.3>

Note: the beneficiary is still protected by the Limitations on Liability statute and the hospital must provide notice in the form of a Hospital Issued Notice of Non-coverage (HINN), discussed below, to hold the patient financially liable.

- b. For an untimely request, and the patient has been discharged from the hospital, the QIO is required to notify the beneficiary and the hospital of their determination within 30 calendar days. <Medicare Claims Processing Manual, Chapter 30 § 200.4.3>

V. Hospital Responsibilities when Beneficiary Requests Expedited Review

A. Detailed Notice of Discharge (DND)

1. When a beneficiary makes a request for an expedited review, the hospital must deliver a DND no later than noon of the day following notification of the request by the QIO. <Medicare Claims Processing Manual, Chapter 30 §§ 200.4.4, 200.4.5>
2. The DND is the required form for providing beneficiaries information about their discharge following an appeal and is available in English, Spanish, and large print versions. Handout 22 is the current DND.
 - a. The latest DND form has an expiration date 12/31/25 and can be downloaded from the Beneficiary Notice Initiative (BNI) page. <cms.gov website, “Beneficiary Notice Initiative (BNI)” page, “FFS & MA IM” page>

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

3. Completion of the DND

- a. The DND is a standardized one page form and may not be altered except as allowed. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>

- b. On the DND, the hospital must complete the form with:
 - i. The facts specific to the beneficiary's discharge and determination that coverage should end;
 - ii. A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered; and
 - iii. A description of and citation to Medicare coverage rules, instructions, or other policies relied on for the review. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>
- c. The DND does not have a signature line for the beneficiary to sign, but if the beneficiary refuses to accept the DND, the hospital should annotate the notice accordingly. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>

B. Documents Supplied to the QIO

- 1. The hospital must forward to the QIO the IM and DND provided to the beneficiary no later than noon of the day following notification of the request by the QIO. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>
- 2. The hospital must provide the QIO with all requested information by phone, in writing, or electronically. If information is provided by phone, the hospital must keep a written record of the information provided in the beneficiary's medical record. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>

C. Documents Supplied to the Patient

- 1. At the beneficiary's request, the hospital must provide access to or a copy of the information sent to the QIO, including written records of information provided by telephone. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>
 - a. The hospital must provide the requested information by close of the first business day following the request and may charge a reasonable copying/delivery fee. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>

Case Study 4

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

VI. Inpatient Hospital Issued Notice of Non-Coverage (HINN)

A. General Rule

1. A properly prepared and delivered HINN using CMS model language satisfies the LOL notice requirement for inpatient services that are not considered reasonable and necessary or are custodial. <Medicare Claims Processing Manual, Chapter 30 §§ 200, and 240>
 - a. A Pre-Admission/Admission HINN may, but is not required, to be used for services that are never covered by Medicare. <Medicare Claims Processing Manual, Chapter 30 § 200.2>

B. The HINN Forms

1. The HINN forms provided by CMS are considered model forms that may be modified, however, unapproved modification of a model notice may cause the notice to be defective.
 - a. Handout 23 is the model forms for the two most common HINNs used for inpatient hospital non-covered services:
 - i. The Pre-Admission/Admission Hospital Issued Notice of Non-Coverage
 - ii. The HINN 12 – Non-covered Continued Stay

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General

C. Timing of Delivery

1. Hospitals provide a HINN to beneficiaries prior to admission or at any point during an inpatient stay if they determine the care the beneficiary is or will receive is not covered because it is not medically necessary, not delivered in the most appropriate setting, or is custodial in nature. <CMS.gov, “FFS HINNs” website; *Medicare Claims Processing Manual*, Chapter 30 §§ 200 and 240>
2. Pre-Admission HINN
 - a. If the Pre-Admission HINN is provided prior to the beneficiary’s admission to the hospital, the beneficiary will be responsible for all charges during the non-covered stay. <*Medicare Claims Processing Manual*, Chapter 30 § 240.2>
3. Admission HINN
 - a. If the Admission HINN is provided upon admission, liability depends on when the patient is provided the HINN. <*Medicare Claims Processing Manual*, Chapter 30 § 240.2>
 - i. If the HINN is provided before 3pm, the beneficiary will be responsible for all charges incurred after provision of the notice.
 - ii. If the HINN is provided after 3pm, the beneficiary will be responsible for all charges beginning on the day following the date of the notice.
4. Continued Stay HINN
 - a. A HINN 12 may be delivered at the direction of the QIO following a beneficiary appeal or if the beneficiary’s continued stay is no longer necessary, but the beneficiary is not appealing their discharge.

D. Requirements for Delivery

1. Hospitals should follow all requirements for in-person delivery, beneficiary representatives, beneficiary comprehension, signature, and date (including refusal to sign), and delivery and retention for the Important Message (IM) from Medicare, in *Medicare Claims Processing Manual*, Chapter 30 § 200.3.1. <*Medicare Claims Processing Manual*, Chapter 30 § 240.1>

CMS has not published detailed manual instructions for HINN 12. CMS has included “Instructions for Completion of the HINN 12” in the same zip file as the HINN forms on the BNI HINN page of the CMS website.

Case Study 5

Facts: A Medicare beneficiary, with a BMI of 32, is admitted for gastric bypass surgery to assist with weight loss and control of his Type II diabetes. The NCD for bariatric surgery states it is covered for beneficiaries that have a BMI of ≥ 35 , have at least one obesity related co-morbidity and have been unsuccessful with medical treatment for their obesity. Is the hospital required to provide the patient with a notice? If so, which notice?

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CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

Analysis: No, in order to bill with condition code 44 the UR committee determination must be made prior to the patient's discharge and notice provided to the patient. The stay may be billed to Medicare as a self-denial for inpatient Part B payment. <Medicare Claims Processing Manual, Chapter 1 § 50.3; MLN Matters Article SE1333; 42 C.F.R 414.5>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e. there was no reasonable expectation of a two midnight stay) and would not be covered under Part A. On what bill type should the hospital submit the pacemaker procedure?

Analysis: The hospital should submit the pacemaker on a 13X (outpatient) bill type because the surgery was an outpatient service provided prior to a non-covered inpatient stay. The three-day window is inapplicable when the inpatient stay is non-covered. Note that full payment for the encounter will be made under the C-APC for the pacemaker procedure on the 131 claim and no inpatient Part B claim will be necessary in this case. <Medicare Claims Processing Manual, Chapter 4 § 10.12>

Case Study 3

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

Analysis: No, the same notice may function as the First IM and the follow-up IM as long as it falls within the required time frame, i.e., within 2 days of admission and at least 4 hours prior to discharge. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2>

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Case Study 4

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

Analysis: The hospital should provide the DND as soon as possible but not later than noon on Saturday. Note the QIO should complete their review by Sunday and the patient would become liable on Monday. <Medicare Claims Processing Manual, Chapter 30 §§ 200.4.4 and 200.4.5>

Case Study 5

Facts: A Medicare beneficiary, with a BMI of 32, is admitted for gastric bypass surgery to assist with weight loss and control of his Type II diabetes. The NCD for bariatric surgery states it is covered for beneficiaries that have a BMI of ≥ 35 , have at least one obesity related co-morbidity and have been unsuccessful with medical treatment for their obesity. Is the hospital required to provide the patient with a notice? If so, which notice?

Analysis: Yes, the hospital should provide a Preadmission/Admission HINN to the patient informing him that his procedure is not covered by Medicare. If the hospital fails to inform the patient that his procedure is not covered by Medicare, the hospital, rather than the patient will be liable for the procedure. The IM notice is not required in this case because the stay is not covered by Medicare. <Medicare Claims Processing Manual, Chapter 30 §§ 240.2 and 200.2>

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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter G - Standards and Certification

Part 482 - Conditions of Participation for Hospitals

Subpart C - Basic Hospital Functions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr, unless otherwise noted.

Source: 51 FR 22042, June 17, 1986, unless otherwise noted.

§ 482.30 Condition of participation: Utilization review.

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

- (a) **Applicability.** The provisions of this section apply except in either of the following circumstances:
 - (1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.
 - (2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.
- (b) **Standard: Composition of utilization review committee.** A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).
 - (1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:
 - (i) A staff committee of the institution;
 - (ii) A group outside the institution -
 - (A) Established by the local medical society and some or all of the hospitals in the locality; or
 - (B) Established in a manner approved by CMS.
 - (2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.
 - (3) The committee's or group's reviews may not be conducted by any individual who -
 - (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or
 - (ii) Was professionally involved in the care of the patient whose case is being reviewed.
- (c) **Standard: Scope and frequency of review.**

- (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -
 - (i) Admissions to the institution;
 - (ii) The duration of stays; and
 - (iii) Professional services furnished, including drugs and biologicals.
 - (2) Review of admissions may be performed before, at, or after hospital admission.
 - (3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.
 - (4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:
 - (i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in § 412.80(a)(1)(i) of this chapter; and
 - (ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in § 412.80(a)(1)(ii) of this chapter.
- (d) **Standard: Determination regarding admissions or continued stays.**
- (1) The determination that an admission or continued stay is not medically necessary -
 - (i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
 - (ii) Must be made by at least two members of the UR committee in all other cases.
 - (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
 - (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);
- (e) **Standard: Extended stay review.**
- (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may -
 - (i) Be the same for all cases; or
 - (ii) Differ for different classes of cases.

- (2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.
- (3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.
- (f) **Standard: Review of professional services.** The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 414 - Payment for Part B Medical and Other Health Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

Source: 55 FR 23441, June 8, 1990, unless otherwise noted.

Editorial Note: Nomenclature changes to part 414 appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

- (a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:
- (1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.
 - (2) Physical therapy services, speech-language pathology services, and occupational therapy services.
 - (3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.
 - (4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.
 - (5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.
 - (6) Clinical diagnostic laboratory services.
 - (7)
 - (i) Effective December 8, 2003, screening mammography services; and
 - (ii) Effective January 1, 2005, diagnostic mammography services.
 - (8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

- (b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).
- (c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

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Excerpt from Medicare Benefit Policy Manual, Chapter 6**10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals****(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

Payment may be made under Part B for physician services and for the nonphysician medical and other health services as provided in this section when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. This 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 hospital services furnished by nonparticipating hospitals. In this section, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements (see chapter 16, §170 of this manual, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider"). A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

10.1 - Reasonable and Necessary Part A Hospital Inpatient Claim Denials**(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, and if waiver of liability payment is not made, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

- 1) Part B services paid under the outpatient prospective payment system (OPPS), excluding observation services and hospital outpatient visits that require an outpatient status. Hospitals that are excluded from payment under the OPPS are instead paid under their alternative payment methodology (e.g., reasonable cost, all inclusive rate, or Maryland waiver) for the services that are otherwise payable under the OPPS.
- 2) The following services excluded from OPPS payment, that are instead paid under the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients:

- a. Physical therapy services, speech-language pathology services, and occupational therapy services (see chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services,”).
- b. Ambulance services.
- c. Prosthetic devices, prosthetic supplies, and orthotic devices paid under the DMEPOS fee schedule (excludes 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) and replacement of such devices).
- d. Durable medical equipment supplied by the hospital for the patient to take home, except durable medical equipment that is implantable.
- e. Certain clinical diagnostic laboratory services.
- f. Screening and diagnostic mammography services.
- g. Annual wellness visit providing personalized prevention plan services.

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.2 - Other Circumstances in Which Payment Cannot Be Made Under Part A

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

Part B payment could be made to a hospital for the medical and other health services listed in this section for inpatients enrolled in Part B if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before or during the admission; or
- The patient was not otherwise eligible for or entitled to coverage under Part A (see chapter 16, §180 of this manual for services received as a result of non-covered services).

Beginning in 2014, for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

The following inpatient services are payable under the OPPS:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Acute dialysis of a hospital inpatient with or without end stage renal disease (ESRD). The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §200.2, "Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)."
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Prostate screening;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;

- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO) that is not covered under the ESRD benefit.

The following inpatient services are payable under the non-OPPS Part B fee schedules or prospectively determined rates listed:

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);
- 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 such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the applicable rate under Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §240.3, “Inpatient Part B Hospital Services - Implantable Prosthetic Devices”);
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient’s physical condition (DMEPOS fee schedule);
- Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services”) (applicable rate based on the Medicare Physician Fee Schedule);
- Ambulance services (ambulance fee schedule); and
- Screening mammography services (Medicare Physician Fee Schedule).

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for these services must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70, “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.3 - Hospital Inpatient Services Paid Only Under Part B (Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The services listed in Chapter 15, §250 of this manual, “Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities,” when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

In all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

20 - Outpatient Hospital Services (Rev. 157, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The rules in this section pertaining to the coverage of outpatient hospital services are not applicable to the following services.

- Physical therapy, speech-language pathology or occupational therapy services when they are furnished “as therapy” meaning under a therapy plan of care. See chapter 15, sections 220 and 230 of this manual, for coverage and payment rules for these services, which are paid at the applicable amount under the physician fee schedule.
- Services that are covered and paid under the End Stage Renal Disease Prospective Payment System. See Chapter 11, “End Stage Renal Disease (ESRD)” of this manual, for rules on the coverage of these services.

Excerpt from Medicare Benefit Policy Manual, Chapter 15

fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an “intensive care” concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

There are several services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are:

- Physicians’ services (including the services of residents and interns in unapproved teaching programs);

- Physician assistant services, furnished after December 31, 1990;

- Certified nurse-midwife services, as described in §180, furnished after December 31, 1990; and

- Qualified clinical psychologist services, as defined in §160, furnished after December 31, 1990;

- Screening mammography services;

- Screening pap smears and pelvic exams;

- Screening glaucoma services;

- Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations;

- Colorectal screening;

- Bone mass measurements; and

- Prostate screening;

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient. The other

services listed are not subject to bundling but, because they are excluded from the statutory definition of inpatient hospital services, may be covered only under Part B.

Payment may be made under Part B to a hospital (or critical access hospital) for certain medical and other health services furnished to its inpatients as provided in Chapter 6, §10 of this manual, “Medical and Other Health Services Furnished to Inpatients of Participating Hospitals.”

Payment may be made under Part B for certain medical and other health services if the beneficiary is an inpatient of a skilled nursing facility (SNF) as provided in chapter 8, §§ 70ff of this manual.

260 - Ambulatory Surgical Center Services

(Rev. 77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and change requests. The ASC must accept Medicare’s payment for such procedures as payment in full with respect to those services defined as ASC facility services.

Where services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services; however, the “professional” rate is then adjusted since the ASC incurs the facility costs.

260.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 104; Issued: 03-13-09; Effective Date: 04-01-09; Implementation Date: 04-06-09)

An ASC for purposes of this benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, a facility elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise. This provision is intended to prohibit such an entity from switching from one payment method to another to maximize its revenues (47 FR 34082, 34099, Aug. 5, 1982). For other general conditions and requirements, see 42 CFR 416.25-416.49. If the hospital based surgery center is certified as an ASC it is considered an ASC and is subject to rules for ASCs. Related survey requirements are published in the State Operations Manual, Pub. 100-07, Appendix L. Claims processing and payment requirements for ASCs are published in Pub. 100-04, the Medicare Claims Processing Manual, chapter 14.

Excerpt from Medicare Claims Processing Manual, Chapter 4

furnished. See Pub. 100-04, chapter 3, §90.3.1 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

Effective January 1, 2017, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0815 (Other Organ Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same claim as the transplant procedure in order to be appropriately packaged for payment purposes. Revenue code 0815 charges for allogeneic stem cell acquisition costs are reported on Worksheet D Part V, column 2, line 77, cost center 0077 of the hospital Medicare cost report (Form CMS-2552-10).

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by A/B MACs (A) under the OPPS is available at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>

240 - Inpatient Part B Hospital Services

(Rev. 3106, Issued: 11-06-14, Effective: 10-01-13, Implementation: 02-10-15)

Medicare pays for hospital (including CAH) inpatient 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. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some provider's customary charging practice has established separate charges for these services following the PRM-1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS in order to separately bill.

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

(Rev.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)

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."

A hospital may also be paid for Part B inpatient services if it 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 would be required to adjust its Part A claim (to make the provider liable) prior to submitting a claim for payment of Part B inpatient services. Whether or not the hospital had submitted a claim to Part A for payment, we require the hospital to submit a 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 could 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.

A hospital part B inpatient services claim billed when a reasonable and necessary part A hospital inpatient was denied must be billed with:

- A condition code “W2” attesting that this is a rebilling and no appeal is in process,
- “A/B REBILLING” in the treatment authorization field, and
- The original, denied inpatient claim (CCN/DCN/ICN) number.

NOTE: Providers submitting an 837I are 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.

NOTE: Providers submitting an 837I are instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~ For DDE or paper Claims, Providers are 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". (The numeric string (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.)

Not Allowed Revenue Codes

The claims processing system shall set edits to prevent payment on Type of Bill 012x 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	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.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
 CARC: 96
 RARC: M28

MSN: 21.21

CWF shall edit to ensure that DSMT services are not billed on a 012x claim.

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

ort 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.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)*

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 012x for claims containing the revenue codes listed in the table below with exceptions as noted. For the exceptions noted, contractors shall ensure that only the exceptions identified are allowed to process with the revenue code.

Not Allowed Revenue Codes

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	026x	0270
0271	0272	0273	0277	0279	028x	029x	036x
0370	0374	0379	038x	039x	041x	045x	0470
0472	0479	0480	0481	0489	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	056x	057x	058x	059x	060x
0620	0624	063x	064x	065x	066x	067x	068x
069x	070x	071x	072x	075x	076x	079X	081x
082x	083x	084x	085x	087x	088x	089x	090x
091x	093x	0940	0941	0942*	0943	0944	0945
0946	0947	0948	0949	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.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
 CARC: 96
 RARC: M28
 MSN: 21.21

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

Allowed Revenue Codes

0240	0274	0275	0276	0278	030x	031x	032x
0333	034x	035x,	040x,	042x	043x	044x	046x
0471	0482	0483	054x	061x	0623	073x	074x
0771	078x*	080x	086x	092x	0942*	0964*	

*Billed prior to admission or on the day of discharge.

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

Additional Allowed services that are identified by HCPCS, not identified by Revenue Codes

Other Diagnostic services: (A MAC maintained)

Preventive services:

COVID-19, Influenza, pneumococcal pneumonia, and hepatitis B vaccines

Colorectal screening

Screening glaucoma services

Bone mass measurements

Prostate screening

Covered drugs:

Hemophilia clotting factors

Immunosuppressive drugs

Oral anti-cancer drugs

Oral anti-emetic

Non-ESRD Epoetin Alfa (EPO)

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 OPPTS 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

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

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

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

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.

250 - Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in §250.1. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee

Revenue Codes Allowed on Inpatient Part B (012X) Claims (Data_Revenue, Column K, "PART_B_BILLABLE")

REVENUE _CODE	DESCRIPTION	PART_B_BILLABLE	LO_ VERS	HI_ VERS
240	All Inclusive Ancillary - General Classification	1	92	94
241	All Inclusive Ancillary - Basic	1	92	94
242	All Inclusive Ancillary - Comprehensive	1	92	94
243	All Inclusive Ancillary - Specialty	1	92	94
249	All Inclusive Ancillary - Other All Inclusive Ancillary	1	92	94
274	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 027x) - Prosthetic/Orthotic Devices	1	92	94
275	Medical/Surgical Supplies and Devices (Also See 062 X, An Extension of 027x) - Pacemaker	1	92	94
276	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 027x) - Intraocular Lens	1	92	94
278	An Extension of 027x) - Other Implant	1	92	94
300	Laboratory - General Classification	1	92	94
301	Laboratory - Chemistry	1	92	94
302	Laboratory - Immunology	1	92	94
303	Laboratory - Renal Patient (Home)	1	92	94
304	Laboratory - Non-Routine Dialysis	1	92	94
305	Laboratory - Hematology	1	92	94
306	Laboratory - Bacteriology & Microbiology	1	92	94
307	Laboratory - Urology	1	92	94
309	Laboratory - Other Laboratory	1	92	94
310	Laboratory Pathology - General Classification	1	92	94
311	Laboratory Pathology - Cytology	1	92	94
312	Laboratory Pathology - Histology	1	92	94
314	Laboratory Pathology - Biopsy	1	92	94
319	Laboratory Pathology - Other Laboratory Pathology	1	92	94
320	Radiology - Diagnostic - General Classification	1	92	94
321	Radiology - Diagnostic - Angiocardiology	1	92	94
322	Radiology - Diagnostic - Arthrography	1	92	94
323	Radiology - Diagnostic - Arteriography	1	92	94
324	Radiology - Diagnostic - Chest X-ray	1	92	94
329	Radiology - Diagnostic - Other Radiology - Diagnostic Radiology - Therapeutic and/or Chemotherapy	1	92	94
333	Administration - Radiation Therapy	1	92	94
340	Nuclear Medicine - General Classification	1	92	94
341	Nuclear Medicine - Diagnostic	1	92	94
342	Nuclear Medicine - Therapeutic	1	92	94
343	Nuclear Medicine - Diagnostic Radiopharmaceuticals	1	92	94
344	Nuclear Medicine - Therapeutic Radiopharmaceuticals	1	92	94
349	Nuclear Medicine - Other Nuclear Medicine	1	92	94
350	CT Scan - General Classification	1	92	94
351	CT Scan - Head Scan	1	92	94
352	CT Scan - Body Scan	1	92	94
359	CT Scan - CT - Other	1	92	94

Revenue Codes Allowed on Inpatient Part B (012X) Claims (Data_Revenue, Column K, "PART_B_BILLABLE")

REVENUE _CODE	DESCRIPTION	PART_B_BILLABLE	LO_ VERS	HI_ VERS
400	Other Imaging Services - General Classification	1	92	94
401	Other Imaging Services - Diagnostic Mammography	1	92	94
402	Other Imaging Services - Ultrasound	1	92	94
403	Other Imaging Services - Screening Mammography	1	92	94
404	Other Imaging Services - Positron Emission Tomography	1	92	94
409	Other Imaging Services - Other Imaging Services	1	92	94
420	Physical Therapy - General Classification	1	92	94
421	Physical Therapy - Visit	1	92	94
422	Physical Therapy - Hourly	1	92	94
423	Physical Therapy - Group	1	92	94
424	Physical Therapy - Evaluation or Re-Evaluation	1	92	94
429	Physical Therapy - Other Physical Therapy	1	92	94
430	Occupational Therapy - General Classification	1	92	94
431	Occupational Therapy - Visit	1	92	94
432	Occupational Therapy - Hourly	1	92	94
433	Occupational Therapy - Group	1	92	94
434	Occupational Therapy - Evaluation or Reevaluation	1	92	94
439	Occupational Therapy - Other Occupational Therapy	1	92	94
440	Speech-language Pathology - General Classification	1	92	94
441	Speech-language Pathology - Visit	1	92	94
442	Speech-language Pathology - Hourly	1	92	94
443	Speech-language Pathology - Group	1	92	94
444	Speech-language Pathology - Evaluation or Reevaluation	1	92	94
449	Speech-language Pathology - Other Speech Therapy	1	92	94
460	Pulmonary Function - General Classification	1	92	94
469	Pulmonary Function - Other Pulmonary Function	1	92	94
471	Audiology - Diagnostic	1	92	94
482	Cardiology - Stress Test	1	92	94
483	Cardiology - Echocardiology	1	92	94
540	Ambulance - General Classification	1	92	94
541	Ambulance - Supplies	1	92	94
542	Ambulance - Medical Transport	1	92	94
543	Ambulance - Heart Mobile	1	92	94
544	Ambulance - Oxygen	1	92	94
545	Ambulance - Air Ambulance	1	92	94
546	Ambulance - Neonatal Ambulance Services	1	92	94
547	Ambulance - Pharmacy	1	92	94
548	Ambulance - EKG Transmission	1	92	94
549	Ambulance - Other Ambulance	1	92	94
610	Magnetic Resonance Technology (MRT) - General Classification	1	92	94
611	Magnetic Resonance Technology (MRT) - MRI - Brain/Brainstem	1	92	94

Revenue Codes Allowed on Inpatient Part B (012X) Claims (Data_Revenue, Column K, "PART_B_BILLABLE")

REVENUE _CODE	DESCRIPTION	PART_B_BILLABLE	LO_ VERS	HI_ VERS
612	Magnetic Resonance Technology (MRT) - MRI - Spinal Cord/Spine	1	92	94
614	Magnetic Resonance Technology (MRT) - MRI - Other	1	92	94
615	Magnetic Resonance Technology (MRT) - Mra - Head and Neck	1	92	94
616	Magnetic Resonance Technology (MRT) - Mra - Lower Extremities	1	92	94
618	Magnetic Resonance Technology (MRT) - Mra - Other	1	92	94
619	Magnetic Resonance Technology (MRT) - Other MRT	1	92	94
623	Medical/Surgical Supplies and Devices - Extension of 027x - Surgical Dressings	1	92	94
730	EKG/ecg (Electrocardiogram) - General Classification	1	92	94
731	EKG/ecg (Electrocardiogram) - Holter Monitor	1	92	94
732	EKG/ecg (Electrocardiogram) - Telemetry	1	92	94
739	EKG/ecg (Electrocardiogram) - Other EKG/ecg	1	92	94
740	EEG (Electroencephalogram) - General Classification	1	92	94
771	Preventive Care Services - Vaccine Administration	1	92	94
780	Telemedicine - General Classification	1	92	94
800	Inpatient Renal Dialysis - General Classification	1	92	94
801	Inpatient Renal Dialysis - Inpatient Hemodialysis	1	92	94
802	Inpatient Renal Dialysis - Inpatient Peritoneal (Non-CAPPD)	1	92	94
803	Inpatient Renal Dialysis - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPPD)	1	92	94
804	Inpatient Renal Dialysis - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	1	92	94
809	Inpatient Renal Dialysis - Other Inpatient Dialysis	1	92	94
860	Magnetoencephalography (Meg) - General Classification	1	92	94
861	Magnetoencephalography (MEG) - MEG	1	92	94
920	Other Diagnostic Services - General Classification	1	92	94
921	Other Diagnostic Services - Peripheral Vascular Lab	1	92	94
922	Other Diagnostic Services - Electromyogram	1	92	94
923	Other Diagnostic Services - Pap Smear	1	92	94
924	Other Diagnostic Services - Allergy Test	1	92	94
925	Other Diagnostic Services - Pregnancy Test	1	92	94
929	Other Diagnostic Services - Other Diagnostic Service	1	92	94
942	Other Therapeutic Services (Also See 095x, An Extension of 094x) - Education/training	1	92	94
964	Professional Fees (Also See 097x and 098x) - Anesthetist (CRNA)	1	92	94

HCPCS Codes Allowed on Inpatient Part B (012X) Claims (Data_HCPCS, Column DR, "PART_B_BILLABLE")

HCPCS	DESCRIPTION	PART_B_ BILLABLE	LO_ VERS	HI_ VERS
76977	Us bone density measure	1	92	94
77078	Ct bone density axial	1	92	94
77080	Dxa bone density axial	1	92	94
77081	Dxa bone density/peripheral	1	92	94
77085	Dxa bone density study	1	92	94
90630	Flu vacc iiv4 no preserv id	1	92	94
90653	liv adjuvant vaccine im	1	92	94
90654	Flu vacc iiv3 no preserv id	1	92	94
90655	liv3 vacc no prsv 0.25 ml im	1	92	94
90656	liv3 vacc no prsv 0.5 ml im	1	92	94
90657	liv3 vaccine splt 0.25 ml im	1	92	94
90658	liv3 vaccine splt 0.5 ml im	1	92	94
90660	Laiv3 vaccine intranasal	1	92	94
90661	Cciiv3 vac no prsv 0.5 ml im	1	92	94
90662	liv no prsv increased ag im	1	92	94
90670	Pcv13 vaccine im	1	92	94
90672	Laiv4 vaccine intranasal	1	92	94
90674	Cciiv4 vac no prsv 0.5 ml im	1	92	94
90677	Pcv20 vaccine im	1	92	94
90682	Riv4 vacc recombinant dna im	1	92	94
90685	liv4 vacc no prsv 0.25 ml im	1	92	94
90686	liv4 vacc no prsv 0.5 ml im	1	92	94
90687	liv4 vaccine splt 0.25 ml im	1	92	94
90688	liv4 vaccine splt 0.5 ml im	1	92	94
90694	Vacc aliiv4 no prsrv 0.5ml im	1	92	94
90732	Ppsv23 vacc 2 yrs+ subq/im	1	92	94
90739	Hepb vacc 2/4 dose adult im	1	92	94
90740	Hepb vacc 3 dose immunusup im	1	92	94
90744	Hepb vacc 3 dose ped/adol im	1	92	94
90746	Hepb vaccine 3 dose adult im	1	92	94
90747	Hepb vacc 4 dose immunusup im	1	92	94
91304	Sarscov2 vac 5mcg/0.5ml im	1	94	94
91318	Sarscov2 vac 3mcg trs-suc im	1	92	94
91319	Sarscv2 vac 10mcg trs-suc im	1	92	94
91320	Sarscv2 vac 30mcg trs-suc im	1	92	94
91321	Sarscov2 vac 25 mcg/.25ml im	1	92	94
91322	Sarscov2 vac 50 mcg/0.5ml im	1	92	94
93015	Cardiovascular stress test	1	92	94
93307	Tte w/o doppler complete	1	92	94
93308	Tte f-up or lmted	1	92	94
93320	Doppler echo exam heart	1	92	94
93451	Right heart cath	1	92	94
93452	Left hrt cath w/ventrclgrphy	1	92	94
93453	R&l hrt cath w/ventriclgrphy	1	92	94
93454	Coronary artery angio s&i	1	92	94

HCPCS Codes Allowed on Inpatient Part B (012X) Claims (Data_HCPCS, Column DR, "PART_B_BILLABLE")

HCPCS	DESCRIPTION	PART_B_ BILLABLE	LO_ VERS	HI_ VERS
93455	Coronary art/grft angio s&i	1	92	94
93456	R hrt coronary artery angio	1	92	94
93457	R hrt art/grft angio	1	92	94
93458	L hrt artery/ventricle angio	1	92	94
93459	L hrt art/grft angio	1	92	94
93460	R&l hrt art/ventricle angio	1	92	94
93461	R&l hrt art/ventricle angio	1	92	94
93462	L hrt cath trnsptl puncture	1	92	94
93463	Drug admin & hemodynamic meas	1	92	94
93464	Exercise w/hemodynamic meas	1	92	94
93503	Insert/place heart catheter	1	92	94
93505	Biopsy of heart lining	1	92	94
93563	Njx cgen car cth slctv c ang	1	92	94
93564	Njx cgen car cath slctv opac	1	92	94
93565	Njx car cth slctv lv/la ang	1	92	94
93566	Njx car cth slctv rv/ra ang	1	92	94
93567	Njx car cth sprlv aortgrphy	1	92	94
93568	Njx car cth nslc p-art angrp	1	92	94
93571	Heart flow reserve measure	1	92	94
93572	Heart flow reserve measure	1	92	94
G0102	Prostate ca screening; dre	1	92	94
G0103	Psa screening	1	92	94
G0104	Ca screen;flexi sigmoidscope	1	92	94
G0105	Colorectal scrn; hi risk ind	1	92	94
G0117	Glaucoma scrn hgh risk direc	1	92	94
G0118	Glaucoma scrn hgh risk direc	1	92	94
G0130	Single energy x-ray study	1	92	94
G0278	Iliac art angio,cardiac cath	1	92	94
J0881	Darbepoetin alfa, non-esrd	1	92	94
J0885	Epoetin alfa, non-esrd	1	92	94
J7170	Inj., emicizumab-kxwh 0.5 mg	1	92	94
J7175	Inj, factor x, (human), 1iu	1	92	94
J7177	Inj., fibryga, 1 mg	1	92	94
J7178	Inj human fibrinogen con nos	1	92	94
J7179	Vonvendi inj 1 iu vwf:rco	1	92	94
J7180	Factor xiii anti-hem factor	1	94	94
J7181	Factor xiii recomb a-subunit	1	94	94
J7182	Factor viii recomb novoeight	1	92	94
J7183	Wilate injection	1	92	94
J7185	Xyntha inj	1	92	94
J7186	Antihemophilic viii/vwf comp	1	92	94
J7187	Humate-p, inj	1	92	94
J7188	Factor viii recomb obizur	1	92	94
J7189	Factor viia recomb novoseven	1	92	94
J7190	Factor viii	1	92	94

HCPCS Codes Allowed on Inpatient Part B (012X) Claims (Data_HCPCS, Column DR, "PART_B_BILLABLE")

HCPCS	DESCRIPTION	PART_B_ BILLABLE	LO_ VERS	HI_ VERS
J7192	Factor viii recombinant nos	1	92	94
J7193	Factor ix non-recombinant	1	92	94
J7194	Factor ix complex	1	92	94
J7195	Factor ix recombinant nos	1	92	94
J7198	Anti-inhibitor	1	92	94
J7200	Factor ix recombinan rixubis	1	92	94
J7201	Factor ix alprolix recomb	1	92	94
J7202	Factor ix idelvion inj	1	92	94
J7203	Factor ix recomb gly rebiny	1	92	94
J7204	Inj recomb esperoct per iu	1	92	94
J7205	Factor viii fc fusion recomb	1	92	94
J7207	Factor viii pegylated recomb	1	92	94
J7208	Inj. jivi 1 iu	1	92	94
J7209	Factor viii nuwiq recomb 1iu	1	92	94
J7210	Inj, afstyla, 1 i.u.	1	92	94
J7211	Inj, kovaltry, 1 i.u.	1	92	94
J7212	Factor viia recomb sevenfact	1	92	94
J7500	Azathioprine oral 50mg	1	92	94
J7501	Azathioprine parenteral	1	92	94
J7502	Cyclosporine oral 100 mg	1	92	94
J7503	Tacrol envarsus ex rel oral	1	92	94
J7504	Lymphocyte immune globulin	1	92	94
J7505	Monoclonal antibodies	1	94	94
J7507	Tacrolimus imme rel oral 1mg	1	92	94
J7508	Tacrol astagraf ex rel oral	1	92	94
J7509	Methylprednisolone oral	1	92	94
J7510	Prednisolone oral per 5 mg	1	92	94
J7511	Antithymocyte globuln rabbit	1	92	94
J7512	Prednisone ir or dr oral 1mg	1	92	94
J7513	Daclizumab, parenteral	1	92	94
J7515	Cyclosporine oral 25 mg	1	92	94
J7516	Cyclosporin parenteral 250mg	1	92	94
J7517	Mycophenolate mofetil oral	1	92	94
J7518	Mycophenolic acid	1	92	94
J7520	Sirolimus, oral	1	92	94
J7525	Tacrolimus injection	1	92	94
J7527	Oral everolimus	1	92	94
J7599	Immunosuppressive drug noc	1	92	94
J8501	Oral aprepitant	1	92	94
J8510	Oral busulfan	1	92	94
J8515	Cabergoline, oral 0.25mg	1	92	94
J8520	Capecitabine, oral, 150 mg	1	92	94
J8521	Capecitabine, oral, 500 mg	1	92	94
J8530	Cyclophosphamide oral 25 mg	1	92	94
J8540	Oral dexamethasone	1	92	94

HCPCS Codes Allowed on Inpatient Part B (012X) Claims (Data_HCPCS, Column DR, "PART_B_BILLABLE")

HCPCS	DESCRIPTION	PART_B_ BILLABLE	LO_ VERS	HI_ VERS
J8560	Etoposide oral 50 mg	1	92	94
J8562	Oral fludarabine phosphate	1	92	94
J8565	Gefitinib oral	1	92	94
J8597	Antiemetic drug oral nos	1	92	94
J8600	Melphalan oral 2 mg	1	92	94
J8610	Methotrexate oral 2.5 mg	1	92	94
J8650	Nabilone oral	1	92	94
J8655	Oral netupitant, palonosetron	1	92	94
J8670	Rolapitant, oral, 1mg	1	92	94
J8700	Temozolomide	1	92	94
J8705	Topotecan oral	1	94	94
J8999	Oral prescription drug chemo	1	92	94
Q0161	Chlorpromazine hcl 5mg oral	1	92	94
Q0162	Ondansetron oral	1	92	94
Q0163	Diphenhydramine hcl 50mg	1	92	94
Q0164	Prochlorperazine maleate 5mg	1	92	94
Q0166	Granisetron hcl 1 mg oral	1	92	94
Q0167	Dronabinol 2.5mg oral	1	92	94
Q0169	Promethazine hcl 12.5mg oral	1	92	94
Q0173	Trimethobenzamide hcl 250mg	1	94	94
Q0174	Thiethylperazine maleate 10mg	1	92	94
Q0175	Perphenazine 4mg oral	1	92	94
Q0177	Hydroxyzine pamoate 25mg	1	92	94
Q0180	Dolasetron mesylate oral	1	92	94
Q0181	Unspecified oral anti-emetic	1	92	94

Instructions for Completion of the HINN 12

A. General Instructions. As with comparable notices, legal or letter-size paper may be used for reproduction of this notice. All information should remain on the same page as it appears in this instruction. If possible, hospitals should use the exact font given in the notice, Times New Roman, 12-point, otherwise another comparable font at least 12-point in size, 18-point for the title should be used. A visually high-contrast combination of dark ink on a pale background must also be used. Do not use font effects, such as bolding, italicizing, or highlighting, other than those appearing in this instruction.

Entries for all blanks on the notices can be hand-written, but handwriting must be legible. The handwriting should be no smaller than approximately font size 10. If typing entries into the notice, font size 12 is recommended, but size 10 is also permissible.

B. HINN-12 Specific Instructions. The model notice itself appears at the end of these instructions. Other general guidance for the reproduction of this specific notice include the following:

- The notice is produced as a one-page document.
- The following text should be removed before reproducing the notice: “Insert Hospital Letterhead And/Or Contact Information”; “Insert Reason Medicare Is Not Expected To Pay”; and “Insert Estimated Total or Average Daily Cost”.
- The following detailed instructions for completing the notice are in two parts: the header section on the first page and the remainder of the first page.

1. Header Section (Page 1 from Top to “*Insert Hospital Letterhead...*”)

Retain the HINN 12 title. Remove the instruction about inserting the letterhead. Insert hospital letterhead, logo and/or basic contact information: hospital name, address and telephone number. If the letterhead or logo does not provide the basic contact information, it must be added here.

2. Instructions for Completing the notice (Remainder of Page after Header)

A. “Name of Patient or Representative”

Write legibly or pre-print the name of the patient or representative affected by this notice.

B. “Identification Number”

Write legibly or pre-print the identification number of the affected Medicare beneficiary [**Note:** Health Insurance Card (HIC) numbers must not be placed on the notice].

C. Purpose of Notice and “Reason Medicare is not Expected to Pay”

The purpose of the notice is to inform the beneficiary that the hospital believes that his/her continued hospital stay will not be covered by Medicare. Hospitals must specify, in plain language the reason for noncoverage of the stay, including a brief description of and citations to the appropriate Medicare coverage policies or guidelines.

D. “...we believe that beginning on _____ ”

Fill in the date upon which the beneficiary will become responsible for payment.

E. “Insert Estimated Total or Average Daily Cost”

Insert the estimated cost of the beneficiary’s stay beginning from the date of noncoverage. This estimate can be an average daily cost.

F. Physician Referral

Advise the beneficiary to speak with his/her physician about his/her health care needs, including continuing his/her current stay.

H. “Signature of Beneficiary or Representative” and “Date”

The notice must be signed and dated by the beneficiary or representative.

The beneficiary or representative must receive a copy of the signed and dated notice.

Version 01/29/2014
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