



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 7: Inpatient Utilization Review and Billing Requirements

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. 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), see *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), see *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. <See *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. 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 and bill with Condition Code 44, discussed below.
2. If the determination an admission is not medically necessary is made after discharge, it is considered a "self-denial". The patient remains inpatient, and the case is submitted on an inpatient Part B claim with Condition Code W2, discussed below.

E. Determination Prior to Discharge

1. 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:
 - a. There is a determination by the UR committee or representative;
 - b. The attending physician concurs with the UR committee's decision;
 - c. The attending physician's concurrence is documented in the medical record; and
 - d. 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. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; see *MLN Matters Article SE0622, Q.8*>
 - i. If the patient does not have Medicare Part B or if the total stay is at least three days, the patient must also be given the Medicare Change of Status Form (MCSN) informing them of their appeal rights, discussed below. <*Medicare Claims Processing Manual*, Chapter 30 § 450.2>

2. If all conditions are met, the claim for the case should be submitted as an outpatient claim (bill type 13X) with condition code 44. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>
 - a. 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. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2 and 290.5.2>
 - b. 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. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
 - i. 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. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

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?

3. Medicare Change of Status Notice (MCSN) and Appeal of Change of Status
 - a. Certain Medicare beneficiaries who are admitted to a hospital as an inpatient and have their status changed to outpatient have a right to appeal their status change to the QIO for an expedited determination. <*Medicare Claims Processing Manual*, Chapter 30 § 450>
 - i. The right to appeal a change in status to the QIO only applies to beneficiaries with original Medicare. <*Medicare Claims Processing Manual*, Chapter 30 § 450>

- ii. The right to appeal a change in status only applies to beneficiaries that are admitted as an inpatient, have their status changed to outpatient, and meet one of the following criteria:

- a) Their stay at the hospital was at least three days; or
- b) They do not have Medicare Part B. <Medicare Claims Processing Manual, Chapter 30 § 450.2>

b. The MCSN Form

- i. The MCSN (CMS 10868, expiration 11/30/27), available on the Beneficiary Notice Initiative page, is the required form for providing notice to beneficiaries of their appeal rights when their status is changed from inpatient to outpatient. Handout 10 is the MCSN form.

Link: Beneficiary Notice Initiative (MOON, IM, ABNs, HINNs) under Medicare-Related Sites – General

- ii. The MCSN must be provided to beneficiaries who have the right to appeal their change in status to the QIO for an expedited determination (i.e., beneficiaries without Part B or with a three day stay) and should not be provided to other beneficiaries who have had a change in status. <Medicare Claims Processing Manual, Chapter 30 § 450.3.2>
- iii. The MCSN is available in English, Spanish, Chinese, Korean, and Vietnamese.
- iv. The MCSN form may not be altered except to add a hospital logo and contact information at the top and relevant information (e.g., witness signatures) to the “Additional Information” section. <Medicare Claims Processing Manual, Chapter 30 § 450.3.1>
- v. Beneficiary Comprehension
 - a) The hospital must ensure the beneficiary comprehends the notice, including use of translators, interpreters, and assistive technology. <Medicare Claims Processing Manual, Chapter 30 § 450.3.5>
 - b) If the beneficiary is unable to comprehend the notice, the notice may be provided to an authorized representative, including an off-site representative, as discussed below for the Important Message for Medicare. <Medicare Claims Processing Manual, Chapter 30 § 450.3.6>

vi. Timeframe for Delivery

- a) For beneficiaries without Medicare Part B, the hospital should deliver the MCSN as soon as possible after the change in status. <Medicare Claims Processing Manual, Chapter 30 § 450.3.3>
- b) For beneficiaries with Part B, the hospital should deliver the MCSN as soon as possible after the change in status AND the third day in the hospital is reached. <Medicare Claims Processing Manual, Chapter 30 § 450.3.3>

vii. Signature

- a) The patient or their representative should sign and date the MCSN to demonstrate they received the notice and understand it. <Medicare Claims Processing Manual, Chapter 30 § 450.3.2>
 - 1) If the beneficiary refuses to sign the notice, the hospital should indicate the date of refusal in the additional information section. The beneficiary remains entitled to an appeal of their change in status. <Medicare Claims Processing Manual, Chapter 30 § 450.3.4>

viii. Copy and Retention

- a) The signed MCSN should be retained in the beneficiary's medical record and a copy should be provided to the beneficiary or their representative. <Medicare Claims Processing Manual, Chapter 30 § 450.3.7>

c. Beneficiary Appeals of Change in Status

- i. A beneficiary who disagrees with their change in status may request an expedited determination by the QIO by phone or in writing before leaving the hospital. <Medicare Claims Processing Manual Chapter 30 § 450.4.1.1>
 - a) The beneficiary may contact the QIO at any time after leaving the hospital, but the request will be considered untimely. <Medicare Claims Processing Manual, Chapter 30 § 450.1.1>
- ii. QIO Responsibilities
 - a) The QIO must notify the hospital "immediately" when a beneficiary requests an expedited determination of their change in status. If the appeal is received after hours, the QIO notifies the hospital as soon

as possible the next morning. <Medicare Claims Processing Manual, Chapter 30 § 450.5.2>

- b) The QIO validates delivery of the MCSN, solicits the views of the beneficiary and the hospital, and makes a determination. <Medicare Claims Processing Manual, Chapter 30 § 450.5.1-450.5.6>
 - 1) For timely requests (i.e., before the patient leaves the hospital), the QIO must make its determination no later than the calendar day after it receives all requested information from the hospital. <Medicare Claims Processing Manual, Chapter 30 § 450.5.6>
 - 2) For untimely requests (i.e., after the patient leaves the hospital), the QIO must make its determination no later than two calendar days after it receives all requested information from the hospital. <Medicare Claims Processing Manual, Chapter 30 § 450.5.6>
- c) The QIO must notify the beneficiary, the hospital, and the SNF (if applicable) of its determination by phone followed by a written determination letter. <Medicare Claims Processing Manual, Chapter 30 § 450.5.6>
 - 1) The determination should include the rationale for the determination, an explanation of the payment consequences, and the beneficiary liability, as well as inform the beneficiary of their right to an expedited reconsideration. <Medicare Claims Processing Manual, Chapter 30 § 450.5.6>

iii. Hospital Responsibilities

- a) The hospital may not bill a beneficiary who has made a timely appeal until the review process is complete. <Medicare Claims Processing Manual, Chapter 30 § 450.4.2>
- b) The hospital must supply the QIO with a copy of the MCSN and all information, including medical records, requested by the QIO as soon as possible but no later than noon of the day after the QIO notifies them of the appeal. <Medicare Claims Processing Manual, Chapter 30 § 450.4.3>
- c) The QIO may request information be provided by phone, in writing, or electronically. If information is provided by phone, the hospital should keep a written record of the information provided. <Medicare Claims Processing Manual, Chapter 30 § 450.4.3>

- 1) The hospital must furnish the beneficiary, at their request, access to or copies of the information provided to the QIO by close of business on the first day after the request. <Medicare Claims Processing Manual, Chapter 30 § 450.4.3?

d. Claims Submission Following a Beneficiary's Appeal of Change in Status

- i. If the QIO upholds the hospital's change in the beneficiary's status, the hospital bills an outpatient claim (013X). The hospital does not include QIO related condition codes. <Medicare Claims Processing Manual, Chapter 1 § 150.4.1 A>
 - a) It is unclear if the hospital continues to report condition code 44 because the Claims Manual instructions note providers "do not report indicators on claims when they receive notification of decisions which uphold the provider's change of the beneficiary's status". It is unclear if this is referring to only the QIO condition codes or also condition code 44. <Medicare Claims Processing Manual, Chapter 1 § 150.4.1 A>
- ii. If the QIO decision reverses the hospital's change in the beneficiary's status, the hospital bills an inpatient claim (011X), with condition code C6 "Admission preauthorization", and "MCSN" in the Remarks field. <Medicare Claims Processing Manual, Chapter 1 § 150.4.1 B>
 - a) The condition code C6 and Remarks "MCSN" should also be reported on any associated SNF or swing bed claim. <Medicare Claims Processing Manual, Chapter 1 § 150.4.1 B>

F. Determination After Discharge

1. 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>

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, See 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; See 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>

Tip: 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>
- a) 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. <See 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. <See 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. <See 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. <See 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; See 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; See 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 allowed 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 § 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. 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 would otherwise be packaged under the OPPS, they are excluded from OPPS packaging (i.e., they are paid separately) if the primary service they would be packaged to is not payable on the inpatient Part B claim. <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 that are allowed and not allowed 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>

CASE STUDIES

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.

Refer to 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.

Refer to *Medicare Claims Processing Manual*, Chapter 4 § 10.12.

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This content is from the eCFR and is authoritative but unofficial.

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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Check for Updates



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Note: This article was updated on October 1, 2012, to reflect current Web addresses. All other information remains unchanged.

Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient"

Introduction

Following issuance of Transmittal 299 (Change Request 3444) on September 10, 2004, the Centers for Medicare & Medicaid Services (CMS) received numerous questions and requests for clarification. This Special Edition article and the Q&As that follow are intended to address those questions and provide clarification of Medicare policy related to inpatient admissions that are determined not to be medically necessary, as well as Medicare policy related to changing a beneficiary status from inpatient to outpatient, and how the two policies interface.

Provider Types Affected

Hospitals, including those for which payment for Medicare Part B services is made under the hospital Outpatient Prospective Payment System (OPPS), as well as hospitals that are not subject to the OPPS for which payment for outpatient services is made under other payment methodologies

Provider Action Needed

Be sure to understand Medicare rules and policy when utilization review (UR) determines that an inpatient admission is not medically necessary or when a hospital should report Condition Code 44 in Form Locator (FL) 24-30, or its electronic equivalent, on outpatient claims (type of bill 13X, 85X) to signal a change in patient status from inpatient to outpatient.

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Background

Hospital Conditions of Participation

The hospital Conditions of Participation (CoPs) require all hospitals to have a utilization review (UR) plan. A hospital must ensure that all the UR requirements of 42 CFR 482.30 are fulfilled. These requirements can be fulfilled by the hospital directly through its policies, procedures, and UR committee. Alternatively, the hospital may fulfill these UR requirements (including the UR committee's functions and responsibilities) through a quality improvement organization (QIO) that has assumed binding review. However, in either case the hospital is responsible to ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stay are fulfilled as described in 42 CFR 482.30. Specifically:

- A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of a hospital's UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in regulation.
- The determination that an admission or continued stay is not medically necessary must either be made by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.
- The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views **before** making the determination.
- If the UR committee determines that the admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

Review of admissions may be performed before, at, or after hospital admission.

Note: Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.

"Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital.

The Use of Condition Code 44

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital's admission criteria. The National Uniform

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Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs. The definition of Condition Code 44 is as follows:

- Condition Code 44 Inpatient admission changed to outpatient
- For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

CMS issued Transmittal 299 (Change Request 3444) on September 10, 2004, to implement new section 50.3 in Chapter 1 of the Medicare Claims Processing Manual. Section 50.3 describes when and how a hospital may change a patient's status from inpatient to outpatient as well as the appropriate use of Condition Code 44.

In cases where a beneficiary's status is changed from inpatient to outpatient subsequent to UR determination that the inpatient admission does not meet the hospital's inpatient criteria, the hospital may submit an outpatient claim (Type of Bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician concurs with the utilization review committee's decision; and
- The physician's concurrence is documented in the patient's medical record.

Questions and Answers (Q&As)

Q1. Isn't there a conflict between the Condition Code 44 policy and the standards included in the hospital Condition of Participation related to review of admissions for medical necessity?

A1. No. The CoP standards in section 482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital. CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. For such cases, prior to implementation of Condition Code 44, a hospital could only receive payment for certain nonphysician

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medical and other health services payable under Part B that were furnished either directly or indirectly to an inpatient for which payment could not be made under Part A. Condition Code 44 allows hospitals to treat the entire episode of care as an outpatient encounter, to report as outpatient services whatever services are furnished, and to receive payment under the outpatient prospective payment system as though the patient had been registered as an outpatient.

Q2. If the hospital complies with the requirement for written notification within two days of the determination, can it still bill for the encounter as an outpatient episode of care and use Condition Code 44?

A2. Yes, as long as the patient has not yet been released from the hospital, and provided that the other prerequisites for use of Condition Code 44 are met.

Q3. Can a case manager or utilization management staff member change a patient's status from inpatient to outpatient after determining that the hospital's admission criteria were not met?

A3. CMS has received many questions regarding who may make the status change, and requests for clarification as to whether utilization management staff or a case manager may implement the change. The CoP in §482.30 of the regulations requires that the utilization review committee be comprised of at least two doctors of medicine or doctors of osteopathy, although it may include other specified practitioners. The CoP provides that the determination concerning the medical necessity of an admission or continued stay must be made by members of the UR committee (or QIO) in consultation with the practitioner(s) responsible for the care of the patient. The CoP in §482.12(c) provides that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in Medicare regulations, the patient must be under the care of a doctor of medicine or osteopathy. Therefore, a case manager or other utilization management staff person who is not a licensed practitioner permitted by the state to admit patients to a hospital or a doctor of medicine or osteopathy would not have the authority to change a patient's status from inpatient to outpatient. However, we encourage and expect hospitals to employ case management staff 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 the decision making process.

Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

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Q4. Is the concurrence of any physician or practitioner acceptable when a hospital has determined that a patient's status should be changed from inpatient to outpatient?

A4. One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. The practitioner(s) responsible for the care of the patient must concur with the hospital's finding that inpatient admission criteria are not met. This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

Q5. How does a hospital bill using Condition Code 44?

A5. When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred.

When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Q6. How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?

A6. If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of Bill 12x for covered Part B Only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B only services is located in the Medicare Benefit Policy Manual (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The Medicare Benefit Policy Manual includes a complete list of the payable Part B Only services.

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Q7. How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?

A7. Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.

A8. The patient rights CoP in §482.13 of the regulations require a hospital to protect and promote each patient's rights. Medicare beneficiaries have the right to participate in treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship.

Additionally, the hospital is responsible to ensure that when there is a question regarding the medical necessity of an inpatient admission that the required UR review of that patient's status is conducted as stated in 42 CFR 482.30. The UR committee's responsibilities and functions may be conducted by the hospital's QIO that has assumed binding UR review. However, the hospital is responsible to have either a UR committee or have a QIO that carries out the UR activities as described in 42 CFR 482.30, including the review for medical necessity of an inpatient admission and continued stay.

Q9: HIPAA establishes NUBC as the keeper of the UB-92 condition codes. How can CMS place extra requirements on the use of the code? Doesn't this violate HIPAA?

A9. No, this does not violate HIPAA. CMS has established conditions when this code may be used for payment purposes under Medicare. The CMS policy neither

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modifies nor contradicts the code descriptor published by NUBC. Instead, it sets additional payment conditions under Medicare. The HIPAA implementation guide is unaffected by payment policy decisions and the other insurers who use the UB-92 codes may continue to rely on the code as they otherwise would.

In another example, CMS and its contractors set payment policy related to CPT and HCPCS codes through national and local coverage determinations (NCDs and LCDs). These determinations include payment policy standards such as when, how, and by whom CPT and HCPCS codes may be used for a particular diagnosis or procedure. CMS pays only for services that meet the requirements of these coverage determinations.

Additional Information

The instructions provided in CR3444 and the information in this article should be followed within the framework of an individual hospital's existing policies and procedures and do not override or supersede other CMS policies or procedures on observation services, beneficiary financial liability protections, or other related policies.

If you have questions regarding this issuance, please contact your fiscal intermediary (FI) for additional guidance with regard to CR3444.

For complete details, please see the official instruction issued to your FI regarding this change. That instruction for Condition Code 44 that affects the Medicare Claims Processing Manual may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R299CP.pdf> on the CMS website.

For details concerning the "Part B Only" rule, see the Medicare Benefit Policy Manual, Chapter 6, Section 10, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> on the CMS website.

For a link to the Code of Federal Regulations, go to http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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Excerpt from Medicare Claims Processing Manual, Chapter 1

furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. This situation occurs most often when long-term care hospitals are involved. For hospice claims, out of sequence processed claims must be reprocessed to maintain the integrity of hospice election periods. If an FI is contacted by another FI or any regional office (RO), they cancel all affected claims and reprocess in accordance with the instructions from the lead FI or RO.

The lead FI is the one contacted by a provider, beneficiary, or other insurer complaining of improper payment as result of out-of-sequence billing. The lead FI will coordinate actions with any other FIs involved to cancel and reprocess the bills, as necessary. For inpatient stays, the lead FI verifies that the provider, beneficiary, or other insurer was adversely affected and coordinates these actions directly with any other affected FI to cancel any out-of-sequence bills they processed and posted. For hospice claims, the lead FI verifies an out-of-sequence claim(s) impacted the hospice election period. The lead FI coordinates actions to cancel any bills posted out-of-sequence directly with any other affected FI. All FIs must reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers or on the actual sequence of hospice services. The lead FI controls the sequence in which the bills are processed and posted to CWF.

If the lead FI experiences any difficulty with another FI, they contact their RO to coordinate with any necessary ROs for other affected FIs' bills.

This approach is to be used only when the beneficiary, provider, or other insurer has increased liability as a result of out-of-sequence processing or when the hospice election periods are incorrect. It is not to be used if the liability stays the same, e.g., if deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.



50.3 - When an Inpatient Admission May Be Changed to Outpatient Status

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

50.3.1 - Background

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Payment is made under the hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under the applicable other payment methodologies for hospitals not subject to the OPPS.

“Outpatient” means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital or CAH as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. In addition,

every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation (“the practitioner responsible for care of the patient”). In some instances, a practitioner may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital’s utilization review (UR) committee determines that an inpatient level of care is not medically necessary.

Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

The utilization review requirements for hospitals and CAH are found in their respective CoPs at §482.30 or §485.641. The hospital must ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays required by §482.30(d), are fulfilled as described in the regulation. Section 482.30(d) delineates requirements that hospitals must follow when making the determination as to whether an admission or discharge of a patient is or was medically necessary. Review of admissions may be performed before, at, or after hospital admission. More information about the hospital CoP may be found in Pub.100-07, State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Section 485.641 requires CAHs to have a similar program for the evaluation of all services they furnish, including the quality and appropriateness of diagnoses and treatments furnished by their staff physician and non-physician practitioners. If in addition to making a medical necessity determination (or evaluating the appropriateness of diagnosis and treatment in a CAH) a hospital or CAH wishes to change a patient’s status from inpatient to outpatient, the following requirements apply.

CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. The State Operations Manual states that in no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals). However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital’s existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make the decision for the committee, provided he or she is a different person from the concurring practitioner who is responsible for the care of the patient.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ASC X12 837 institutional claim format in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition

Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence by the practitioner who is responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 for a discussion of the billing and payment rules regarding services furnished within the payment window for outpatient services treated as inpatient services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this manual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

60 – Provider Billing of Non-covered Charges on Institutional Claims (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

60.1 - General Information on Non-covered Charges on Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

Charges are tied to items or services described by coding on a line of a claim where they appear together. The institutional claim formats (the ASC X12 837 institutional claim transaction and the Form CMS-1450 paper claim) provide separate fields for the submission of total charges and non-covered charges.

When billing, claims submitters make a choice between submitting charges as covered, or as non-covered. When total charges are submitted and non-covered charges are not submitted, the charges for the claim line are submitted as covered. When a claim line is submitted with covered charges, the provider is seeking payment for that line.

When total charges and non-covered charges submitted on a claim line are equal, the charges for that claim line are submitted as non-covered. When a claim line is submitted with non-covered charges, the provider is not seeking payment for that line and the line is denied payment by Medicare systems. Therefore, Medicare accepts any National Uniform Billing Committee-approved revenue codes when they are submitted with non-covered charges, without regard to whether these revenue codes would be valid for Medicare billing if submitted seeking payment.

Lines submitted with covered and non-covered charges can appear together on a single Medicare claim. In rare instances, covered and non-covered charges can appear on the

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

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450 - Expedited Determinations When a Beneficiary is Reclassified from an Inpatient to an Outpatient Receiving Observation Services

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Medicare beneficiaries with Original Medicare who have been reclassified by a hospital from an inpatient to an outpatient receiving observation services and meet additional criteria (See 450.2 of this section) have a right to appeal their status change to a Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO).

450.1 –Authority

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

This process was implemented through a final rule, CMS-4204-F, effective November 15, 2024. The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

450.2 - Scope

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The expedited determination process is available to beneficiaries in Original Medicare who, after formally being admitted as an inpatient, have subsequently been reclassified by the hospital as an outpatient receiving observation services. The reclassification must have happened while the beneficiary was still in the hospital, and also met one of the following criteria:

- *For beneficiaries with Medicare Part B, their stay in the hospital must last at least three days.*
- *For beneficiaries that do not have Medicare Part B, no three day stay is required to qualify for this expedited appeals process.*

NOTE:

For purposes of these instructions, the term “beneficiary” means either beneficiary or representative, when a representative is acting on a beneficiary’s behalf.

Hospitals Affected by these Instructions. *These instructions apply to any facility providing care at the inpatient hospital level, whether that care is short-term or long-term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals (CAHs).*

450.3 – Medicare Change of Status Notice (MCSN)

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The Medicare Change of Status Notice (MCSN) is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The MCSN may only be modified as per the accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized MCSN. The notice and accompanying instructions may be found online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices>

450.3.1 Alterations to the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

- *The MCSN must remain two pages. The notice can be two sides of one page or one side of two separate pages but **must not** be condensed to one page.*
- *Hospitals may include their business logo and contact information on the top of the MCSN. Text may not be shifted from page one to page two to accommodate large logos, address headers, etc.*
- *Hospitals may include information in the optional “Additional Information” section relevant to the beneficiary’s situation.*

450.3.2 - Hospital Delivery of the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Hospitals must deliver the MCSN to all beneficiaries eligible for the expedited determination process per §450.2.

- *The hospital must ensure that the beneficiary or representative signs and dates the MCSN to demonstrate that the beneficiary or representative received the notice and understands its contents. See §450.3.6 ‘Ensuring Beneficiary Comprehension’.*
- *Use of assistive devices may be used to obtain a signature.*
- *Electronic issuance of the MCSN is permitted.*

If a hospital elects to issue an MCSN viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the required beneficiary specific information must be inserted, and the beneficiary must be given a paper copy of the MCSN at the time of notice delivery.

450.3.3 - Required Delivery Timeframes of the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

Hospitals must deliver the MCSN as soon as possible after a beneficiary is eligible for this process per §450.2, but no later than four hours prior to discharge.

For beneficiaries with Part B, the notice must be delivered as soon as possible after the hospital reclassifies the beneficiary from inpatient to outpatient receiving observation services and the third day in the hospital is reached.

For beneficiaries without Medicare Part B coverage, hospitals must deliver the notice as soon as possible after the change in status from inpatient to outpatient receiving observation services because a three day hospital stay is not required for these beneficiaries to be eligible for this expedited appeals process.

450.3.4 - Refusal to Sign the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

If the beneficiary refuses to sign the MCSN, the hospital should annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the MCSN remain entitled to an expedited determination.

450.3.5 - Ensuring Beneficiary Comprehension

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The OMB-approved standardized MCSN is available in English, Spanish, and additional languages as they become available. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

450.3.6 - MCSN Delivery to Representatives

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The MCSN may be delivered to a beneficiary's appointed or authorized representative.

Type Of Representative

<i>Appointed Representative</i>	<i>Authorized Representative</i>
<i>An appointed representative is an individual designated by a beneficiary to act on the beneficiary's behalf. A beneficiary may designate an appointed representative via the "Appointment of Representative" form <u>CMS-1696</u> (or a similar written instrument containing the required elements under <u>42 CFR 405.910</u>). See <u>Chapter 29 of the Medicare Claims Processing Manual, section 270.1</u>, for more information on appointed representatives.</i>	<i>An authorized representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).</i>

Notes:

- If a beneficiary is temporarily incapacitated and there is no appointed or authorized representative, a person (typically, a family member or close friend) whom the hospital has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MCSN. Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. There should be no relevant conflict between the representative's and the beneficiary's interests.*
- In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital must annotate the MCSN with the name of*

the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

Delivery to off-site representatives

If the MCSN must be delivered to a representative who is not physically present, the hospital is not required to personally deliver the MCSN or have the MCSN delivered via courier to the representative. The hospital must complete the MCSN as required and may telephone the representative instead, and then also mail the MCSN. The date and time of the telephone call is considered the receipt date of the MCSN.

The hospital must complete all of the following actions under this delivery method:

- 1. Verbally convey all contents of the MCSN.*
- 2. Note the date and time this information is communicated verbally.*
- 3. Annotate the “Additional Information” section to reflect that the MCSN was communicated verbally to the representative.*
- 4. Annotate the “Additional Information” section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.*
- 5. Mail a copy of the annotated MCSN to the representative the day telephone contact is made.*

The burden is on the hospital to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital and the representative both agree, the hospital may send the notice by fax or e-mail; however, the hospital or CAH’s fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

450.3.7- Notice Retention for the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The hospital or CAH must retain the signed MCSN in the beneficiary’s medical record. The beneficiary or their representative receives a paper copy of the MCSN that includes all of the required information described in this section. Electronic notice retention is permitted.

450.4 Expedited Determination Process

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.4.1 - Beneficiary Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.4.1.1 - Timeframes for Requesting an Expedited Determination

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who receives an MCSN and disagrees with the status change may request an expedited determination by the appropriate BFCC-QIO for the state where the services were provided. The beneficiary may contact the BFCC-QIO by telephone or in writing.

For timely requests:

The beneficiary must contact the BFCC-QIO before leaving the hospital for a timely request.

For untimely requests:

The beneficiary may contact the BFCC-QIO at any time, including after a related claim has been filed with the Medicare Administrative Contractor (MAC).

450.4.1.2 - Provide Information to BFCC-QIO

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

450.4.2 - Beneficiary Liability During BFCC-QIO Review

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital may not bill a beneficiary who has timely filed an expedited determination until the review process is complete.

450.4.3 - Hospital Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When a hospital is notified by a BFCC-QIO of a beneficiary request for an expedited determination, the hospital must perform all of the following actions.

- 1. Supply the BFCC-QIO with a copy of the MCSN as soon as possible, but no later than noon of the day after BFCC-QIO notification.*
- 2. Supply all information, including medical records, requested by the BFCC-QIO. The BFCC-QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record.*
- 3. Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the BFCC-QIO. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.*

450.5 – BFCC-QIO Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

450.5.1 – Receive Beneficiary Requests for Expedited Review

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, seven days a week.

450.5.2 – Notify Hospitals

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the hospital that a request for an expedited determination was made. If the

request is received after normal working hours, the BFCC-QIO should notify the hospital as soon as possible on the morning after the request was made.

450.5.3 – Validate Delivery of the MCSN

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO should determine that MCSN delivery was valid if all of the following criteria are met:

- *The notice used is the OMB approved MCSN published by CMS.*
- *The notice was delivered timely per §450.3.3.*
- *The notice was signed and dated by the beneficiary.*

If the BFCC-QIO determines that the hospital did not deliver a valid notice, the BFCC-QIO will instruct the hospital to reissue the notice.

450.5.4 - Solicit the Views of the Beneficiary

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must solicit the views of the beneficiary who requested the expedited determination.

450.5.5 - Solicit the Views of the Hospital

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must provide the hospital an opportunity to explain why the reclassification of the beneficiary from an inpatient to an outpatient receiving observation services was appropriate.

450.5.6 – Make Determination and Notify Required Parties

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

For timely requests (received before the beneficiary leaves the hospital):

The BFCC-QIO must make its determination no later than one calendar day after it receives all requested pertinent information from the hospital.

For untimely requests (received after the beneficiary leaves the hospital):

The BFCC-QIO must make its determination no later than two calendar days after it receives all requested pertinent information from the hospital.

The BFCC-QIO must perform the following actions for timely and untimely requests.

1. *Notify the beneficiary, the hospital, and SNF (if applicable) of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability.*
2. *Inform the beneficiary of the right to an expedited reconsideration by the BFCC-QIO and how to request a timely expedited reconsideration.*
3. *Make its initial notification via telephone and follow up with a written determination letter.*

NOTE: *If the BFCC-QIO does not receive supporting information from the hospital, it may make its determination based on the evidence at hand or defer a decision until it receives the necessary information.*

450.6 - Effect of a BFCC-QIO Expedited Determination

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO determination is binding for payment purposes on the beneficiary, hospital, and MAC, unless the beneficiary pursues an expedited reconsideration per section 460 of this chapter.

460- Expedited Reconsiderations

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who is dissatisfied with a QIO determination may request an expedited reconsideration by the BFCC-QIO.

460.1- Beneficiary Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

460.1.1- Timeframe for Requesting an Expedited Reconsideration

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A beneficiary who is dissatisfied with a BFCC-QIO's expedited determination may request an expedited reconsideration. The beneficiary may contact the BFCC-QIO by telephone or in writing.

- **For timely requests:**

The beneficiary must contact the BFCC-QIO no later than noon of the calendar day following receipt of the initial notification (whether by telephone or in writing).

- **For untimely requests:**

The beneficiary may contact the BFCC-QIO anytime, including after a related claim has been filed with the MAC.

460.1.2- Provide Information to the BFCC-QIO

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The beneficiary must be available to answer questions or supply information requested by the BFCC-QIO. The beneficiary may, but is not required to, supply additional information to the BFCC-QIO that he or she believes is pertinent to the case.

460.1.3- Beneficiary Liability During BFCC-QIO

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital may not bill a beneficiary who has timely filed an expedited reconsideration until the review process is complete.

460.2- Hospital Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

A hospital is required to submit any and all documentation requested by the BFCC-QIO during the expedited determination process, as described in §450.4.3. The hospital may, but is not required to, submit evidence to the BFCC-QIO to be considered in the reconsideration

decision. If a hospital fails to comply with a QIO's request for additional information, the BFCC-QIO makes its reconsideration decision based on the information available.

460.3- BFCC-QIO Responsibilities

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

460.3.1- Receive Beneficiary requests for Expedited Reconsiderations

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

BFCC-QIOs must be available to receive beneficiary requests for review 24 hours a day, seven days a week.

460.3.2- Notify Hospitals

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

When the BFCC-QIO receives a request from a beneficiary, the BFCC-QIO must immediately notify the hospital that a request for an expedited reconsideration was made. If the request is received after normal working hours, the BFCC-QIO should notify the hospital as soon as possible on the morning after the request was made.

460.3.3- Solicit the Views of the Beneficiary

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must solicit the views of the beneficiary who requested the expedited reconsideration.

460.3.4- Solicit the Views of the Hospital

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO must provide the hospital an opportunity to provide information not submitted for the expedited redetermination.

460.3.5- Make Determination and Notify Required Parties

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

For timely requests:

The BFCC-QIO must make its reconsideration determination no later than two calendar days after it receives all requested pertinent information from the hospital.

For untimely requests:

The BFCC-QIO must make its reconsideration determination no later than three calendar days after it receives all requested pertinent information from the hospital.

460.4- Effect of a BFCC-QIO Expedited Reconsideration

(Rev.: 12934; Issued: 10-31-24; Effective: 11-15-24; Implementation: 02-14-25)

The BFCC-QIO reconsideration determination is binding for payment purposes on the beneficiary, hospital, and MAC, unless the beneficiary requests a hearing by an ALJ in accordance with 42 CFR part 478 subpart B.

Providers may be liable as a result of two specific situations in the expedited review process:

- (1) if the provider is not timely in giving information to the QIO; and
- (2) if the provider does not give valid notice to the beneficiary.

Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However, if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.

150.4 - General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)

(Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

This section provides claims processing instructions to implement an expedited hospital status change appeals process required by final rule, CMS-4204-F. The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

Expedited hospital status change appeals are afforded to certain beneficiaries in Original Medicare only who were initially admitted to a hospital as an inpatient by a physician but whose status during their stay was changed to an outpatient receiving observation services by the hospital's utilization review committee (URC) (thereby effectively denying Part A coverage for their hospital stay), and meet other conditions specified in the court order. Regulations at 42 CFR 405.1210(b) require hospitals to notify beneficiaries of their right to pursue an appeal regarding the decision to reclassify the beneficiary from an inpatient to an outpatient receiving observation services. The Medicare Change of Status Notice (CMS-10868) is the standardized notice to satisfy the notification requirement.

After receipt of the MCSN, eligible beneficiaries are given the opportunity to appeal, and may argue that their inpatient admission satisfied the relevant criteria for Part A coverage and that the hospital URC's determination to reclassify the beneficiary as an outpatient receiving observation services was therefore erroneous. The change in status from inpatient to outpatient may also affect coverage of the beneficiary's post-hospital extended care services furnished in a skilled nursing facility (SNF).

A. QIO Role

Once an eligible beneficiary has requested an appeal, the QIO reviews the records from the hospital relative to the change in status, and verifies that the provider has given valid

notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can be used in making a determination, although QIOs can still make such decisions even if records are not provided. The QIO makes a decision on coverage in answer to the beneficiary's request for review of their change in status, relaying this decision back to the beneficiary or their representative, as well as the hospital. If the beneficiary does not agree with the QIO determination, they may request that the QIO conduct a reconsideration.

B. A/B MAC (A) Role

A/B MACs (A) support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review.

A/B MAC (A) medical review should never repeat or contradict the results of QIO review regarding the change of status of the hospital claim, since this would be duplicative and QIO decisions are binding. But the scope of these QIO decisions is limited to the change in status, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim may follow a change of status reviewed by a QIO, but it also contains other days of billing that are subject to additional coverage criteria. Other issues not considered by the QIO may still be subject to medical review.

150.4.1- Billing and Claims Processing Requirements Related to Expedited Determinations Following Appeal of Status Changes (Rev.13026, Issued: 12-27-2024, Effective: 10-11-2024 , Implementation: 02-15- 2025)

The outcome of expedited determinations and reconsiderations based on appeals of hospital status changes are reported on Medicare claims to assure A/B MAC (A) adjudication of claims is consistent with QIO decisions. Note that the expedited review process for timely submitted appeals is completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and reconsiderations. A set of condition codes are used to reflect these determinations. These condition codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process based on appeals of hospital status changes, these QIO approval indicators are used in new ways on inpatient hospital claims and skilled nursing facility. The QIO approval indicator code uses described below are valid for Original Medicare billing on the following Types of Bill: 11x, 18x, and 21x.

Providers should note that no indicators are required on claims subject to a change in status where the beneficiary does not request an expedited determination.

A. QIO Decisions Upholding a Change in Status

Providers do not report indicators on claims when they receive notification of decisions which uphold the provider's change of the beneficiary's status from inpatient to outpatient. Providers do not annotate these claims with condition code C4 to reflect the QIO denial of the appeal, since the code is defined as "Services Denied" and hospital services are not denied but will be billed on outpatient Types of Bill. In these cases, SNF services will not be billed to Original Medicare because there is no qualifying hospital stay.

B. Reporting of QIO Decisions Reversing a Change of Status

When providers are notified of QIO decisions to reverse a change of status from inpatient to outpatient, hospitals must bill the beneficiary's stay using Type of Bill 011x. Hospitals must annotate these claims with condition code C6, which is defined "Admission preauthorization" and indicates the QIO has authorized the admission but has not reviewed the services provided. Hospital shall also add Remarks stating "MCSN" to specify the circumstance of the review. These indicators will alert A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO.

When billing for a SNF stay where the 3-day qualifying hospital stay was subject to a change of status review, SNFs and swing bed providers must also add condition code C6 and Remarks "MCSN" to their Type of Bill 021x or 018x admission claims. These indicators will alert the A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO for the qualifying hospital stay dates reported in occurrence span code 70.

C. Billing Beneficiaries in Cases Subject to Expedited Determinations Related to Expedited Determinations Following Appeal of Status Change

If an eligible beneficiary requests an appeal timely, they would not be billed during the QIO appeals process. However, if the appeal is untimely, the hospital may bill a beneficiary before this QIO process is complete. An eligible beneficiary may file a request for review by the QIO regarding the change in status after the timely filing deadline established in regulation (that is, the beneficiary may file the request after release from the hospital) but the QIO's determination will be provided on a different timeframe and the eligible beneficiary will not be entitled to protection from billing during this time.

This content is from the eCFR and is authoritative but unofficial.

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]

Version 07/07/2025
Check for Updates

Excerpt from 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



REVISED products from the Medicare Learning Network® (MLN)

- **“ICD-10-CM/PCS The Next Generation of Coding,”** Fact Sheet, ICN 901044, Downloadable and Hard Copy.

MLN Matters® Number: SE1333 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims

Note: This article was revised on September 22, 2014, to add links to MLN Matters® article MM8445 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8445.pdf>) and to MM8666 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8666.pdf>). MM8445 discusses provider and beneficiary liabilities under the Final Rule 1599-F. **It is important to note that MM8445 describes changes when the payment can not be made because an inpatient admission is not reasonable and necessary and otherwise there are no changes to the policies for billing Part B under other circumstances.** MM8666 implements revised policies related to payment of hospital Part B inpatient services charges. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

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What You Need to Know

This article conveys temporary instructions for the implementation of that portion of final rule 1599-FI that relates to billing for Part B services that were provided during a hospital inpatient stay, for which Medicare denied payment. Make sure billing staff are aware of these instructions.

Background

For Admissions on or after October 1, 2013

When an inpatient admission is found to be not reasonable and necessary, the Centers for Medicare & Medicaid Services (CMS) will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.

Hospitals are required to maintain documentation to support the services billed on a Part B inpatient claim for services rendered during the inpatient stay.

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 cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services. **Any coinsurance or deductible collected for the Part A claim must be refunded.** Whether or not the hospital had submitted a claim to Part A for payment, Medicare requires 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 would indicate Provider Liability period on the Part A claim by including the Occurrence Span Code "M1" and the inpatient admission Dates of Service.** The hospital could then submit an inpatient claim for payment under Part B on a Type of Bill (TOB) 12X for inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

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

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All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), hospitals paid under the OPSS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPSS would continue billing the OPSS for Part B inpatient services. Hospitals that are excluded from payment under the OPSS in 42 CFR 419.20(b) would be eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. For example, beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid.

CMS notes that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the "Medicare Benefit Policy Manual" (Chapter 6, Section 10), which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> on the CMS website.

Hospitals may continue to bill Part B for outpatient services provided to the beneficiary prior to the point of inpatient admission in the 3 calendar day (or 1 calendar day for a non-IPPS hospital) payment window prior to the admission, including those services that require an outpatient status (see the "Medicare Claims Processing Manual" Chapter 4, Section 10.12, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c02.pdf>). These services should be billed on a 131 Part B outpatient TOB and must be filed timely (within 1 calendar year of date of service) in order to be paid.

Services provided prior to the point of inpatient admission are outpatient services and may not be included on the 121 Part B inpatient claim; services provided after the point of admission are inpatient services and may not be included on the 131 Part B outpatient claim. Two complementary claims are therefore necessary if some services are provided before admission and others are provided after admission. In placing services on the appropriate claim, hospitals should use the same billing and coding rules used for assigning dates of service to services that cross midnight, using the start of the service to determine correct claim placement unless other specific instructions are provided, and ensuring that services are not double billed. If inpatient only services, such as procedures on the inpatient only list, were delivered prior to the point of admission, they cannot be paid because they were provided as outpatient services; they may not be reported on the 121 Part B inpatient claim because they were provided prior to the point of admission. If outpatient only services, such

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as outpatient observation, were continued after the point of admission, the post admission services cannot be paid because they were provided as inpatient services; the time may not be included on the 131 Part B outpatient claim because it was provided after the point of admission.

Appeals

If a hospital chooses to submit a Part B claim for payment following the denial of an inpatient admission on a Part A claim, the hospital cannot also maintain its request for payment for the same services on the Part A claim (including an appeal of the Part A claim). In this situation, before the hospital submits a Part B claim, it must ensure that there is no pending appeal request on the Part A claim. In addition, if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot submit a Part B claim in order to extinguish a beneficiary's appeal rights. Therefore, the hospital's submission of a Part B claim does not affect a beneficiary's pending appeal or right to appeal the Part A claim. If a beneficiary has a pending Part A appeal for an inpatient admission denial, any claims re-billed under Part B by the hospital will be denied as duplicates by the Medicare contractor. Once a Part B claim is filed, there are no further appeal rights available with respect to the Part A claim. However, the hospital and beneficiary have appeal rights with respect to an initial determination made on the Part B claim under existing policies set forth at 42 CFR Part 405, Subpart I.

Billing Tips

For “self-audit” claims, providers shall submit a Part A Provider Liabile claim. The inpatient claim must indicate the following information on the UB-04 claim form when billed to Medicare:

- Type of Bill (TOB) 110 in Form Locator (FL) 4.
- Non-covered days.
- The services from admission through discharge.
- The appropriate patient status.
- Occurrence Span Code “M1” and dates of service.
- Non-covered charges for all services rendered.
- All diagnosis codes.
- All procedures codes.

After the inpatient claim has processed and a Remittance Advice (RA) has been issued, a Part B inpatient claim (TOB 12X) can be submitted. **For Part A Inpatient admissions denied as not reasonable and necessary**, providers shall submit a qualifying Part B inpatient claim (TOB 12x) with:

1. A treatment authorization code of A/B Rebilling submitted by a provider.

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NOTE: Providers billing an 837I shall place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

REF*G1*A/B Rebilling~

2. A condition code "W2" attesting that this is a rebilling and no appeal is in process; and
3. The original, denied inpatient claim (CCN/DCN/ICN) number

NOTE: Providers billing an 837I shall place DCN in the Billing Notes loop 2300/NTE in the format:

NTE*ADD*ABREBILL12345678901234~

For DDE or paper Claims, Providers shall place the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".

NOTE: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.

Inpatient Part B Hospital Services

Inpatient Part B services include services which are not strictly provided in an outpatient setting. Examples of services that are strictly provided in an outpatient setting include services such as Diabetes Self-Management Training (DSMT), Clinic Visits, Emergency Department, 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. Routine services are 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. Examples of routine nursing services that are captured in the Room and Board rate include patients that receive from the floor nurse IV infusions and injections, blood administration, and nebulizer treatments. These services **are not separately billable** Inpatient Part B services.

Medicare pays under Inpatient Part B for the non-physician medical and other health services listed in the "Medicare Benefit Policy Manual," Chapter 6, Section 10.1. The revenue codes listed in the table below are a guide for providers to use when a service is non-covered at the revenue code level. Some revenue codes allow many services, some of which are covered and some of which are non-covered by Medicare Inpatient Part B for inpatients. When a revenue code can be sometimes covered, sometime not covered, providers should use the HCPCS to determine if the service is covered (i.e., Revenue Code

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0942 is not listed below. However, when DSMT services are billed with this revenue code, the DSMT service remains non-covered under Medicare Inpatient Part B).

Revenue Codes not covered under Inpatient Part B Medical Necessity Denials							
010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390	0391	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						

Editor's note: see updated table in manual above

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

Implantable Prosthetic Devices

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in "Medicare Benefit Policy Manual," Chapter 6, Section 10, to an inpatient who has coverage under Part B, 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).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B due to Part A medical necessity denial, the hospital should report the HCPCS that describes the device as outlined under OPPS rules. The OPPS hospital **should not** report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, when the Part A claim has been medically denied. The OPPS hospital should only report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, due to no Part A coverage or Part A benefits exhausted.

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Additional Information

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

You may also want to review MLN Matters® article MM8445 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8445.pdf>) and to MM8666 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8666.pdf>).

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