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Inpatient Psychiatric Facilities: Preparing and Submitting Compliant Claims to Medicare

4/10/2025

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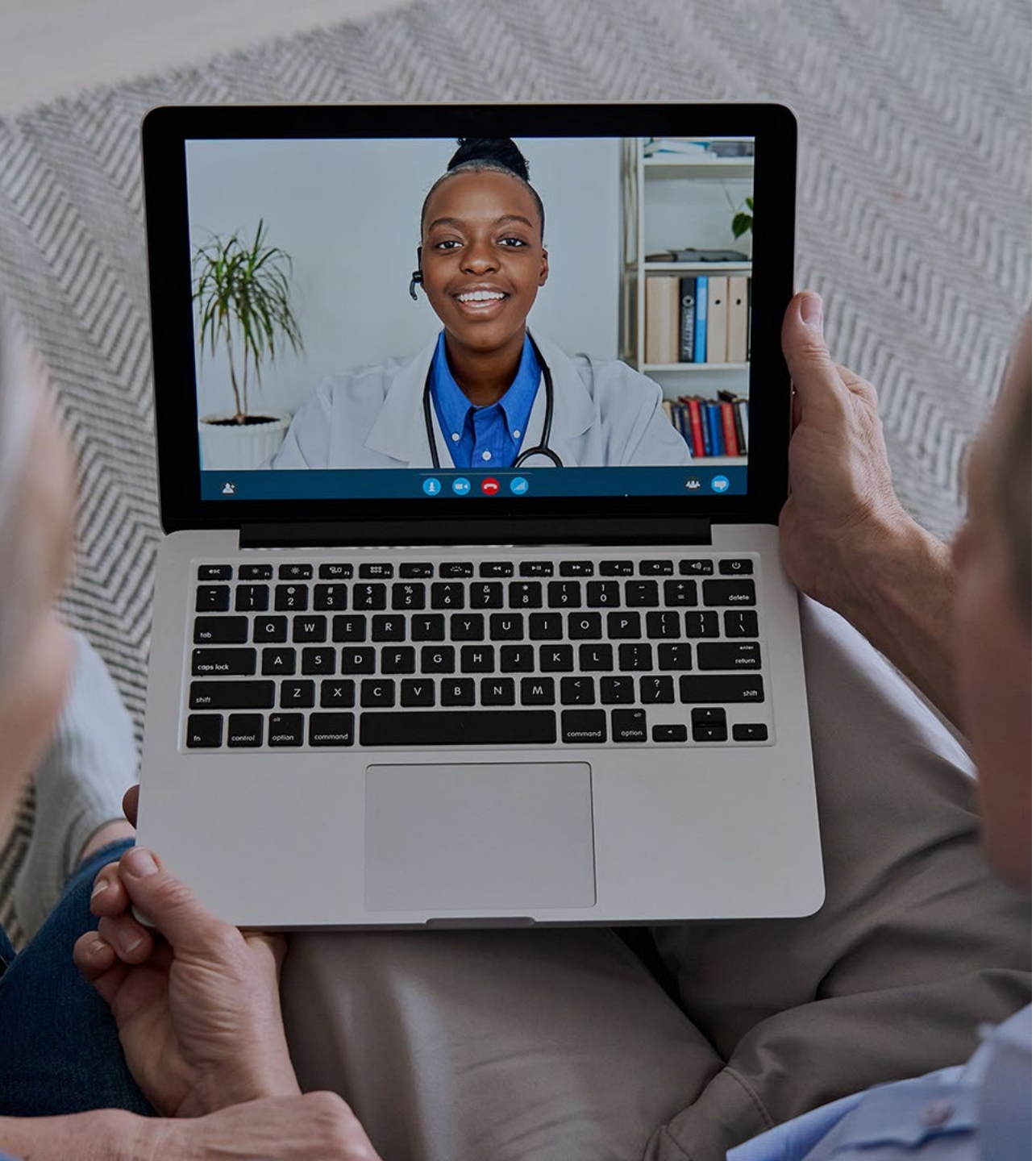

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Objective

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

Today's Presenters

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

Agenda

- Billing and Claim Resources
- Frequency of Billing and TOBs
- Benefits Exhaust During Stay
- One-Day Payment Window Policy
- Miscellaneous IP Situations
- IPF References and Resources
- Questions

Billing and Claim Resources

Billing Resources

- Complete IPF claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Section 190

Claim Resources

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

Assumptions for Presentation

- You determined Medicare primary payer
  - No other primary payers involved
    - Not reviewing MSP-related claim FLs or codes
- You understand how to code required claim information for
  - Provider identification
  - Patient identification

Claim FLs for Provider Identification

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

Claim FLs for Patient Identification

- FL 3a = Patient control number
- FL 3b = Medical/health record number (situational)
- FL 8 = Patient's name and identifier
- FL 9 = Patient's address
- FL 10 = Patient's birth date
- FL 11 - Patient's sex
- FL 50a = Medicare
- FL 51a = Health plan ID
- FL 58a = Insured's name
- FL 59a = Patient's relationship to insured (self)
- FL 60a = Insured's Unique ID (Certificate/Social Security Number/MBI)

Other Claim FLs

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

Other Claim FLs (continued)

- FL 42 = Revenue code
- FL 44 = HCPCS/Rates/HIPPS Rate codes (accommodation rate)
- FL 46 = Unit(s) of service
- FL 47 = Total charges (not needed for electronic billing)
- FL 48 = Noncovered charges
- FL 64 = DCN
- FL 67 = Principal diagnosis code (follow Code First guidelines)
- FLs 67 A-Q = Other diagnosis codes
- FL 69 = Admitting diagnosis code
- FL 74 = Principal procedure code and date
- FLs 74 A-E = Other procedure codes and dates
- FL 80 = Remarks

Frequency of Billing and TOBs

Frequency of Billing Guidelines for IPFs

- While beneficiary has Medicare IP hospital benefit days available, you may submit
  - Admission to discharge claim or
  - Interim claims every 60 days
- If BE during stay, you must submit
  - Interim claim(s) through BE date and
  - No-payment claims in 60-day increments until final discharge/death
    - Once interim claim(s) through BE date processed

TOBs for IPF Claims

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

TOB 111

- IP claim from admission to final discharge/death
  - Admission date = actual admission date
  - Statement from date = admission date
    - If payment window policy applies, report earliest OP DOS added to IP claim
  - Statement through date = discharge/death date
    - Always report PSC that accurately represents beneficiary's status as of this date
- Submit
  - At final discharge/death
- Do not submit
  - If BE during stay

TOBs 112 and 117 for Interim Billing

- IP interim claims
  - TOB 112 = First 60-day interim claim
  - TOB 117 = Subsequent 60-day interim claims
    - Each contains original stay(s) plus each subsequent 60-day perios
- You may submit
  - If stay greater than 60 days
- You must submit
  - If BE during stay

Interim Claims Less Than 60 Days

- Interim claims can include less than 60 days if beneficiary
  - Exhausts Medicare IP hospital benefit days
  - Discharged/transferred from IPF
  - Dies

Interim Claim Coding

- TOB = 112 (first interim claim) or 117 (subsequent interim claim)
- Admission date = actual admission date
- Statement **from** date = admission date
  - If payment window applies, report earliest OP DOS added to claim
- Statement **through** date = 60th day, BE, discharge/death date
- PSC = 30 (still a patient) or appropriate PSC (if final claim)
- Claim change reason code = D3 (on TOB 117)
- Diagnosis codes = from admission to through date
- Procedure codes/dates = from admission to through date

TOB 117 for Adjustments

- IP adjustment claim
  - Submit to change or correct original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires claim change reason code (reason for adjustment)
    - **D0** = Change to service dates
    - **D1** = Change to charges
    - **D2** = Change in revenue codes/HCPCS/HIPPS rate code
    - **D3** = Second or subsequent interim PPS bill
    - **D4** = Change in clinical codes (ICD) for diagnosis and/or procedure codes/Grouper PRICER input (DRG)
    - **D7** = Change to make Medicare secondary
    - **D8** = Change to make Medicare primary
    - **D9** = Any other change
    - **E0** = Change in patient status

TOB 118

- IP cancel claim
  - Submit to cancel original claim
  - Requires claim change reason code (reason for cancel)
    - **D5** = Cancel-only to correct MBI or provider identification number
    - **D6** = Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of OP bill containing services required to be included on IP bill)

TOB 110

- IP no-payment claim
  - Submit when no payment expected from Medicare
- You must submit
  - For all noncovered IP stays
    - Except when beneficiary not enrolled in Medicare Part A (enrolled in Part B only)
  - At final discharge/death
  - In 60-day increments until final discharge/death

TOB 110 Situations

- Submit TOB 110 if beneficiary
  - Exhausts Medicare IP hospital benefit days
    - Prior to 2005 IPF PPS implementation date and remains in IPF
    - At admission
    - During stay; submit interim claim(s) through BE date first
  - At noncovered LOC
    - Prior to 2005 IPF PPS implementation date and remains in IPF
    - At admission and for entire stay
      - Claim coding for admission denials (not reasonable and necessary): CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.2 letter E
      - If care becomes covered during stay, cancel TOB 110s, submit corrected claims: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.1

TOB 12X

- IP ancillary claim for services to inpatients submitted under Part B when Part A can't pay for IP stay
  - Payment can be made under Part B for certain billable services
  - Report revenue codes, units, charges, LIDOS (FL 45) and HCPCS codes
  - Billable services depend on reason Part A can't pay for IP stay
    - IP stay not R&N per MAC or Medical Review Contractor (e.g., CERT Contractor): CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1
    - Beneficiary does not have Part A or BE: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2

Did You Know

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

TOB 12X for Vaccines and Administration

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

Benefits Exhaust During Stay

Medicare IP Hospital Benefit Days

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

Psychiatric Hospital IP Benefit Day Lifetime Limitation

- Maximum of 190 benefit days in free-standing IPF in lifetime
  - Not a separate set of benefit days
  - Does not apply to IPFs within hospital as a DPU
  - Beneficiary uses available benefit days per benefit period as usual
    - 90 renewable days (full days and coinsurance days)
    - 60 nonrenewable days (LTR days)
  - If 150 benefit days used in a benefit period, a new benefit period must begin for beneficiary to use remaining 40 days

Benefits Exhaust

- BE when beneficiary has
  - No Medicare IP hospital benefit days remaining in applicable benefit period
  - Reached 190-day lifetime maximum benefit limitation
    - Freestanding IPFs only
- OC = A3 and BE date
  - Date of last available benefit day

Submitting Claims When Benefits Exhaust

- If BE during stay
  - Submit claim up to BE date
    - TOB 112 or 117, as applicable
    - Report OC = A3 with BE date
  - Once claim processed, submit no-payment claims, in 60-day increments, for as long as beneficiary remains an inpatient
    - TOB 110

Submitting Claims Up to Benefits Exhaust Date

- If no prior interim claim submitted, submit one claim from admission through BE date and report
  - TOB = 112
  - Admission date = actual admission date
  - Statement from date = admission date unless payment window applies
  - Statement through date = BE date
  - PSC = 30
  - OC = A3 and BE date

Submitting Claims Up to Benefits Exhaust Date (continued)

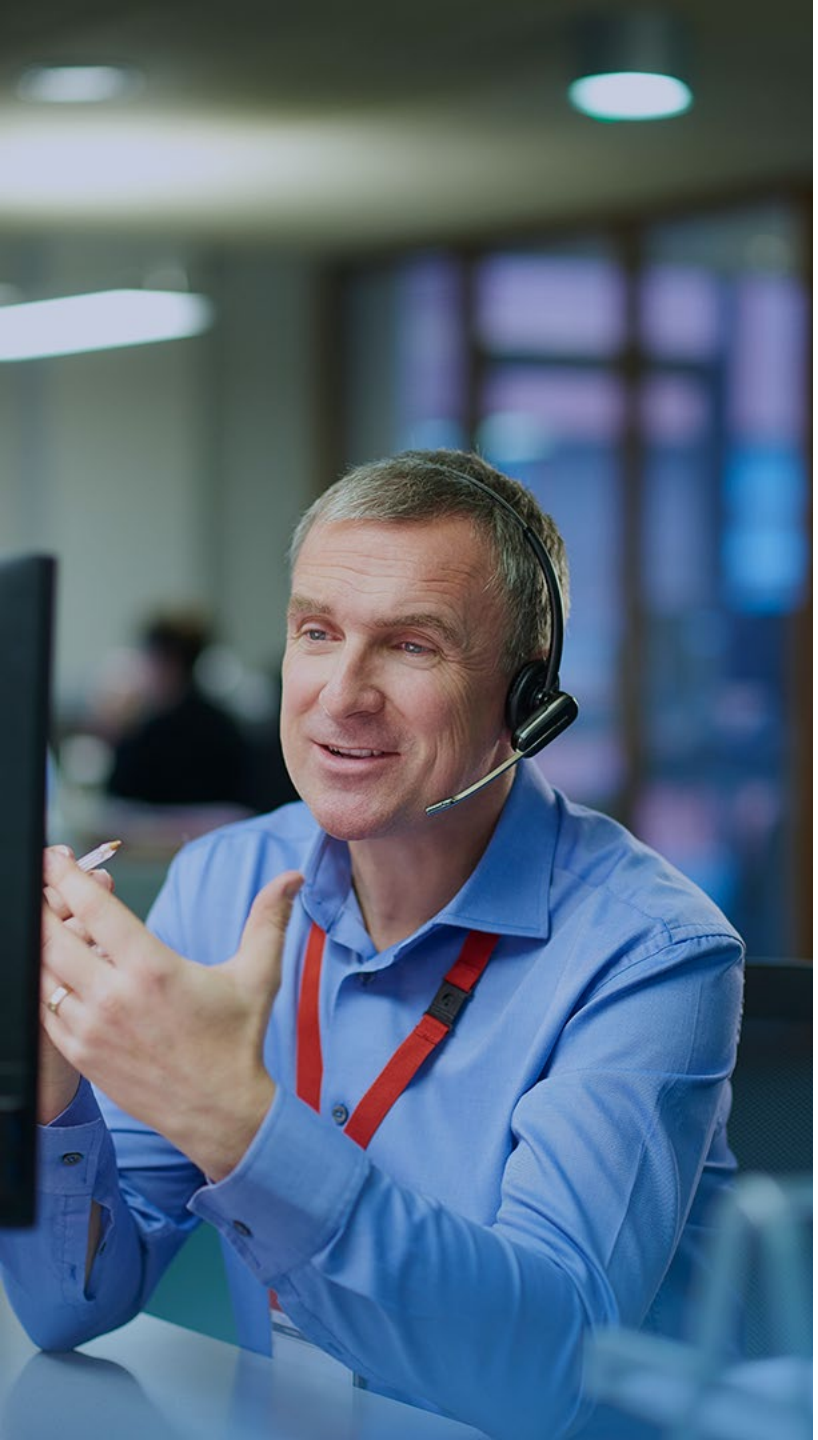
- If prior interim claim submitted, adjust it to add dates/services through BE and report
  - DCN of most recent interim claim
  - TOB = 117
  - Admission date = actual admission date
  - Statement from date = admission date unless payment window applies
  - Statement through date = BE date
  - PSC = 30
  - OC = A3 and BE date

First No-Payment Claim After Benefits Exhaust

- Once BE claim processed, submit first no-payment claim and report
  - TOB = 110
  - Admission date = actual admission date
  - Statement from date = day after BE date
  - Statement through date = 60th day/discharge/death date
  - PSC = 30 or appropriate PSC if final claim
  - All days/services noncovered

Subsequent No-Payment Claims After Benefits Exhaust

- Once first no-payment claim processed, submit subsequent no payment claim(s) and report
  - TOB = 110
  - Admission date = actual admission date
  - Statement from date = day after through date on prior TOB 110
  - Statement through date = 60th day/discharge/death date
  - PSC = 30 or appropriate PSC if final claim
  - All days/services noncovered



RTP Reason Code 7A000

- We RTP your claim with reason code 7A000 and remarks “claim requires a split per CR5474”
  - If you submit claim through incorrect BE date, or
  - If you submit claim and do not report OC A3 and BE date when BE during stay
- References:
  - Inpatient Psychiatric Facilities Billing When Benefits Exhaust Job Aid
  - CR5474, Use of BE Day as Day of Discharge for Payment Purposes for IPF PPS and Clarification of Discharge for LTCH and Allowance of No-Pay BE Bills (TOB 110)

One-Day Payment Window Policy

Policy Overview

- Applies when payment can be made on Part A claim
  - **Admitting IPF** reports on its IP claim
    - OP **diagnostic** services it rendered on
      - IPF admission date and/or
      - Day prior to IPF admission date
    - OP **nondiagnostic** services it rendered on
      - IPF admission date
      - Day prior to IPF admission date unless IPF determines **not related** to IPF stay
        - If not related to IPF stay, you may submit separate OP claim with **CC 51**
- References:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.3 and Chapter 4, Section 10.12

Admitting Hospital

- Admitting IPF includes
  - Any entity IPF wholly-owns or wholly-operates or
  - Any entity under arrangement with IPF
- References
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Sections 90.7 and 90.7.1

OP Diagnostic Services

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

OP Nondiagnostic Services

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

Reporting OP Services on IP Claim

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

Miscellaneous IP Situations

Did You Know

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

Services to Inpatients Under Arrangement

- Send beneficiary to another facility for services you could not provide
  - Usually OP services, beneficiary returns to IPF on same day
- Reimburse that facility for such services
  - Other facility submits claim to your IPF; not to Medicare
- Report arranged service and cost on your claim including transportation cost
  - Revenue code for arranged service only
  - Do not report revenue code for transportation (0540)

Under Arrangement Example

- Example
  - IPF inpatient requires MRI
  - Send beneficiary to ACH for MRI on 1/15 at 8am by ambulance
  - Beneficiary returns to same IPF on 1/15 at 1pm
- Action
  - Pay ACH for MRI
  - Pay transportation provider for ambulance
  - On IP claim, report revenue code for MRI with total cost for MRI and transportation
- **Note:** This is also an example of an IPF one-day interruption

Three-Day or Less Interruptions From IPF

- If you missed our webinar “Inpatient Psychiatric Facilities: Three-Day or Less Interruptions” on 1/23/2025, you may review the materials on the Past Events page of our website.

Beneficiary Admitted to IPF Prior to Part A Medicare Entitlement Date

- Per Inpatient Admission Prior to Medicare Entitlement Job Aid:
  - Admission date = actual admission date
  - Statement covers period = Part A effective date to discharge date
  - Covered days (VC 80) = days in statement covered period
  - Accommodation days/units (R&B revenue codes) = VC 80 days
  - Revenue codes = admission to discharge
  - Charges = admission to discharge except R&B prior to Part A
  - ICD-10-CM diagnosis codes = admission to discharge
  - ICD-10-PCS procedure codes = admission to discharge
  - Remarks to indicate beneficiary's Part A effective date

Did You Know

- If an individual is in a participating psychiatric hospital on the first day of their Part A entitlement, the number of IP hospital benefit days in the first benefit period is subject to a reduction.
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 4, Sections 10 through 50

Beneficiary Admitted to IPF From Your Facility's ACH

- Beneficiary transferred to your IPF from same facility's ACH where he/she was an inpatient
  - Submit IPF claim and report point of origin or visit = D
    - Identifies claims that should not receive ED adjustment
- References:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 190.6.4.1
  - CR3881, Source of Admission Code D
  - CR7072, Implementation of Edits for ED Adjustment Policy Under IPF PPS

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

- If beneficiary incurs one-day IPF stay in between ACH stays
  - IP in ACH
  - Transferred to IPF on same day
  - Readmitted to same ACH by midnight on same day
- Contact ACH to determine who to bill for one day
  - ACH determines – Are two ACH stays related to each other?
    - If yes, IPF bills ACH for one-day IPF stay and ACH pays IPF under arrangement
    - If no, IPF bills Medicare directly for one-day IPF stay (refer to next slide)
  - Reference: CR3389, Revision of CWF Editing for Same-Day, Same-Provider Acute Care Readmissions

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

- If beneficiary incurs one-day stay
  - Admitted to IPF but transferred to another IP facility on same day before midnight
  - Not same situation as indicated on prior slide
- Submit claim and report
  - Same admission, from, and through date
  - CC 40 (same-day transfer)
  - Report day as noncovered but services/charges as covered
- Reference
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 190.10.12

Beneficiary Received ECT Treatment During IPF Stay – Billing

- On claim, report
  - Revenue code 0901 with number of units
    - Cannot exceed number of covered days on claim
  - ECT procedure code with date of last ECT treatment
    - Inpatient Psychiatric Facility PPS Files
      - FY 2025 Addendum B-1 IPF PPS Final Electroconvulsive Therapy (ZIP) file
        - GZB0ZZZ = Electroconvulsive Therapy, Unilateral-Single Seizure
        - GZB2ZZZ = Electroconvulsive Therapy, Bilateral-Single Seizure
        - GZB4ZZZ = Other Electroconvulsive Therapy

Beneficiary Received ECT Treatment During IPF Stay – Payment

- Effective 10/1/2024, payment per treatment
  - $661.52
    - Complied with quality data submission requirements
  - $648.65
    - Did not comply with quality data submission requirements (two percentage point reduction)
- References:
  - CR13766, IPF PPS Updates for FY 2025
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Sections 190.7.3 and 190.10.4

Beneficiary Received Oncology Treatment During IPF Stay – Billing and Payment

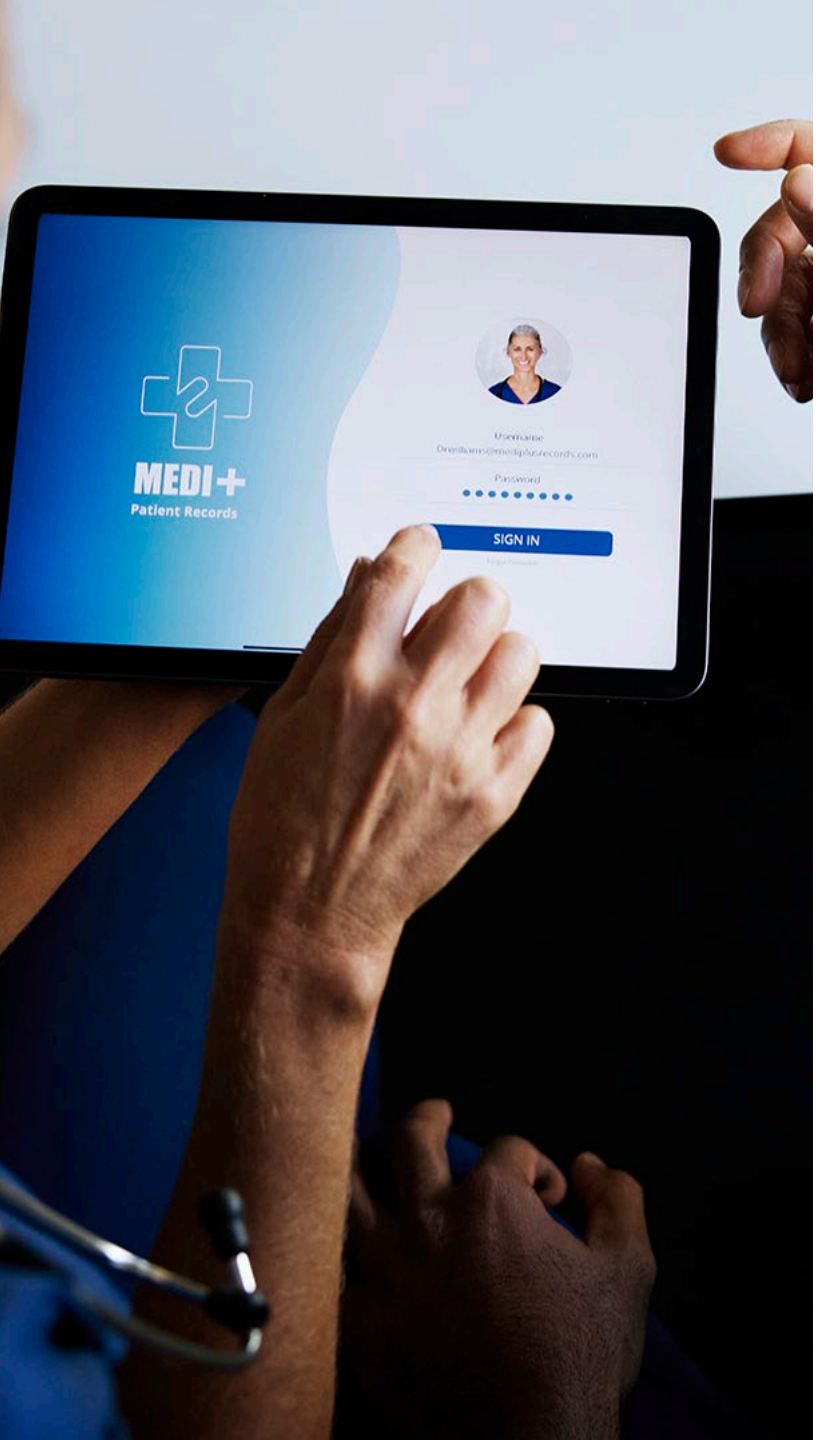
- On claim, report
  - Revenue code 033X with number of units
  - Procedure code/date of modality
    - Inpatient Psychiatric Facility PPS Files
      - FY 2025 Addendum B-3 Final ICD-10 IPF Comorbidity Codes with Adjustment Factor (ZIP) - Updated 03/14/2025
      - FY 2025 Addendum B-4 Final ICD-10 IPF Comorbidity Codes without Adjustment Factor (ZIP) - Updated 03/14/2025
- Reference:
  - CR5470, IPF PPS for Oncology Treatment Payment Adjustment

Beneficiary Received Noncovered Care During IPF Stay

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

Beneficiary Received Noncovered Care During IPF Stay (continued)

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



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

- Plan effective at admission responsible for entire IP stay
  - Traditional Medicare responsible
    - If patient enrolled in traditional Medicare at admission
  - MAO plan responsible
    - If patient enrolled in MAO plan at admission
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 190.10.6

Teaching IPF Bills Traditional Medicare for MAO Plan Enrollee

- Teaching IPFs submit IP informational claims to us for MAO plan enrollees to receive payment for DGME and/or N&AH via cost report
  - After billing MAO plan, submit IP claim to us and report
    - Covered TOB 11X (unless N&AH only; submit TOB 110)
    - Covered days/charges (unless N&AH only; submit noncovered days/charges)
    - CCs 04 and 69
    - Medicare as first payer (obtain MBI from patient); not as MSP claim
    - All other required claim elements
- References:
  - CR2476, Payment to Hospitals and Units Excluded from Acute IPPS for DGME and N&AH Education for Medicare + Choice (M+C) Enrollees
  - Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans

Teaching IPF Bills Traditional Medicare for MAO Plan Enrollee (continued)

- Medicare processes these IP claims as follows:
  - Rejects TOB 111 with reason code 37574 resulting in TOB 110
    - DGME paid via cost report
  - Rejects TOB 110 with reason code 39934
    - N&AH paid via cost report
- Tip: Do not forget to report CCs 04 and 69
  - If you do not report CCs 04 and 69, claim rejects with reason code U5233 and you won't receive payment for DGME or N&AH

What You Should Do Now

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

IPF References and Resources

CMS References and Resources

- CMS IOMs
  - Publication 100-02, *Medicare Benefit Policy Manual*
    - Chapter 4, Sections 10 through 50
    - Chapter 6, Sections 10.1 and 10.2
    - Chapter 15, Section 250
  - Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 1, Section 50.2.1
    - Chapter 3, Sections 10.4, 40.2.1, 40.2.2 (letter E), 40.3, 190, 190.6.4.1, 190.7.3, 190.10.4, 190.10.6 and 190.10.12
    - Chapter 4, Section 10.12
    - Chapter 12, Sections 90.7 and 90.7.1
    - Chapter 18, Section 10.2.2
    - Chapter 25, Section 75

CMS References and Resources

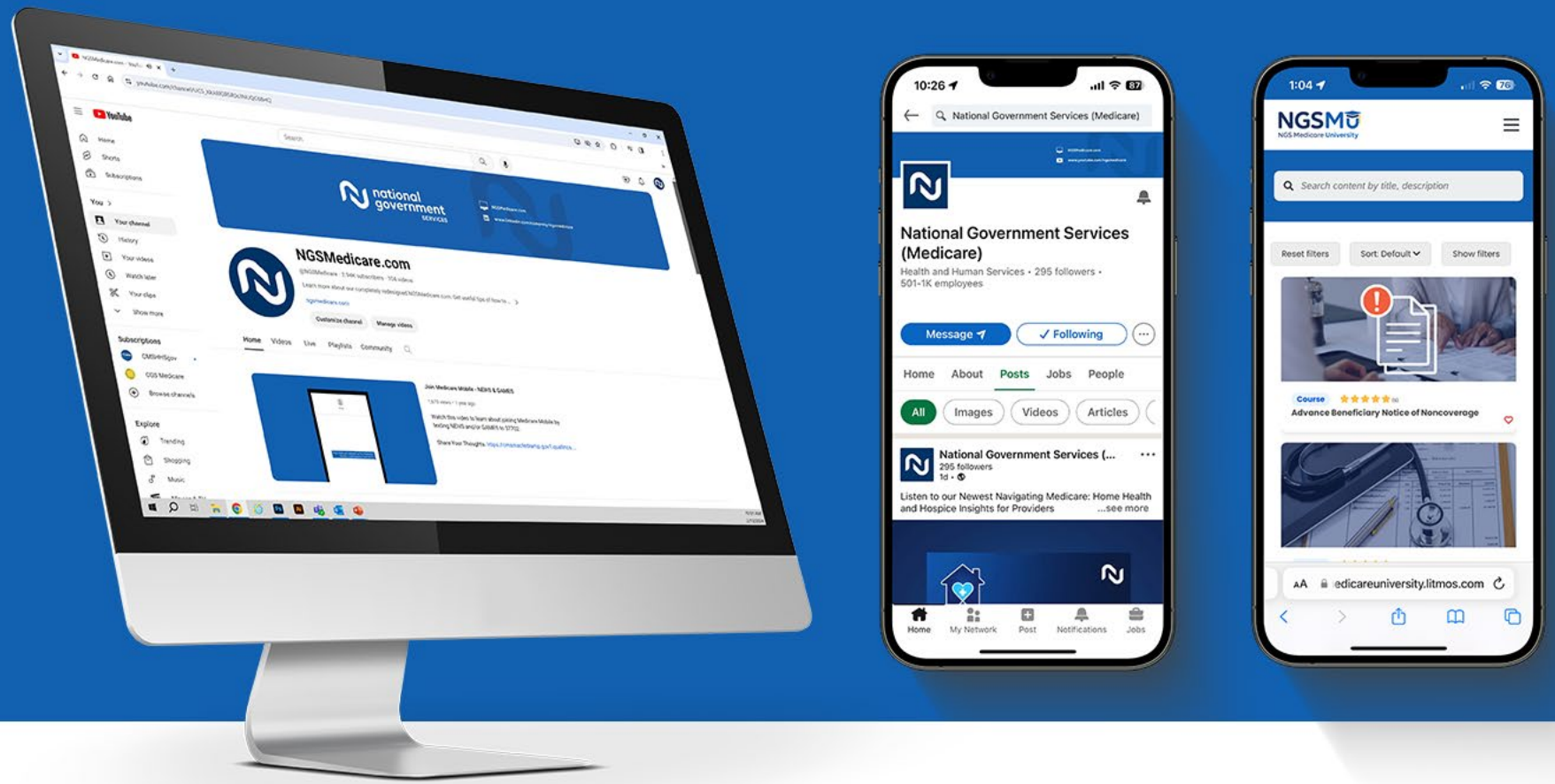
- Inpatient Psychiatric Facility PPS
- Inpatient Psychiatric Facility PPS Files
- CR2476, Payment to Hospitals and Units Excluded from Acute IPPS for DGME and N&AH Education for Medicare + Choice (M+C) Enrollees
- CR3389, Revision of CWF Editing for Same-Day, Same-Provider Acute Care Readmissions
- CR3881, Source of Admission Code D
- CR5470, IPF PPS for Oncology Treatment Payment Adjustment
- CR5474, Use of BE Day as Day of Discharge for Payment Purposes for IPF PPS and Clarification of Discharge for LTCH and Allowance of No-Pay BE Bills (TOB 110)
- CR7072, Implementation of Edits for ED Adjustment Policy Under IPF PPS
- CR13766, IPF PPS Updates for FY 2025

National Government Services References and Resources

- Acronym Search Tool
- *FISS DDE Provider Online Guide*
- Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
- Inpatient Admission Prior to Medicare Entitlement Job Aid
- Inpatient Psychiatric Facilities Billing When Benefits Exhaust Job Aid

Questions?

Thank you!



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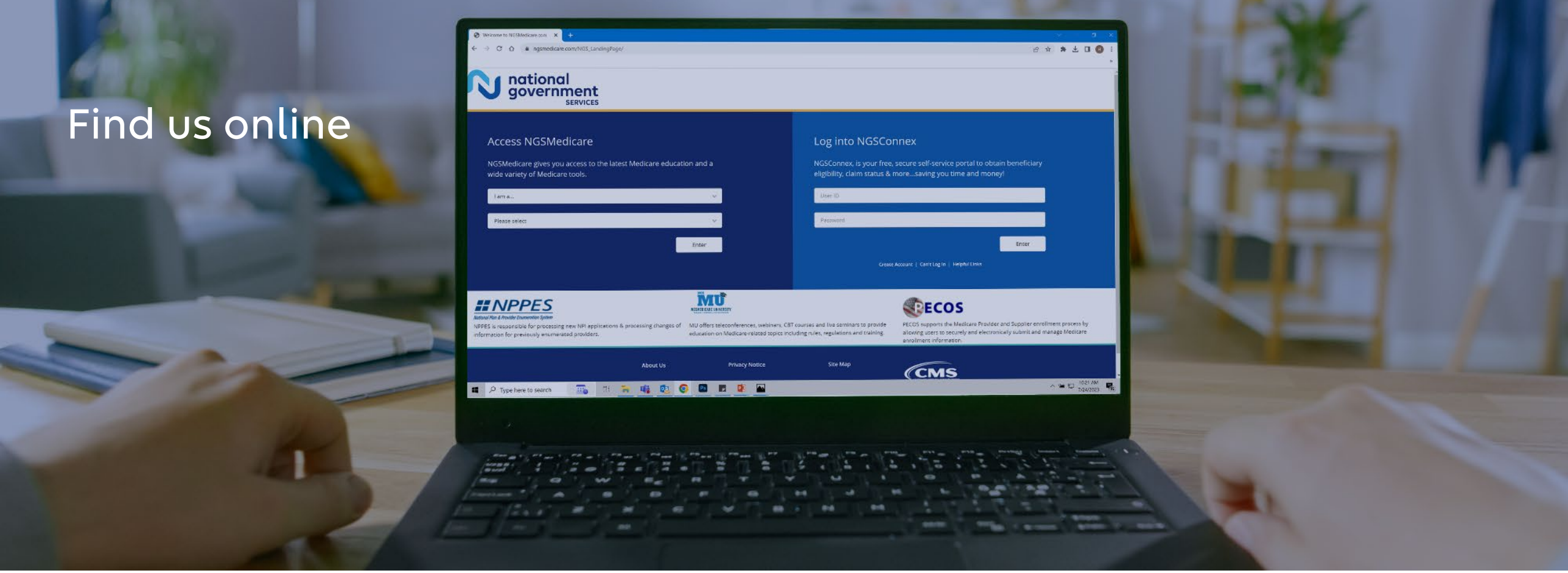

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