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Acute Care Hospitals: Preparing Inpatient Claims – Taking a Deeper Dive Part 2

4/24/2025

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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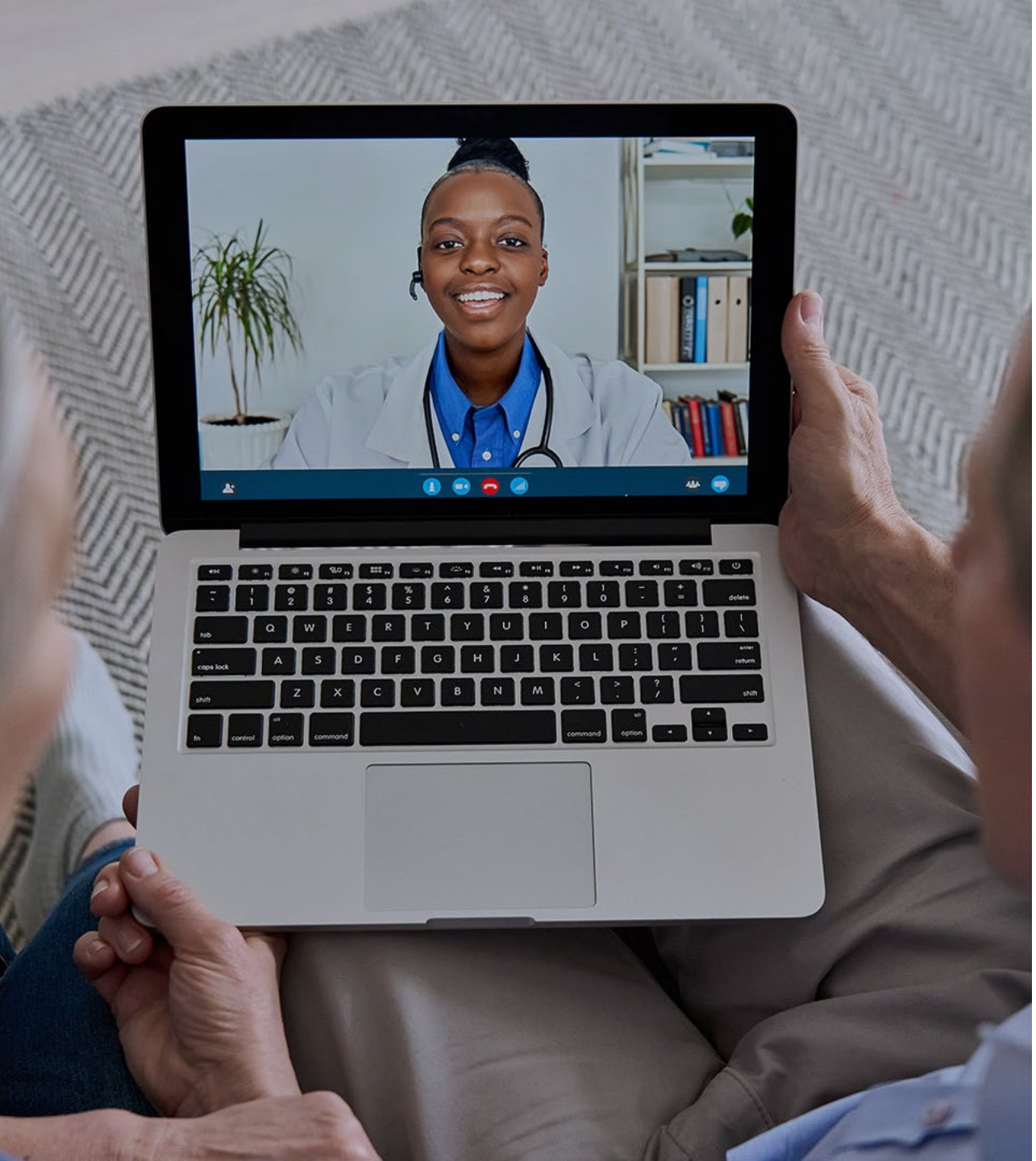

Recording

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Objective

Assist ACHs in understanding how to prepare and submit compliant claims to Medicare in a variety of specific situations 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

- Reminders from Webinar Part 1
- TOBs for IP Claims and Frequency of Billing
- Services Rendered Under Arrangement
- LOAs
- Same-Day Readmissions
- IP Hospital Benefit Day Application, BE and HCOs
- MAO Plan Enrollees
- Wrap Up, References and Resources
- Questions

Reminders from Webinar Part 1

Billing Instructions

- Complete IP ACH claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Inpatient Hospital Billing

Claim Resources

- Claim form
  - UB-04/CMS-1450, 837I claim or claim entry via FISS DDE
  - MLN® Booklet *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- FLs
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
    - FL 1 to FL 81 names and descriptions but no codes
    - FLs may be required or situational
- Codes
  - NUBC members access billing codes from NUBC's UB-04 Data Specifications Manual

Submitting Claims to Medicare

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

TOBs for IP Claims and Frequency of Billing

IP ACH Claims

- One claim-per-stay concept
  - Submit one claim through discharge or death even if
    - BE (OC A3 and date) or
    - Care becomes noncovered

TOBs for IP Hospital Claims

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

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
    - If admitted prior to Part A entitlement date, report Part A entitlement date
  - Statement through date = discharge/death date
    - Always report PSC that accurately represents beneficiary's status as of this date
- Submit at final discharge/death

TOBs 112 and 117 for Interim Claims

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

Interim Claim Coding

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

Beneficiary Admitted Prior to Part A Entitlement Date

- Per Inpatient Admission Prior to Medicare Entitlement Job Aid
  - Admission date = actual admission date
  - Statement from/through dates = **Part A effective** to discharge date
  - Covered days (VC 80) = days in statement covered period
  - Accommodation days/units (room/board 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

Noncovered Care During Stay

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

Noncovered Care During Stay (continued)

- OSC 77 and from/through dates
  - Provider liable for this period of noncovered care
    - Reason – other than lack of medical necessity or as custodial care
  - Beneficiary's record charged with utilization
    - Collect deductible and/or coinsurance
- OSC M1 and from/through dates
  - Provider liable for this period of noncovered care
    - Denied due to lack of medical necessity or as custodial care
  - Beneficiary's record not charged with utilization
    - Do not collect deductible and/or coinsurance

Noncovered Admission Followed by Covered Level of Care

- Admission deemed to be when covered services became medically needed and rendered
- Claim coding
  - TOB 111
  - Covered and noncovered days/charges
  - Admission date = actual admission date; not deemed date
  - OC 31 and date
  - OSC 76 and from/through dates
  - VC 31 and amount
  - Principal diagnosis that caused covered level of care
  - Procedures performed during covered level of care

TOB 117 for Adjustment Claims

- IP adjustment claim
  - Submit to change or correct original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires one claim change reason code (reason for adjustment)
    - **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 one claim change reason code (reason for cancel)
    - **D5** = Cancel to correct MBI or provider identification number
    - **D6** = Cancel to repay a duplicate payment or OIG overpayment (includes cancel of OP bill with services required to be on IP bill)

TOB 110 for IP No Payment Claims

- Submit for all IP stays when no payment expected from us
  - Except when beneficiary enrolled in Part B only
- Submit TOB 110 if beneficiary's
  - Medicare IP hospital benefit days exhausted at admission
  - Admission denied (not reasonable and necessary for entire stay)
  - Stay denied per hospital self-audit
  - Stay denied per MAC or medical review contractor
  - Stay included noncovered procedure

Noncovered Admission (Admission Denial)

- Coding for admission denials (not reasonable and necessary)
  - TOB 110
  - Noncovered days/charges
  - OC 31 and date
  - OSC 76 and from/through dates
  - OSC 77 and from/through dates, if applicable
  - VC 31 and amount
- If care becomes covered
  - Cancel TOB 110s and
  - Submit corrected claims

Hospital Denied IP Stay per Self-Audit

- Coding for provider liable IP claim
  - TOB 110
  - Noncovered days/charges
  - Services from admission through discharge
  - Appropriate PSC
  - OSC M1 and from/through dates (DOS)
  - All diagnosis codes
  - All procedures codes

Noncovered Procedure During IP Stay

- If noncovered procedure and covered procedure provided during IP stay
  - Submit payable TOB 11X with covered procedure codes/charges
  - If Medicare denial needed, also submit noncovered TOB 110 with noncovered procedure codes/charges
    - Report same statement covers period (from/through dates) as payable TOB 11X (CC 20 for demand or CC 21 for insurance denial)

TOB 12X for IP Ancillary Claims

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

TOB 12X for IP Ancillary Claims (continued)

- May submit for certain services if Part A cannot pay for certain portion of IP stay
  - Review CR7949, Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission

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.
- Review 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

Services Rendered Under Arrangement

Services Furnished to Hospital Inpatients

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

Services to Inpatients Under Arrangement

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

Under Arrangement Example

- Example
  - ACH IP beneficiary requires MRI
  - ACH sent beneficiary to another facility for MRI on 1/15 at 8 am by ambulance
  - Beneficiary returns to same ACH same day at 1 pm
- ACH action
  - Pay other facility for MRI
  - Pay transportation provider for ambulance
  - On IP claim, report revenue code for MRI with total cost for MRI and transportation

LOAs

LOA

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

LOA – Situations

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

LOA – Claim Instructions

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

LOA – Beneficiary Does Not Return

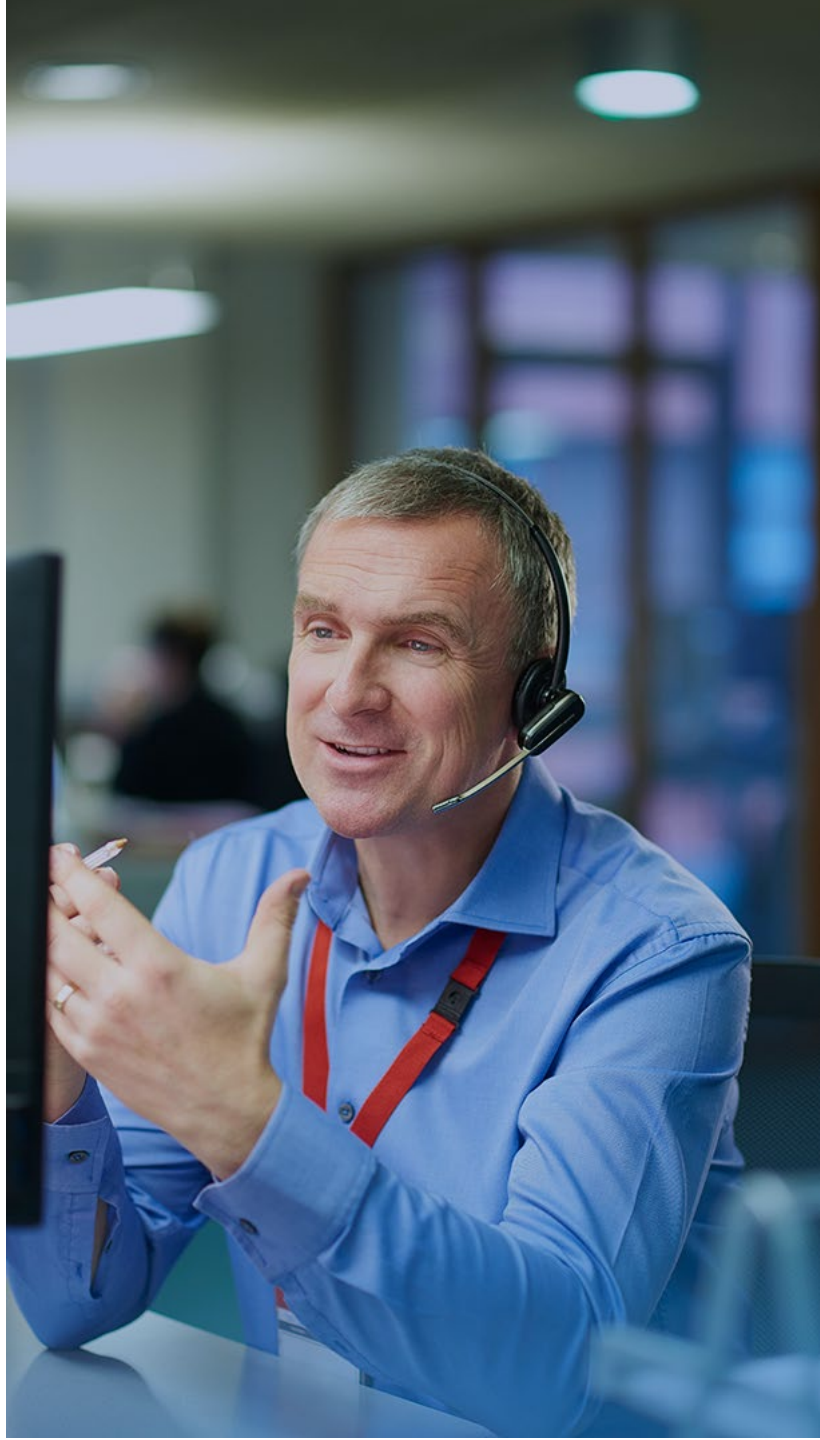
- If you place beneficiary on LOA but he/she doesn't return
  - Communicate with beneficiary/representative to determine status
  - May submit discharge claim with through date = date LOA began
    - CMS has not set certain amount of time that must pass before ACH can submit discharge claim

LOA – Payment and Services Rendered During LOAs

- When LOA occurs, we
  - Pay one DRG for both IP ACH stays (billed as one claim)
  - Do not pay separately for OP hospital/facility services during LOA
    - If you rendered OP services to beneficiary during LOA from your ACH
      - Report services on your IP ACH claim; do not submit OP claim(s) to us
    - If another facility rendered OP services to beneficiary during LOA from your ACH
      - Report services on your IP claim and pay that facility under arrangement
        - Other facility cannot submit OP claim(s) to us
    - If your ACH rendered OP services to beneficiary during LOA from another ACH
      - Bill that ACH under arrangement; do not submit OP claim(s) to us

Did You Know

- If a beneficiary receives OP or IP services at your ACH during a three-day or less interruption from an LTCH, you must bill the LTCH for these services under arrangement.
- Review What All Facilities Need to Know About the Long-Term Care Hospital Three-Day or Less Interrupted Stay Policy.



Same-Day Readmissions

Readmissions and Same-Day Readmissions

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

Same-Day Readmissions – Are Two Stays Related?

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

Same-Day Readmissions – Submitting One Claim or Two

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

Same-Day Readmissions – Claim Editing

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

IP Hospital Benefit Day Application, BE and HCOs

Payment Under IPPS

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

IP Hospital Medicare Benefit Days

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

Medicare's Application of IP Hospital Benefit Days Under IPPS

- Medicare uses unique methodology when applying IP hospital benefit days to IP claim
  - We do not apply
    - IP hospital benefit days on a "day by day" basis
    - Regular benefit days and LTR days to same claim
      - Unless LTR days needed for HCO period in which case we apply LTR days in HCO period only
  - We do apply
    - LTR days if they are all that remain at admission

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

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

BE

- If beneficiary has at least one IP hospital benefit day
  - We pay DRG up to any HCO period
    - Even if IP hospital benefit days exhaust before HCO period
- If all IP hospital benefit days exhaust during IP stay
  - Report OC A3 with BE date on claim
    - We correct BE date if incorrect
  - Let us determine BE date per IPPS benefit day application
    - We add OC A3 and BE date

Inlier Days, Inlier Period and OSC 70

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

Preparing IP Claims

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

Claim RTP for OC 47 and Date

- If claim qualifies for HCO, it may RTP for OC 47 and date if
  - Claim's covered charges exceed HCO threshold amount and beneficiary
    - Does not have enough IP hospital regular benefit days to cover medically necessary days or
    - Has only LTR days but not enough to cover medically necessary days

RTP Reason Codes 37036 and 37045 for HCO Claims

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

RTP Reason Codes 37036 and 37045 for HCO Claims (continued)

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

Processing Claim With OC 47 and Date

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

BE Without HCO

- Beneficiary
  - Has regular IP hospital benefit days that exhaust prior to end of claim
  - May/may not have LTR days
- We
  - Apply OSC 70
    - From = last available regular IP hospital benefit day
    - Through = end of claim
  - Do not add OC A3 and date
    - Benefits do not exhaust
  - Pay full DRG

- Beneficiary
  - Does not have regular IP hospital benefit days
  - Has LTR days that exhaust prior to end of claim
- We
  - Apply OSC 70
    - From = last available LTR day
    - Through = end of claim
  - Add OC A3 and date
    - Day before discharge date
  - Pay full DRG

BE With HCO

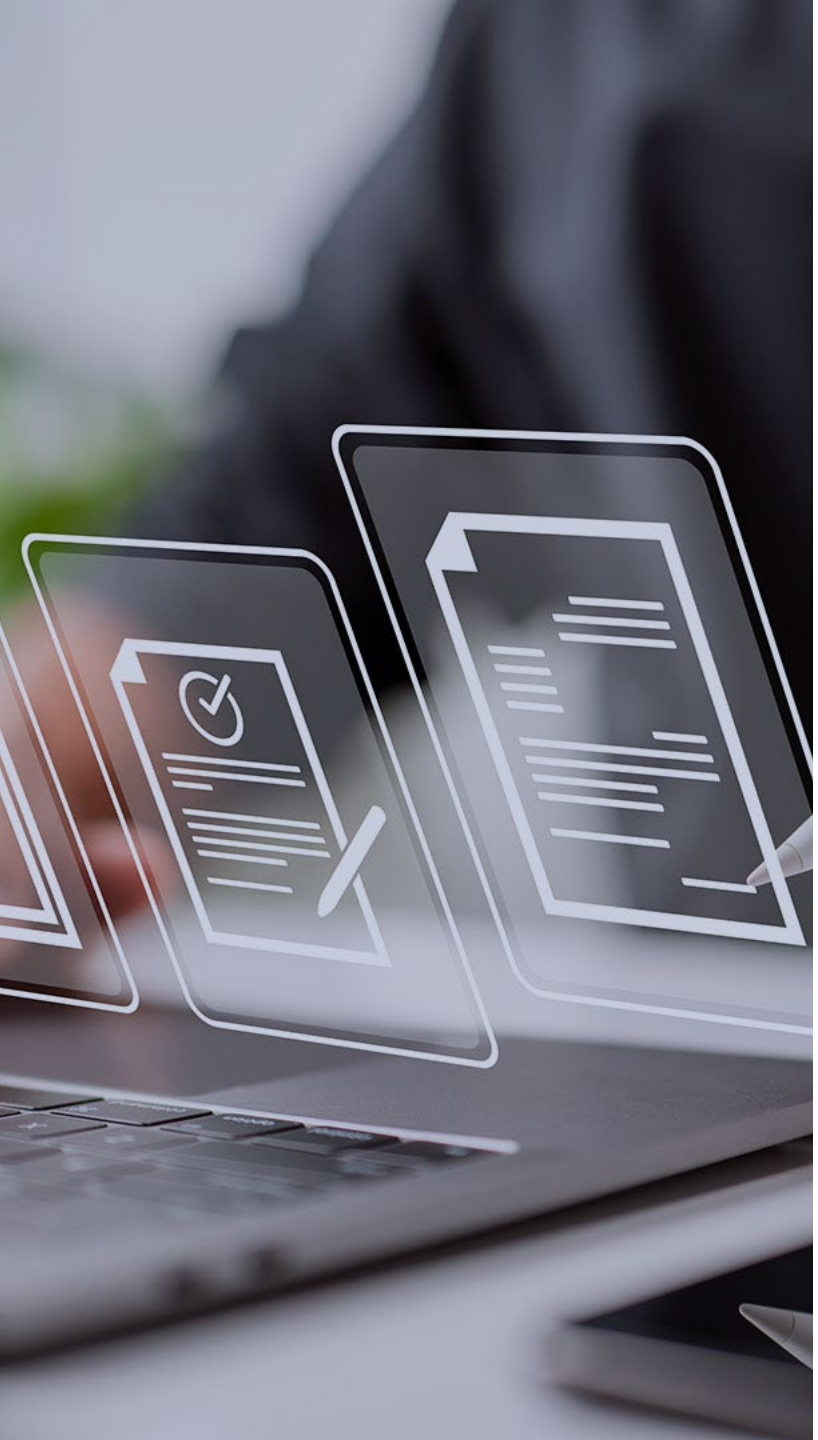
- Beneficiary
  - Has regular IP hospital benefit days that exhaust prior to HCO
  - Has no LTR days/elects not to use
- We
  - Apply OSC 70
    - From = last available regular IP hospital benefit day
    - Through = day before OC 47 date
  - Add OC A3 date
    - Day before OC 47 date
  - Pay full DRG but not HCO

- Beneficiary
  - Has regular IP hospital benefit days that exhaust prior to HCO
  - Has LTR days
- We
  - Apply OSC 70
    - From = last available benefit day
    - Through = day before OC 47 date
  - Add OC A3 date
    - Last available LTR day
  - Pay full DRG and some or all of HCO

MAO Plan Enrollees

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

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



IP Informational Claims – Billing Tips

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

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

- Submit IP informational claim to FFS Medicare
  - Covered TOB (not 110)
  - Covered days/charges
  - CCs 04 and 69
  - All required claim elements
- We pay claim with reason code 37210 (pay IME via claim)

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

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

IP Informational Claims – Non-Teaching ACHs

- Submit IP informational claim to FFS Medicare
  - Covered TOB (not 110)
  - Covered days/charges
  - CC 04
  - All required claim elements
- We process claim with reason code 3719C (TOB remains 111) and capture days in DSH (no payment due)

Wrap Up, References and Resources

What You Should Do Now

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

NGS References and Resources

- ASCA Requirements for Paper Claim Submission
- CBT modules in Medicare University
- Contact Us (NGSConnex, IVR, PCC)
- EDI information
- *Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide*
- FISS Claim Change/Condition Reason Codes
- Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
- Inpatient Admission Prior to Medicare Entitlement Job Aid Top Claim Errors
- What All Facilities Need to Know About the Long-Term Care Hospital Three-Day or Less Interrupted Stay Policy

CMS References and Resources

- Acute Inpatient PPS
- MLN® Educational Tool: *Medicare Payment Systems*
- MLN Connects® Newsletter
- MLN Matters® Articles
- MLN Publications & Multimedia
- MLN Web-Based Training
- Open Door Forums
- Transmittals/CRs
- Web Pricers

CMS References and Resources (continued 1)

- CMS IOM Publications
  - 100-01, *Medicare General Information, Eligibility and Entitlement Manual*
    - Chapter 3 (all)
    - Section 10.4, Benefit Period
  - 100-02, *Medicare Benefit Policy Manual*
    - Chapter 3 Sections
      - 10, Benefit Period
      - 20, Inpatient Benefit Days
    - Chapter 6, Sections
      - 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
      - 10.2, Other Circumstances in Which Payment Cannot Be Made Under Part A
      - 10.3, Hospital Inpatient Services Paid Only Under Part B
    - Chapter 15, Section 250, Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

CMS References and Resources (continued 2)

- 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Sections
    - 50.2.1, Frequency of Billing
    - 60.2.1, Billing for Noncovered Procedures in Inpatient Stay
    - 90, Patient Is a Member of a MA Organization for Only a Portion of the Billing Period
  - Chapter 3, Sections
    - 10.4, Payment of Nonphysician Services for Inpatients
    - 10.5, Hospital Inpatient Bundling
    - 20.3, Additional Payment Amount for Hospitals with Disproportionate Share of Low-Income Patient
    - 20.7.4, Cost Outlier Bills With Benefits Exhaust
    - 40.2.1, Noncovered Admission Followed by a Covered Level of Care
    - 40.2.2, Charges to Beneficiaries for Part A Services
    - 40.2.5, Repeat Admissions
    - 40.2.6, Leaves of Absence
    - 50.2, Claim Change Reason Codes

CMS References and Resources (continued 3)

- Chapter 4, Sections
  - 240.1, Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials
  - 240.2, Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made Under Part A
  - 240.6, Submitting Provider-Liable Part A No-Pay Claims
- Chapter 18, Section 10.2.2, Claims Submitted to MACs Using Institutional Formats
- Chapter 25, Section 75, Billing Code Fields

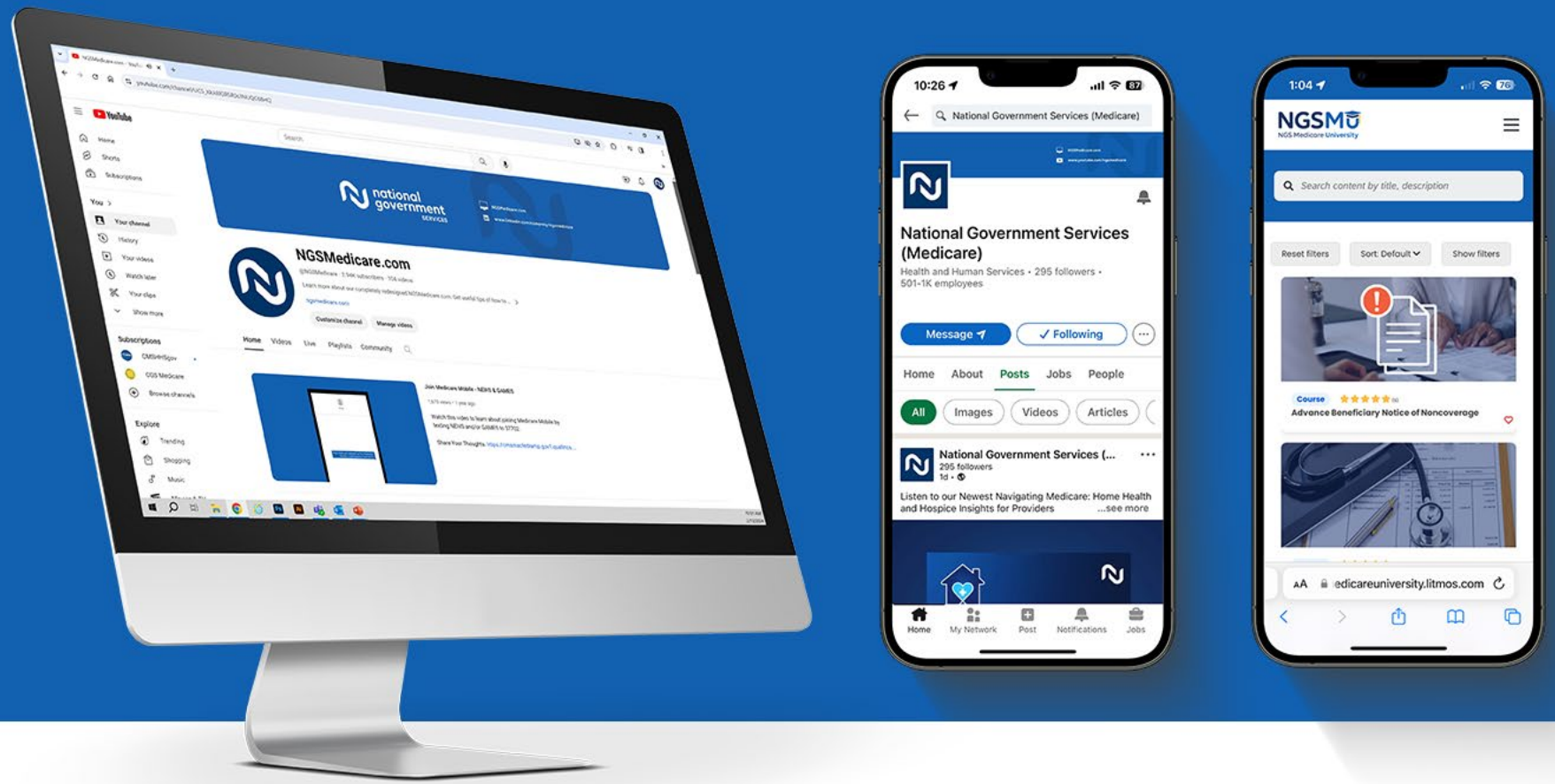
- 100-16, *Medicare Managed Care Manual*

CMS References and Resources (continued 4)

- CR3389, Revision of Common Working File (CWF) Editing for Same-Day, Same-Provider Acute Care Readmissions
- CR7849, Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission
- CR8185, CMS Administrators Ruling: Part A to B Rebilling of Denied Hospital Inpatient Claims
- CR8445, Implementing the Part B Inpatient Payment Policies from CMS-1599-F
- CR8666, Implementing the Part B Inpatient Payment Policies from CMS-1599-F
- MLN® Booklet *Medicare Billing: Form CMS-1450 and the 837 Institutional*
- MLN Matters® *MM13846: Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services*
- MLN Matters® *SE17033 Revised: Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities*

Questions?

Thank you!



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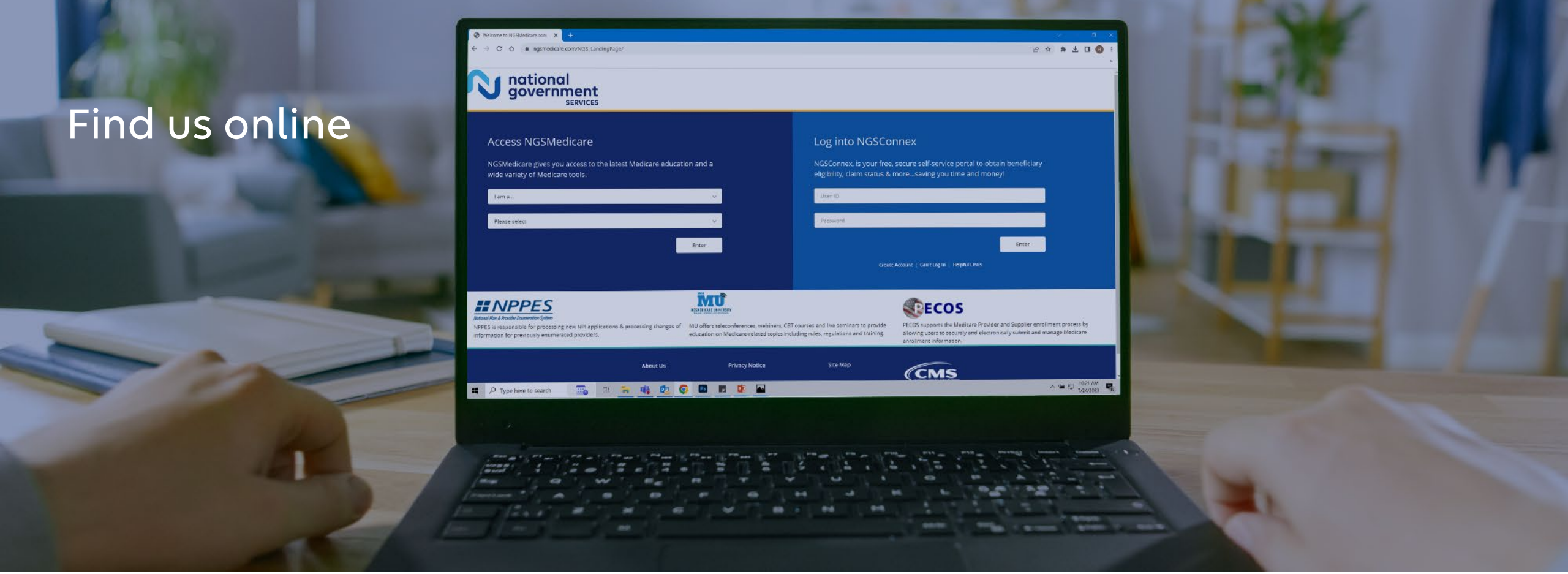

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