

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 843

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 9, 2006
Change Request 4202

NOTE: This transmittal rescinds and replaces Transmittal 836, dated February 3, 2006. The only substantive change is to Chapter 3, Section 40.2.2K; code 7 is now identified as a patient status code instead of a condition code. All other information remains the same.

SUBJECT: Inpatient Admission Followed by Discharge or Death Prior to Room Assignment

I. SUMMARY OF CHANGES: This CR provides billing instructions when there is an inpatient admission and discharge prior to a room being assigned and/or occupied.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : July 1, 2006

IMPLEMENTATION DATE : July 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/40.2.2/Charges to Beneficiaries for Part A Services

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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SUBJECT: Inpatient Admission Followed By a Death or Discharge Prior To Room Assignment

I. GENERAL INFORMATION

A. Background: The American Hospital Association requested that CMS update the policy for billing room and board charges prior to room assignment.

B. Policy: A patient of a hospital is considered an inpatient upon issuance of written doctor orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. Hospitals are not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		F I H I	R H H I	C a r i e r	D M E R C	Shared System Maintainers			
				F I S S	M C S	V M S	C M W F		
4202.1	Contractors shall pay acute care inpatient hospital claims with room and board charges for a patient who has either died or is discharged prior to being assigned and/or occupying a room.	X							
4202.1.1	Contractors shall not reject claims if the hospital does not submit a room and board charge for a patient who has either died or is discharged prior to being assigned and/or					X			X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	occupying a room.								
4202.2	The standard system maintainer and CWF maintainer shall alter current edits that require charges on inpatient claims to allow claims with less than 2 covered days to process even if there are no charges present.					X			X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
4202.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established 'medlearn matters' listserv. Contractors shall post this article, or a direct link to this article, on their Website and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F	R	C	D	Shared System Maintainers				Other
		I	H	a	M	F	M	V	C	
		I	H	r	E	I	C	S	W	
		r	i	e	r	S	S	S	F	
	Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: July 1, 2006</p> <p>Implementation Date: July 3, 2006</p> <p>Pre-Implementation Contact(s): Stu Barranco at stuart.barranco@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Regional Office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

40.2.2 - Charges to Beneficiaries for Part A Services

(Rev.843, Issued: 02-09-06, Effective: 07-01-06, Implementation: 07-03-06)

The hospital submits a bill even where the patient is responsible for a deductible which covers the entire amount of the charges for non-PPS hospitals, or in PPS hospitals, where the DRG payment amount will be less than the deductible.

A beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 where the admission is found not to be reasonable and necessary and no payment will be made for the stay under limitation on liability. A hospital receiving payment for a covered hospital stay (or PPS hospital that includes at least one covered day, or one treated as covered under guarantee of payment or limitation on liability) may charge the beneficiary, or other person, for items and services furnished during the stay only as described in subsections A through H.

A - Deductible and Coinsurance

The hospital may charge the beneficiary or other person for applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. The FI deducts the deductible and coinsurance first from the PPS payment. Where the deductible exceeds the PPS amount, the excess will be applied to a subsequent payment to the hospital. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

B - Blood Deductible

The Part A blood deductible provision applies and reporting of the number of pints is applicable to both PPS and non-PPS hospitals. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

C - Inpatient Care No Longer Required

The hospital may charge for services that are not reasonable and necessary or that constitute custodial care, furnished on or after the third day following the date of the written notification when the following requirements are met:

- The hospital (acting directly or through its URC) determined that the beneficiary no longer required inpatient hospital care. (For this purpose, a beneficiary is considered to require inpatient hospital care if the beneficiary needed a SNF level of care but an SNF-level bed was unavailable.) The hospital cannot issue a notice of noncoverage if a bed is not available. Medicare pays for days awaiting placement until a bed is available and it is documented in the medical record that SNF placement is actively being sought.

- The attending physician agreed with the hospital's determination in writing, i.e., by issuing a written discharge order. Or, if the physician disagreed with the hospital's determination, the hospital requested a review by the QIO and the QIO concurred with the hospital's notice.

Prior to charging for the noncovered period, the hospital (acting directly or through the URC) notified the beneficiary (or person acting on the beneficiary's behalf) in writing that:

- In its opinion and with the concurrence of the attending physician (or of the QIO), the beneficiary no longer requires inpatient hospital care (See §§130 for coordination with a QIO); or
- Customary charges will be made for continued hospital care beginning with the third day following the date of the notice.

The beneficiary may request that the QIO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital after becoming liable for charges. If the beneficiary wants an immediate review by the QIO, the beneficiary must request it within 3 days of receiving the hospital's notice. Any patient during the course of a stay will receive the QIO decision within 2 workdays.;

The determination of the QIO may be appealed if it is unfavorable to the beneficiary in any way and the QIO decision will be made within 30 days.

To the extent that a finding is made that the beneficiary required continued hospital care beyond the point indicated by the hospital, the charges for the continued care will be invalidated and any money paid by the beneficiary, or on the beneficiary's behalf, refunded.

The manner in which the hospital gives the notice to the beneficiary is in Chapter 30.

If a hospital furnishing covered inpatient hospital services is able to determine in advance that the beneficiary will not require inpatient hospital care as of a certain date, it may give the notice in advance of that date, but ordinarily no earlier than 3 days before that date. If a hospital determines, however, that a beneficiary needs (or by the third day thereafter, will need) only a SNF-level of care but a SNF bed is not or will not be available, it may notify the beneficiary (or the beneficiary's representative) that the beneficiary will be subject to charges beginning with the third day after the date of the notice that the SNF bed becomes available. This can be done as an advance beneficiary notice. The hospital needs to notify the beneficiary or representative the day the bed becomes available or has knowledge of the bed available.

The beneficiary has the same right to appeal the QIO's determination that the beneficiary no longer required inpatient hospital care as of a certain date as applies to QIO determinations regarding medical necessity. The hospital also has the right to appeal a QIO's determination that is unfavorable to the beneficiary.

When the hospital appeals in such cases the following entries are required on the bill:

- Occurrence code 3l (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;
- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and
- Value code 31 (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D - Change in the Beneficiary's Condition

If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the QIO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after the beneficiary again required inpatient hospital care until the conditions in subsection C. are again met. If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with a subsequent notice when the patient chose not to be discharged to the SNF bed.

E - Admission Denied

If the entire hospital admission is determined to be not reasonable or necessary:

- If the beneficiary was notified in writing prior to, or upon admission, the hospital may charge for the entire period of hospitalization.
- If the beneficiary was notified in writing on the day following the admission or subsequently, the hospital may charge the beneficiary for the hospitalization beginning with the day following the day the written notice was given. In this circumstance, the provider is liable for the period between admission and the day after the beneficiary was notified.

The notice to the beneficiary must state:

- The basis of the determination that inpatient hospital care is not necessary or reasonable (e.g., coverage exclusions);
- That customary charges will be made for hospital care beginning with the day following the day on which the notice is given to either the beneficiary or to a representative on his behalf;
- The beneficiary may request that the QIO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital. If the beneficiary wishes immediate QIO review, it must be requested within 3 days of receiving the hospital's notice;
- The beneficiary may appeal the determination of the QIO if it is unfavorable to the beneficiary in any way. The hospital also has the right to appeal a QIO's decision; and

- If a finding is made that the beneficiary required the hospitalization, the charges for the hospital stay will be invalidated, and money paid by the beneficiary or on his behalf will be refunded.

In such cases the following entries are required on the bill:

- Occurrence code 31 (and date) to indicate the date the hospital notified the beneficiary.
- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.
- Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.
- Value code 31 (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization that was not necessary or reasonable. They are included as noncovered charges on the bill.

F - Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary

If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires inpatient hospital care) the hospital may charge the beneficiary or other person for the services or care under the following circumstances:

- If the beneficiary was notified in writing prior to receipt of the care or services that the hospital may charge for the excluded care or services; and
- The notice to the beneficiary must state:
 - The basis of the determination that inpatient hospital care is not necessary or reasonable (i.e., coverage exclusions);
 - The determination is the hospital's opinion. (If the hospital obtained concurrence from the FI or the QIO this may be stated);
 - Customary charges will be made if the beneficiary receives the services;
 - The beneficiary may request the FI, or the QIO when medical necessity is involved, to make a formal determination on the validity of the hospital's finding if the beneficiary receives the items or services. If the beneficiary wants immediate QIO review, the beneficiary must request it within 3 days of receiving the hospital's notice;
 - The FI's determination, or the QIO's where a medical necessity determination is involved, may be appealed by the beneficiary if unfavorable to the beneficiary in any way. The hospital also has the right to appeal the FI's or the QIO's decision; and
 - The charges for the services will be invalidated and refunded if they are found to be covered.

The hospital may consult with the FI (on coverage exclusions) or the QIO (on medical necessity determinations) prior to issuing the notice to the beneficiary.

The following bill entries apply to these circumstances:

- Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.
- Value code 31 (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G - Nonentitlement Days and Days after Benefits Exhausted

If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). It may charge the beneficiary for the lesser of:

- The number of days on which the patient was not entitled to benefits or after the benefits were exhausted; or
- The number of outlier days. (Day outliers were discontinued at the end of FY 1997.)

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits, or after benefits were exhausted, the hospital may charge for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until the number of days counted off equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H - Contractual Exclusions

In addition to receiving the basic prospective payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, non-entitlement to Part A, or exhaustion of benefits. For example, it may charge for most cosmetic and dental surgery.

I - Private Room Care

Payment for medically necessary private room care is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See the Medicare Benefit Policy Manual, Chapter 1.) When the beneficiary accepts the liability, the hospital will supply the service, and bill the beneficiary directly. If the beneficiary believes the private room was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

J - Deluxe Item or Service

Where a beneficiary requests a deluxe item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition, after the hospital informs the beneficiary of the additional charge, it may collect the additional charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested. If the beneficiary believes that the more expensive item or service was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

K – Inpatient Acute Care Hospital Admission Followed By a Death or Discharge Prior To Room Assignment

A patient of an acute care hospital is considered an inpatient upon issuance of written doctor's orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of their own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07 which indicates they left against medical advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.