



VCU Medical Center

Office of Health Innovation

Ruling: Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B)

Description: This notice announces a CMS Ruling that establishes a policy that revises the current policy on Part B billing following the denial of a Part A inpatient hospital claim by a Medicare review contractor on the basis that the inpatient admission was determined not reasonable and necessary. This revised policy is intended as an interim measure until CMS can finalize a policy to address the issues raised by the Administrative Law Judge and Medicare Appeals Council decisions going forward.

Summary of Ruling

Part B Hospital Inpatient Billing

Pursuant to this Ruling, when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for more services than just those listed in the MBPM, Chapter 6, Section 10, to the extent additional reasonable and necessary services were furnished.

- In this case, the hospital may submit a Part B inpatient claim for payment for the Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient.
 - o Except when those services specifically require an outpatient status, for example, outpatient visits, emergency department visits, and observation services.

Hospitals must submit their Part B claim within the timeframes specified in this Ruling.

Three-Day Payment Window Prior to Inpatient Admission

Where no Part A payment is made because the Part A inpatient claim is denied on the basis that the inpatient admission was not reasonable and necessary, hospitals may continue to bill separately for the outpatient services furnished during the 3-day (or 1-day for non-IPPS hospitals) payment window prior to the inpatient admission, including observation and other services that were furnished in accordance with Medicare's requirements.

- Because services provided during the 3-day (or 1-day for non-IPPS hospitals) payment window prior to the denied inpatient admission are outpatient services, these services may not be included on the Part B inpatient claim. Instead, hospitals may bill for these services on a Part B outpatient claim, which will not be subject to the usual timely filing restrictions.

Treatment of Pending Appeals and Appeal Rights

In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service. Thus, if a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, the hospital cannot also maintain its request for payment for the same services on the Part A claim.

- In this situation, the hospital must either choose to no longer pursue an appeal of the Part A claim denial (and thus, as a practical matter, any determination or appeal decision becomes final or binding, allowing the hospital to submit its Part B claim) or must withdraw any pending appeal request on the Part A claim denial prior to the submission of the Part B claim.
- If a hospital submits a Part B claim for payment without withdrawing its appeal request, the Part B claim for payment may be denied as a duplicate.

If the hospital elects to withdraw its Part A appeal and submit a Part B claim, the hospital will have 180 days from the date of receipt of the appeal dismissal notice to submit the claim.