| CMS Manual System | Department of Health & Human Services (DHHS |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 982** | **Date: JUNE 16, 2006** |
| | **Change Request 5070** |

**Subject: New Use of Hospital Issued Notice of Noncoverage (HINN)**

**I. SUMMARY OF CHANGES:** While there are several different versions of the HINN, none of the current versions adequately addresses the ability of hospitals to charge their inpatients for certain noncovered services severable from the inpatient stay (i.e., not bundled or integral to payment or treatment for the diagnoses/reasons justifying the stay under Medicare policy). This instruction offers model language for a new HINN to fit this specific case, "HINN 11". Instructions for use of this language are also provided.

**New / Revised Material**
**Effective Date: September 18, 2006**
**Implementation Date: September 18, 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

| Pub. 100-04 | Transmittal: 982 | Date: June 16, 2006 | Change Request 5070 |
|---|---|---|---|

**SUBJECT: New Use of Hospital Issued Notices of Noncoverage (HINNs)**

## I. GENERAL INFORMATION

### A. Background:

Currently, the only limitation of liability (LOL) notice for fee-for-service beneficiaries who are hospital inpatients is the HINN. LOL notices are required under §1879 of the Social Security Act (the Act) in order to hold beneficiaries liable for certain noncovered services. Chapter 30 of Pub.100-04 provides basic information on LOL.

While there are several different versions of the HINN, none of the current versions adequately addresses the ability of hospitals to charge their inpatients for certain noncovered services severable from the inpatient stay (i.e., not bundled or integral to payment or treatment for the diagnoses/reasons justifying the stay under Medicare policy). The ability to charge beneficiaries for such items-- medically unnecessary diagnostic and therapeutic services-- is codified under regulations at 42 CFR 412.42 (d).

This instruction offers model language for a new HINN to fit this specific case, "HINN 11". Instructions for use of this language are also provided.

Unlike other HINNs, there will not be automatic review of HINN 11 by QIOs. QIOs will only exercise medical judgment by reviewing cases related to this new HINN when specifically requested by the involved beneficiary, beneficiary representative, or intermediary, after services have been delivered. Intermediaries have the discretion to review this HINN for other than inpatient hospital stays if relevant to a claim being reviewed as part of the progressive corrective action process (IOM Pub.100-8 Chapter 8). The intermediaries shall include this cost as part of the review of the claim.

### B. Policy:

Creation of this new model language is authorized by §§1869 and 1879 of the Act, and specifically under regulations at 42 CFR 412.42 (d). It is consistent with general LOL instructions in Chapter 30 of Pub. 100-04 , and will be added to approved HINNs now found in 2005 CMS transmittal 594 (section V. of the attachment). Note the pertinent HINN instructions in that transmittal and this instruction will be manualized in Chapter 30 at a later time. The occasional review by QIOs of these new forms is covered in the broad scope of their duties as set forth in Pub. 100-10.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*

*"Should" denotes an optional requirement*

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5070.1 | Fiscal Intermediaries shall review the instructions in the attachment and review the new HINN as indicated therein. | X | | | | | | | | |
| 5070.2 | Fiscal Intermediaries shall perform additional individual provider education subsequent to the requirement below if alerted that there is a potential misuse of this HINN by a specific provider. | X | | | | | | | | |
| 5070.3 | QIOs will perform review of cases related to this new HINN only when requested by the affected beneficiary, beneficiary representative, or intermediary. | | | | | | | | | QIOs |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 5070.4 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ 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 Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next | X | | | | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | | | | | | | |
| 5070.4.1 | Contractors shall instruct hospitals that they may start using HINN 11 at anytime after publication of this CR. | X | | | | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions:

| X-Ref Requirement # | Instructions |
|---|---|
| | N/A |

### B. Design Considerations:

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | N/A |

**C. Interfaces:** N/A

**D. Contractor Financial Reporting /Workload Impact:** Since providers are expected to make only limited use of this new HINN, and because related oversight activities are NOT uniformly required and limited when performed, current staff already involved with LOL notices (ABN oversight, etc.) should be able to perform it along with current duties. CMS should be alerted if workload for this new HINN appears which cannot be done within current operating budgets.

**E. Dependencies:** N/A

**F. Testing Considerations:** N/A

## V. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date***: September 18, 2006; though providers may voluntarily use this model language upon publication of this instruction.<br><br>**Implementation Date:** September 18, 2006.<br><br>**Pre-Implementation Contact(s):** Eileen Zerhusen, Eileen.zerhusen@cms.hhs.gov or 410-786-7803;<br><br>Elizabeth Carmody, elizabeth.carmody@cms.hhs.gov or 410-786-7533.<br><br>**Post-Implementation Contact(s):** Appropriate CMS Regional Office | **No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.** |

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

ATTACHMENT:

New Model Language and Instructions

**ATTACHMENT** - **HINN 11 Model Language and Instructions**

## I. Introduction

Historically, the only limitation of liability (LOL) notices for fee-for-service beneficiaries who are hospital inpatients have been the Hospital Issued Notices of Noncoverage (HINNs). LOL notices are required under §1879 of the Social Security Act (the Act) in order to hold beneficiaries liable for certain noncovered services. See Chapter 30 of the on-line Medicare Claims Processing Manual for general information on LOL.

While there are several different versions of the HINNs, none of them addressed the ability of hospitals to charge their inpatients for certain noncovered services severable from covered inpatient stays. The ability to charge beneficiaries for such items-- medically unnecessary diagnostic and therapeutic services-- during these covered stays is codified under regulations at 42 Code of Federal Regulations (CFR) 412.42(d). Note that the term "medically unnecessary" in these cases specifically means Medicare has made a coverage decision that the service(s) at issue is/are not reasonable or necessary under its own coverage policy in accordance with §1862(a)(1)(A) of the Act. It does not mean hospitals treating these patients believe such service(s) to be unnecessary, as providing completely unnecessary services would be unethical and potentially fraudulent.

HINN 11 has now been completed to fit this specific case for hospital inpatients. This HINN, and instructions for its use, are provided below.

> **NOTE:** Hospitals may continue to opt NOT to charge beneficiaries for noncovered services, and must only give notice when planning to charge.

## II. Use of HINN 11

Hospitals will only use HINN 11 when specific criteria are met. First, all criteria of regulations at 42 CFR 412.42 (d) must be in evidence, as follows:

- The item or service at issue must be a diagnostic or therapeutic service excluded from coverage as medically unnecessary, and
- The beneficiary must require continued hospital inpatient care.

When these conditions apply, any type of Medicare facility providing hospital-level inpatient care to beneficiaries under the Original Medicare program may use this notice.

Second, related to the first bullet above, HINN 11 is only used for items or services when there is published Medicare coverage policy-- national or local-- confirming the item or service is noncovered based on a medical necessity determination. Local policy is formulated by intermediaries; therefore, intermediaries should be contacted for more information. National coverage policy can be found at the Centers for Medicare and Medicaid Services (CMS) coverage Web site at:

http://www.cms.hhs.gov/center/coverage.asp

There is information at this site on how a national coverage determination can be obtained for any new procedure.

Finally, there are also Medicare payment policy requirements for use of this form. First, the inpatient stay must be covered, since if the stay was or had become noncovered, other notification requirements would apply (for example, HINN 1). Second, the item or service in question must not be bundled into or integral to payment or treatment for the diagnoses/reasons justifying the covered inpatient stay. If needed, hospitals should contact their intermediaries to assure item(s) or service(s) listed on HINN 11 are distinct from any care considered packaged into the inpatient stay.

## III. Delivery of HINN 11

Delivery of HINN 11 must meet the basic delivery standards of other HINNs.

> **NOTE:** There is no period to wait before HINN 11 becomes effective, such as the 1-3 day period hospitals must wait after the delivery of other HINNs addressing entire stays. HINN 11 is immediately effective if understood and signed by the beneficiary or his/her representative.

> **NOTE:** When referring to the entity that receives the notice, the term "beneficiary" means "beneficiary and his/her representative".

Current HINN instructions are found in 2005 CMS transmittal 594, Section V. of the attachment to the business requirements. In short, the hospital staff must go over the HINN letter with the beneficiary before signature and ensure that the individual understands the HINN before signing it. This HINN should be kept on file in medical records.

Providers must give a copy of the completed notice to the beneficiary, and must also give a copy to the beneficiary's attending physician. Copies must be given to intermediaries or Quality Improvement Organizations (QIOs) upon request.

## IV. Model Language

Since all HINNs are produced in model language, they have not been subject to clearance under the Paperwork Reduction Act, and in fact pre-date that Act. CMS cannot prohibit changes, but any adaptation of the CMS model could lead to a finding that notice was invalid if the mandatory elements listed below in section VII are either missing or unintelligible. Intermediaries also have limited discretion to find HINN 11 invalid for other reasons that they deem extraordinary/could not have been foreseen.

## V. Completion of the HINN 11

General and HINN 11 specific form preparation and completion instructions follow.

**A. General Instructions**. As with comparable notices, legal or letter-size paper may be used for reproduction of this letter. All information should remain on the same page as it appears in this instruction, with the exception to go to a third page noted below. Hospitals should use the exact font

given in the notice, Times New Roman, 12 point, if possible, or another as close to the font shown in these instructions as possible. The font should be at least 12 point in size, 18 point font for the title. A visually high-contrast combination of dark ink on a pale background must also be used. Do not use font effects, such as bolding, italicizing, or highlighting, other than those appearing in this instruction.

Entries for all blanks on the notices can be hand-written, but handwriting must be legible. The handwriting should be no smaller than approximately font size 10. If typing entries to the notice, font size 12 is recommended, but 10 is permitted.

**B. HINN-11 Specific Instructions.** The model letter itself appears at the end of this attachment. Other general guidance for the reproduction of this specific letter:

- The letter is produced as a two-page document, but it may be produced as 3 pages if needed to complete the content requirements, such as additional lines for logos, long names or titles; however, new or superfluous content should not be added to the form.
- The form can be reproduced as two or more separate pages, or the front and back of the same page.
- Blanks in the letter are either labeled immediately under the blank as to what information should be entered, or instructions appear below on completion of unlabelled blanks in order of their appearance on the letter.
- Text in *SHADOWED SMALL CAPS* should be removed before reproducing the letter.
- The following detailed instructions for completing the letter are in three parts: the header section on the first page, the remainder of the first page, and the second page.

**1. Header Section (Page 1 from Top to "*Insert Hospital Letterhead…*")**

Retain the HINN 11 title. Remove the instruction about inserting the letterhead. Insert hospital letterhead, logo and/or basic contact information: hospital name, address and telephone number. If the letterhead or logo does not provide the contact information, it must be added.

**2. Instructions for Completing Page 1 (Remainder of Page after Header)**

**Top Section.** Complete the first box containing seven labeled blanks: the name of the patient or representative and two blanks for his/her address information, his/her Medicare or health insurance claim (HIC) number, the date of the notice (the date it is given to the beneficiary or representative), the admission date of this hospital stay and name of the beneficiary's attending physician.

**Middle Section.** Each blank unlabelled in the letter itself is filled with a temporary reference to a Blank number and subject in *SHADOWED SMALL CAPS*. Remove these temporary references and then complete the first four unlabeled blanks as follows:

| | |
|---|---|
| **Blank 1** | Insert the name(s) of the applicable medically unnecessary diagnostic or therapeutic service(s). |
| **Blank 2** | Specify the reason for noncoverage of these services, such as: "according to Medicare national coverage decision, this service is medically unnecessary". |
| **Blank 3** | Provide justification of the assessment of noncoverage by briefly |

| | |
|---|---|
| | describing and giving a citation to the appropriate Medicare coverage policies or guidelines. |
| **Blank 4** | Fill in the patient financial responsibility by giving the best estimate of the total dollar amount the beneficiary will be charged for this/these service(s). |

**Bottom Section.** The boxed signature area at the end of the page should be completed by the beneficiary when comprehending the notice after review with hospital staff. The beneficiary must sign the boxed signature line at the end of the page, though hospital staff may enter the date for that person if needed.

### 3. Instructions for Completing Page 2

**Top Section.** The first part of this page gives a general description of the appeal rights available and refunds required in accordance with 42 CFR 412.42(d). There are no blanks to complete in this section.

> **NOTE:** There is no QIO immediate review/appeal option with HINN 11 as with other HINNs.

**Lower Section.** This section gives general information on the intermediary and QIO roles. Remove the temporary references in Blanks 5 and 6, and otherwise complete these blanks as follows:

| | |
|---|---|
| **Blank 5** | Provide the name of the applicable Medicare intermediary and the 1-800-Medicare number for beneficiary questions. |
| **Blank 6** | Provide the name, address and telephone number of QIO for the State. |

**Final Signature.** This is a blank for a signature from appropriate hospital personnel approving delivery of this notice. Having removed the temporary reference information in Blank 7, complete the blank as follows:

| | |
|---|---|
| **Blank 7** | Have the appropriate hospital staff person, chairperson of the utilization review committee, etc., sign the line. Print the name and title of the person under the signature line. |

## VI. Procedures After Signature

HINN 11 documents the beneficiary's consent to accept financial liability for a noncovered procedure, or procedures, unlike other HINNs that relate to entire stays. If after signing HINN 11, but before the actual procedure itself is performed, the beneficiary changes his/her mind, or if the hospital decides against delivering the procedure for whatever reason, HINN 11 should be annotated appropriately and retained in the file.

Funds may be collected after the form is signed, but beneficiaries should be advised in advance if hospitals plan to collect funds prior to discharge. If the service(s) in question are found to be covered, all related monies collected from the beneficiary must be refunded.

## VII. Oversight

Unlike other HINNs, there will not be automatic review of HINN 11 by QIOs. QIOs will exercise medical judgment by reviewing this new HINN and related cases only when specifically requested by the involved beneficiary, beneficiary representative, or intermediary when they receive a complaint. Intermediaries make such requests of QIOs as needed to avoid duplicating QIO expertise on medical necessity relative to hospital inpatients.

Intermediaries have the discretion to review this HINN for other than inpatient hospital stays if relevant to a claim being reviewed as part of the progressive corrective action process (IOM Pub. 100-8 Chapter 8). The intermediaries shall include this cost as part of the review of the claim. If requests for review are not made, and if the intermediary does not review for another reason, the notice will be considered valid, and such validity can only be revisited if a related claim appeal is filed. If requests for review are not made, and if the intermediary does not review for another reason, the notice will be considered valid, and such validity can only be revisited if a related claim appeal is filed.

When reviewing HINN 11, intermediaries only determine if adequate notice was given and related instructions were followed. Review may be similar to that done for other liability notices, such as the Advance Beneficiary Notice (ABN). At minimum, the intermediary will ensure the HINN 11 model language letter conveys the following information:

- The basis of the determination that a specific inpatient hospital procedure is not necessary or reasonable (i.e., coverage exclusions) based on published Medicare coverage policy;
- The determination is the hospital's opinion, which Medicare can confirm by making a payment determination on a related claim;
- Customary charges will be made if the beneficiary receives the services for which the beneficiary will be liable;
- The beneficiary may request that the intermediary or QIO review the validity of the hospital's opinion if the beneficiary receives the services (only the QIO reviews when medical judgment is involved). The intermediary performs such review by adjudicating the related claim, and the QIO only when contacted by the beneficiary, responding to the beneficiary and relaying any actionable findings to intermediary;
- Any determination made by the intermediary or the QIO may be appealed by the beneficiary though the standard claims appeal process. The hospital and the attending physician when acting for the beneficiary, also may appeal through this process as in noted in 42 CFR 412.42 (d); and
- Any charges for the services will be refunded if they are found to be covered by Medicare.

The intermediary will also ensure that the hospital’s use of the notice conforms to the requirements of II. above.

*[HINN 11 FOLLOWS STARTING AT THE TOP OF THE NEXT PAGE.]*

**Letter 11 - Model HINN - Noncovered Service(s) during Covered Stay**

*INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION*

| | |
|---|---|
| ______________________________ | ______________________________ |
| Name of Patient or Representative | Date of Notice |
| ______________________________ | ______________________________ |
| Street Address | Admission Date |
| ______________________________ | ______________________________ |
| City, State, Zip Code | Attending Physician |
| ______________________________ | |
| Health Insurance Claim (HIC) Number | |

**YOUR IMMEDIATE ATTENTION IS REQUIRED**

The purpose of this notice is to inform you that: __*(BLANK_1 - SERVICE NAME)*__________________________ is/are not covered under Medicare because: _*(BLANK_2 - REASON FOR NONCOVERAGE)*______________________________. Our opinion was based upon the following Medicare policy we and our Medicare intermediary follow: __________*(BLANK 3 - JUSTIFICATION OF ASSESSMENT OF NONCOVERAGE)*__________________________. **If you decide to receive the service(s) listed above, based on our customary charges for this/these service(s), you will have payment responsibility for:** __*(BLANK 4 - PATIENT FINANCIAL RESPONSIBILITY)*______________________. Your attending physician has been advised of our opinion. You should talk with your physician about your health care needs, including the service(s) listed above.

**RECEIPT OF THIS NOTICE**

This notice is not an official Medicare decision. Your signature below only shows you have received the notice and understand what you may have to pay for. **On the next page is information to use if you get the service(s) and you want to ask Medicare if it agrees with our opinion.** Note we will also give a copy of this notice to your physician listed above. Call 1-800-MEDICARE (1-800-633-4227) if you have questions about this notice.

| | |
|---|---|
| ________________________________________ | ____________ |
| Signature of Beneficiary or Representative | Date |

**YOUR RIGHT TO A MEDICARE REVIEW (APPEAL):**

You can ask us to file a Medicare claim for the service(s) listed on this notice. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this/these service(s), and how to ask for an appeal of that decision if Medicare does not pay.

- If Medicare has covered your hospital stay, it reviews any individual service it does not cover during that stay, only after you file a claim.
- If you appeal and Medicare decides to pay despite our opinion, any charges we collected will be refunded to you.
- You can ask your physician among others to represent you in filing an appeal.

**Your Medicare intermediary** does the formal review and makes the payment decision on the service(s) listed on this notice when processing the related claim. If you have questions on that claim or the MSN for the service(s) listed on this notice, you can contact your intermediary. **Your intermediary contact information:**

_(BLANK 5 - INTERMEDIARY NAME, ADDRESS AND TELEPHONE NUMBER)_

______________________________.

**Quality Improvement Organizations (QIOs)** in each State do certain types of reviews for Medicare, including judging the need for certain medical services and quality of care. You can ask your QIO in your State to review the service(s) listed on this notice after you have received them. **Your QIO contact information:**

_(BLANK 6 - QIO NAME, ADDRESS AND TELEPHONE NUMBER)_

______________________________.

Sincerely,

_(BLANK 7 - HOSPITAL SIGNATURE)_

## 40.2.2 - Charges to Beneficiaries for Part A Services

***(Rev. 982, Issued: 06-16-06; Effective/Implementation Dates: 09-18-06)***

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 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. *If limitation of liability applies, a beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 of this manual. For related notices for inpatient hospitals, see CMS Transmittal 594, Change Request3903, dated June 24, 2005.*

**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. *Notification may be required under limitation of liability. See CMS Transmittal 594, Change Request3903, dated June 24, 2005, section V. of the attachment, for specific notification requirements. Note this transmittal will be placed in Chapter 30 of this manual at a future point. Chapter 1, section 150 of this manual also contains related billing information in addition to that provided below.*

*In general, after proper notification has occurred, and assuming an expedited decision is received from a Quality Improvement Organization (QIO),* the following entries are required on the bill *the hospital prepares:*

- 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 3l (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 *proper notification occurs (see* subsection C*)*.

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 *another* 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*, limitation of liability may apply. See 2005 CMS transmittal 594, section V. of the attachment, for specific notification requirements.*

*NOTE: this transmittal will be placed in Chapter 30 of this manual at a future point.*

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

- Occurrence code 3l (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 3l (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 *according the procedures given in CMS Transmittal 594, Change Request3903, dated June 24, 2005.*

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 3l (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, the hospital may collect the additional charge if it informs the beneficiary of 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.