n05670

# Medicare A/B Rebill

## *Values*

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration


## Abstract Purpose:

This reimbursement policy outlines Network Health's process, for Medicare Part B services, when the inpatient hospital stay is denied for not meeting medical necessity.


## Policy Detail:

I. For Medicare products for which the Part A hospital inpatient admission was determined not reasonable and necessary, a rebill may be submitted within one hundred and twenty days (120) from notice of denial.

II. Part B inpatient and Part B outpatient claims that are filed later than one calendar year after the date of service should not be rejected as untimely by Medicare's claims processing system, as long as the corresponding denied Part A inpatient claim was filed timely and as long as one of the below criteria is met:

A. If a provider appealed the medical necessity denial and:

1. Withdraws the appeal, the provider will have one hundred and twenty days (120) from the date of receipt of the dismissal notice to file it's Part B claim(s).

2. The provider has one hundred and twenty days (120) from the date of receipt of the final or binding unfavorable appeal decision (or subsequent dismissal notice following a withdrawal) to submit its Part B claim(s).

3. If a provider receives a denial for a Part A hospital inpatient claim subject to the Ruling but does NOT appeal, it will have one hundred and twenty days (120) from the date of receipt of the initial or revised determination on the Part A claim (that is, the date of the remittance advice) to submit its Part B claim(s).

B. Services prior to the inpatient admission are outpatient services and may not be included on the 012X bill type.

C. Services provided after the admission are inpatient services and may not be included on the 013X bill type. All authorization requirements apply.

D. Two claims may be necessary for submission dependent upon whether outpatient services were rendered prior to the admission.

III. Providers must submit the claim as follows for A/B rebill reimbursement:

A. Bill type 012X with condition code W2
    1. When bill type 0121 is submitted, standard timely filing limitations apply.
    2. When bill type 0127 is submitted, the services will be manually reviewed for claims payment. This will ensure the claim does not deny in error for timely filing, or as a duplicate billing.
        i. Condition code(s) D0-D4, D7-D9 or E0 must be billed in conjunction with all XX7 bill types.
        ii. If one of these condition code(s) is not listed, the claim will be denied with Claim Adjustment Reason Code (CARC) 5 "*The procedure code/type of bill is inconsistent with the place of service*."

B. ABREBILL must be indicated in the Treatment Authorization field on the claim.

## Definitions:

**AB Rebill** – Allows hospitals to rebill for ninety percent (90%) of the Part B payment when a Medicare contractor denies a Part A inpatient short stay claim as not reasonable and necessary.

## Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)

## Related Policies:

Claim Submission Policy

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