Guidelines for billing acute inpatient noncovered days

Billing acute inpatient noncovered provider liable days

If an acute care hospital determines the entire admission is non-covered and the provider is liable, bill as follows:

* Type of bill – 11X (Full provider liable claim)
* Admit date – Date the patient was actually admitted (not the deemed date)
* From & through dates - This span of dates should include all days
* Noncovered days - The entire length of stay should be entered as noncovered
* Occurrence span code M1 – The first provider liable day through the last provider liable day
* Revenue code - Room & board revenue code line report as follows:
* Total units should equal the total number of days.
* Noncovered units should equal the total days.
* Total charge should equal the rate times the total number of units.
* Noncovered charge should equal the rate times the number of noncovered days.

Billing acute partial inpatient noncovered provider liable days

If an acute care hospital determines a portion of the admission is noncovered and the provider is liable, bill as follows:

* Type of bill – 11X
* Admit date – Date the patient was actually admitted (not the deemed date)
* From & through dates - This span of dates should include all days, both covered and noncovered
* Covered days – The portion of the stay in which the patient received medically necessary services
* Noncovered days – The portion of the stay in which the provider is liable due to the services rendered were not medically necessary
* Occurrence span code M1 – The first provider liable day through the last provider liable day
* Revenue code - Room & board revenue code line report as follows:
* Total units should equal the total number of days.
* Covered units should equal the total days minus the noncovered days (Provider Liable Days).
* Total charge should equal the rate times the total number of units.
* Noncovered charge should equal the rate times the number of noncovered days.

Billing acute inpatient noncovered beneficiary liable days

If an acute care hospital determines that a portion of the admission, or the entire admission, is noncovered and the beneficiary is liable, bill as follows:

* Type of bill – 11X.
* Admit date – Date the patient was actually admitted (not the deemed date).
* From & through dates - This span of dates should include all days, both covered and noncovered.
* Covered days – Report only days the patient was at a covered level of care. If the entire stay is noncovered, report zero covered days.
* Noncovered days – Report all the days that are noncovered for the duration of the stay.
* Occurrence span code 76 - The first beneficiary liable day through the last beneficiary liable day.
* Occurrence code 31 – The date the facility provided notice to the beneficiary.
* Value code 31 – The amount charged to the beneficiary for noncovered services.
* Revenue code - Room & board revenue code line report as follows:
* Total units should equal the total number of days.
* Covered units should equal the total days minus the noncovered days.
* Total charge should equal the rate times the total number of units.
* Noncovered charges should equal the rate times the number of noncovered days.

The above instructions do not apply to benefits exhaust billing.

For benefits exhaust please refer to:

* [CMS IOM Pub. 100-04 Medicare Claims Processing Manual, Chapter 3, Inpatient hospital billing section 190.12.1 - Benefits exhaust](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf)
* [CMS IOM Pub. 100-4 Medicare Claims Processing Manual Chapter 4, Part B Hospital (Including inpatient hospital Part B and OPPS), Section 240.2 - Editing of hospital Part B inpatient services: Other circumstances in which payment cannot be made under Part A](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf)

To assist us with understanding the reason for noncovered billing, you may include one of these recommended remarks:

* Benefits exhausted.
* DGME (Direct graduate medical education).
* Does not meet medical necessity for inpatient stay criteria.
* Lower level of care, non-acute care, non-skilled, MCR rejection or cardiac rehab.
* Provider/beneficiary liable.
* No Part A entitlement.
* No pay, noncovered or non-billable procedure.

Reference

* [CMS IOM Pub. 100-4 Medicare Claims Processing Manual Chapter 4, Part B Hospital (Including inpatient hospital Part B and OPPS), Section 240.1 - Editing of hospital Part B inpatient services: Reasonable and necessary Part A hospital inpatient denials](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf)