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 (do not include the discharge date if billing patient status other than 30).
* Examples:
* If the date of service (DOS) is 10/15/2023 - 10/31/2023 with the first provider liable day as 10/15/2023 and the patient status is anything other than 30, report the M1 span dates as 10/15/2023 - 10/30/2023.
* If the DOS is 10/15/2023 - 10/31/2023 with the first provider liable day as 10/15/2023 with patient status 30, report the M1 span dates as 10/15/2023 - 10/31/2023.
* If the DOS is 10/15/2023 - 10/15/2023 with the first provider liable day as 10/15/2023 and the admit and discharge date are the same, the M1 span dates are the same. Report M1 span dates as 10/15/2023-10/15/2023.
* 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 (do not include the discharge date if billing patient status other than 30)
* Examples:
* If the DOS is 10/1/2023 - 10/31/2023 with the first provider liable day as 10/15/2023 and patient status is anything other than 30, report the M1 span dates as 10/15/2023 - 10/30/2023.
* If the DOS is 10/1/2023 - 10/31/2023 with the first provider liable day as 10/15/2023 with patient status 30, report the M1 span dates as 10/15/2023 - 10/31/2023.
* 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. Please refer to the [CMS IOM Pub. 100-04 Medicare Claims Processing Manual, Chapter 3, sections 20.7.4 (acute care hospital - ACH), 140 (inpatient rehabilitation facilities - IRF), 190 (long term care hospitals - LTCH).](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf%22%20%5Co%20%22CMS%20Pub.%20100-04%2C%20Chapter%203%22%20%5Ct%20%22_blank)

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