CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11731	**Date: December 9, 2022**
	Change Request 12992

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 1, Section 90, to include Critical Access Hospitals (CAHs) for a Portion of a Medicare Advantage (MA) Billing Period

I. SUMMARY OF CHANGES: The purpose of this change request is to update chapter 1 of the Medicare Claims Processing manual for clarification in section 90.

EFFECTIVE DATE: January 11, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 11, 2023

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	1/90 Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11731	Date: December 9, 2022	Change Request: 12992

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 1, Section 90, to include Critical Access Hospitals (CAHs) for a Portion of a Medicare Advantage (MA) Billing Period

EFFECTIVE DATE: January 11, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 11, 2023

I. GENERAL INFORMATION

A. Background: This change request constitutes an update to Pub. 100-04, Chapter 1, Section 90 Patient Is a Member of a MA Organization for Only a Portion of the Billing Period for the Billing Requirements of the Medicare Claims Processing manual for clarification.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12992.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 1, Section 90.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov , Tracey Mackey, Tracey.Mackey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

90 - Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

(Rev. 11731, Issued: 12-09-22, Effective: 01-11-23, Implementation: 01-11-23)

Where a patient either enrolls or disenrolls in an MA organization (See Pub. 100-01, the General Information, Eligibility, and Entitlement Manual, Chapter 5, §80 for definition) during a period of services, two factors determine whether the MA organization is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS, and
- The date of enrollment.

Hospital Services

If the provider is an inpatient acute care hospital, inpatient rehabilitation facility or a long term care hospital, and the patient changes MA status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability.

If the hospital inpatient was not an MA enrollee upon admission but enrolls before discharge, the MA organization is not responsible for payment.

For hospitals exempt from PPS (children's hospitals, cancer hospitals, *CAHs* and Maryland waiver hospitals), if the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When forwarding a bill to an MA organization, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the MA organization is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Home Health

If the patient was enrolled in the MA organization before start of care, the MA organization is liable until disenrollment. Upon disenrollment, an episode must be opened under home heath PPS for billing to the FI.

If the beneficiary was not an MA enrollee upon admission but enrolls before discharge, the home health PPS episode will end as of the day before the MA enrollment. The episode will be proportionately paid according to its shortened length (i.e., paid a partial episode payment [PEP] adjustment). The MA organization is responsible for payment as of the MA enrollment date.