CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 232	**Date: December 22, 2016**
	Change Request 9930

SUBJECT: January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Change Request implements the manual changes only for Chapter 1, section 10, *Covered Inpatient Hospital Services Covered Under Part A* of the Benefits Policy Manual, Pub. 100-02.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

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	1/10/Covered Inpatient Hospital Services Covered Under Part A

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. 100-02	Transmittal: 232	Date: December 22, 2016	Change Request: 9930

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I. GENERAL INFORMATION

A. Background: This Change Request implements the manual changes only for Chapter 1, section 10, *Covered Inpatient Hospital Services Covered Under Part A* of the Benefits Policy Manual, Pub. 100-02.

B. Policy: This is a clarification to the Benefits Policy Manual, Pub. 100-02, Chapter 1, section 10, *Covered Inpatient Hospital Services Covered Under Part A.*

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	
9930 - 02.1	Medicare contractors shall refer to Pub.100-02, Medicare Benefit Policy Manual, chapter 1, section 10 for the latest revisions.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9930 - 02.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

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

"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): Marina Kushnirova, marina.kushnirova@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

Medicare Benefit Policy Manual
Chapter 1 - Inpatient Hospital Services Covered Under Part A

(Rev.232, Issued: 12-22-16)

10 - Covered Inpatient Hospital Services Covered Under Part A
(Rev. 232, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals. See Pub. 100-1, Chapter 8, §10.1, "Hospital Providers of Extended Care Services."). However, both inpatient hospital and inpatient SNF benefits are provided under Part A - Hospital Insurance Benefits for the Aged and Disabled, of Title XVIII).

Additional information concerning the following topics can be found in the following manual chapters:

- Benefit periods is found in Chapter 3, "Duration of Covered Inpatient Services";
- Copayment days is found in Chapter 2, "Duration of Covered Inpatient Services";
- Lifetime reserve days is found in Chapter 5, "Lifetime Reserve Days";
- Related payment information is housed in the Provider Reimbursement Manual.

Blood must be furnished on a day which counts as a day of inpatient hospital services to be covered as a Part A service and to count toward the blood deductible. Thus, blood is not covered under Part A and does not count toward the Part A blood deductible when furnished to an inpatient after the inpatient has exhausted all benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the patient is discharged on their first day of entitlement or on the hospital's first day of participation, the hospital is permitted to submit a billing form with no accommodation charge, but with ancillary charges including blood.

The records for all Medicare hospital inpatient discharges are maintained in CMS for statistical analysis and use in determining future PPS DRG classifications and rates.

Non-PPS hospitals do not pay for noncovered services generally excluded from coverage in the Medicare Program. This may result in denial of a part of the billed charges or in denial of the entire admission, depending upon circumstance. In PPS hospitals, the following are also possible:

1. In appropriately admitted cases where a noncovered procedure was performed, denied services may result in payment of a different DRG (i.e., one which excludes payment for the noncovered procedure); or

2. In appropriately admitted cases that become cost outlier cases, denied services may lead to denial of some or all of an outlier payment.

The following examples illustrate this principle. If care is noncovered because a patient does not need to be hospitalized, the intermediary denies the admission and makes no Part A (i.e., PPS) payment unless paid under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider **and** the beneficiary were **not** aware the services were not necessary and could not reasonably be expected to know that he services were not necessary. For detailed instructions, see the Medicare Claims Processing Manual, Chapter 30,"Limitation on Liability." If a patient is appropriately hospitalized but receives (beyond routine services) only noncovered care, the admission is denied.

NOTE: The intermediary does not deny an admission that includes covered care, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for **only** the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided.

If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If noncovered procedures are elevating costs into the cost outlier category, outlier payment is denied in whole or in part.

When the hospital is included in PPS, most of the subsequent discussion regarding coverage of inpatient hospital services is relevant only in the context of determining the appropriateness of admissions, which DRG, if any, to pay, and the appropriateness of payment for any outlier cases.

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program. If the items or services were requested by the patient, the hospital may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will *require hospital care that is expected to span at least two midnights* and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use *the expectation of the patient to require hospital care that spans at least two midnights* period as a benchmark, i.e., they should order admission for patients who *are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.* However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Renal Dialysis - Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Patients staying at home, who are ambulatory, whose conditions are stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. On the other hand, patients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Refer to Parts 4 and 7 of the QIO Manual with regard to initial determinations for these services. The QIO will review the swing bed services in these PPS hospitals as well.

NOTE: When patients requiring extended care services are admitted to beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services.