CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 182	**Date: March 21, 2014**
	Change Request 8666

SUBJECT: Implementing the Part B Inpatient Payment Policies from CMS-1599-F

I. SUMMARY OF CHANGES: Implementing revised policies related to payment of hospital Part B inpatient services from the Fiscal Year 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule, CMS-1599-F. This includes several conforming changes to the manual for payment of Part B inpatient services in skilled nursing facilities (SNFs). This document includes policy (not systems) changes to the Medicare Benefit Policy Manual, and is a companion piece to the recently issued CR 8445.

EFFECTIVE DATE: October 1, 2013
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2014

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/Table of Contents
R	6/10/Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
N	6/10.1/Reasonable and Necessary Part A Hospital Inpatient Claim Denials
N	6/10.2/Other Circumstances in Which Payment Cannot Be Made Under Part A
N	6/10.3/Hospital Inpatient Services Paid Only Under Part B
R	8/70/Medical and Other Health Services Furnished to SNF Patients
R	15/250/Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

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 obliged 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: 182	Date: March 21, 2014	Change Request: 8666

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I. GENERAL INFORMATION

A. Background: When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired. The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospitals services furnished by nonparticipating hospitals. In this document, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

B. Policy: When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients. Part B payment may only be made if the beneficiary is enrolled in Part B and waiver of liability payment is not made.

This policy applies when a hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a "no pay" Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

For Part B inpatient services furnished by the hospital that are not paid under the hospital Outpatient Prospective Payment System (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment is made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

When payment cannot be made under Medicare Part A, Medicare continues to pay for Part B services included in the 3-day (1-day for hospitals not paid under the Inpatient Prospective Payment System (IPPS)) payment

window preceding the inpatient admission, including services requiring an outpatient status.

The Part B coverage and payment rules for individual services apply. Hospitals are required to maintain documentation to support the Part B services rendered and billed.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the IPPS, hospitals paid under the OPPS, LTCHs, inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, CAHs, children's hospitals, cancer hospitals, Maryland waiver hospitals and other facilities as provided by CMS. Hospitals paid under the OPPS must continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the services they received, the beneficiary may face greater cost sharing.

Timely filing restrictions apply for the Part B services billed. Claims that are filed beyond 1 calendar year from the date of service will be rejected as untimely and will not be paid.

CMS notes that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of ancillary Part B inpatient services specified in the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 6, Section 10.2).

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	
8666.1	Medicare contractor shall refer to Pub.100-02, Medicare Benefit Policy Manual, chapter 6, section 10, chapter 8, section 70, and chapter 15, section 250, for the latest revisions.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8666.2	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 one week of the availability of the provider education 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.	X				

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): Ann Marshall, ann.marshall@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.

Medicare Benefit Policy Manual
Chapter 6 - Hospital Services Covered Under Part B

Table of Contents
(Rev. 182, 03-21-14)

10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

Payment may be made under Part B for physician services and for the nonphysician medical and other health services *as provided in this section* when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. *This policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. In this section, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.*

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements *(see chapter 16, §170 of this manual, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider")*. A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

10.1 - Reasonable and Necessary Part A Hospital Inpatient Claim Denials

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, and if waiver of liability payment is not made, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

1) *Part B services paid under the outpatient prospective payment system (OPPS), excluding observation services and hospital outpatient visits that require an outpatient status. Hospitals that are excluded from payment under the OPPS are instead paid under their alternative payment methodology (e.g., reasonable cost, all inclusive rate, or Maryland waiver) for the services that are otherwise payable under the OPPS.*

2) *The following services excluded from OPPS payment, that are instead paid under the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients:*

    a. *Physical therapy services, speech-language pathology services, and occupational therapy services (see chapter 15, §§220 and 230 of this manual, "Covered Medical and Other Health Services,").*

    b. *Ambulance services.*

    c. *Prosthetic devices, prosthetic supplies, and orthotic devices paid under the DMEPOS fee schedule (excludes implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) and replacement of such devices).*

    d. *Durable medical equipment supplied by the hospital for the patient to take home, except durable medical equipment that is implantable.*

e. *Certain clinical diagnostic laboratory services.*

f. *Screening and diagnostic mammography services.*

g. *Annual wellness visit providing personalized prevention plan services.*

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, "Payment Window for Outpatient Services Treated as Inpatient Services"), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician's office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, "Laboratories Billing for Referred Tests").

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 "Time Limitations for Filing Part A and Part B Claims"). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.2 - Other Circumstances in Which Payment Cannot Be Made Under Part A

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

Part B payment could be made to a hospital for the medical and other health services listed in this section for inpatients enrolled in Part B if:

- *No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before or during the admission; or*

- *The patient was not otherwise eligible for or entitled to coverage under Part A (see chapter 16, §180 of this manual for services received as a result of non-covered services).*

Beginning in 2014, for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

The following inpatient services are payable under the OPPS:

- *Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;*

- *X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;*

- *Acute dialysis of a hospital inpatient with or without end stage renal disease (ESRD). The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §200.2, "Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)."*

- *Screening pap smears;*

- *Influenza, pneumococcal pneumonia, and hepatitis B vaccines;*
- *Colorectal screening;*
- *Bone mass measurements;*
- *Prostate screening;*
- *Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;*
- *Immunosuppressive drugs;*
- *Oral anti-cancer drugs;*
- *Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and*
- *Epoetin Alfa (EPO) that is not covered under the ESRD benefit.*

The following inpatient services are payable under the non-OPPS Part B fee schedules or prospectively determined rates listed:

- *Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);*
- *Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the applicable rate under Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §240.3, "Inpatient Part B Hospital Services - Implantable Prosthetic Devices");*
- *Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient's physical condition (DMEPOS fee schedule);*
- *Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15, §§220 and 230 of this manual, "Covered Medical and Other Health Services") (applicable rate based on the Medicare Physician Fee Schedule);*
- *Ambulance services (ambulance fee schedule); and*
- *Screening mammography services (Medicare Physician Fee Schedule).*

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, "Payment Window for Outpatient Services Treated as Inpatient Services"), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician's office), may not be billed by the hospital to Part B. Reference labs may be billed

only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, "Laboratories Billing for Referred Tests").

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for these services must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70, "Time Limitations for Filing Part A and Part B Claims"). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.3 - Hospital Inpatient Services Paid Only Under Part B

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The services listed in Chapter 15, §250 of this manual, "Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities," when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

In all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

70 - Medical and Other Health Services Furnished to SNF Patients
(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The medical and other health services listed below are covered under Part B when furnished by a participating SNF either directly or under arrangements to inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met).

Services payable under Part B are:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, "Covered Medical and Other Health Services," §220.1.4);
- Screening mammography services;
- Screening pap smears and pelvic exams;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Some colorectal screening;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors.
- Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

See Pub. 100-04, Medicare Claims Processing Manual chapter 6, for information on billing for these services. *See* §70.1 *of this chapter* for the conditions under which diagnostic services and radiological therapy furnished

by SNFs are covered. For coverage of total parenteral nutrition (TPN) and enteral nutrition (EN) as a prosthetic device, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, “Hospital Services Covered Under Part B,” and the Medicare National Coverage Determinations Manual, chapter 1, Part 3, §180.2.

Rental or purchase of durable medical equipment from SNFs for use in the patient’s home is covered under Part B in accordance with the provisions of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, “Hospital Services Covered Under Part B,” §80. DME rendered to inpatients of a SNF is covered as part of the prospective payment system and is not separately payable. For coverage of provider ambulance services, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, “Hospital Services Covered Under Part B".

Drugs, biologicals, and blood are not covered under Part B when furnished by a SNF.

Medicare Benefit Policy Manual
Chapter 15 - Covered Medical and Other Health Services

250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

There are several services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are:

Physicians' services (including the services of residents and interns in unapproved teaching programs);

Physician assistant services, furnished after December 31, 1990;

Certified nurse-midwife services, as described in §180, furnished after December 31, 1990; and

Qualified clinical psychologist services, as defined in §160, furnished after December 31, 1990;

Screening mammography services;

Screening pap smears and pelvic exams;

Screening glaucoma services;

Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations;

Colorectal screening;

Bone mass measurements; and

Prostate screening;

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient. The other services listed are not subject to bundling but, because they are excluded from the statutory definition of inpatient hospital services, may be covered only under Part B.

Payment may be made under Part B *to a hospital (or critical access hospital)* for *certain* medical and other health services *furnished to its inpatients as provided in Chapter 6, §10 of this manual, "Medical and Other Health Services Furnished to Inpatients of Participating Hospitals."*

Payment may be made under Part B for *certain medical and other health* services *if* the beneficiary is an inpatient of a skilled nursing facility (SNF) *as provided in chapter 8, §§ 70ff of this manual.*