

Medicare Benefit Policy Manual

Chapter 1 - Inpatient Hospital Services Covered Under Part A

Table of Contents *(Rev. 119, 01-15-10)*

[Transmittals for Chapter 1](#)

[Crosswalk to Old Manual](#)

- 1 – Definition of Inpatient Hospital Services
- 10 - Covered Inpatient Hospital Services Covered Under Part A
 - 10.1 - Bed and Board
 - 10.1.1 - Accommodations - General
 - 10.1.2 - Medical Necessity - Need for Isolation
 - 10.1.3 - Medical Necessity - Admission Required and Only Private Rooms Available
 - 10.1.4 - Charges for Deluxe Private Room
 - 10.1.5 - All Private Room Providers
 - 10.1.6 - Wards
 - 10.1.6.1 - Assignment Consistent With Program Purposes
 - 10.1.6.2 - Assignment Not Consistent With Program Purposes
 - 10.1.7 - Charges
- 20 - Nursing and Other Services
 - 20.1 - Anesthetist Services
 - 20.2 - Medical Social Services to Meet the Patient's Medically Related Social Needs
- 30 - Drugs and Biologicals
 - 30.1 - Drugs Included in the Drug Compendia
 - 30.2 - Approval by Pharmacy and Drug Therapeutics Committee
 - 30.3 - Combination Drugs
 - 30.4 - Drugs Specially Ordered for Inpatients
 - 30.5 - Drugs for Use Outside the Hospital
- 40 - Supplies, Appliances, and Equipment
- 50 - Other Diagnostic or Therapeutic Items or Services

- 50.1 - Therapeutic Items
- 50.2 - Diagnostic Services of Psychologists and Physical Therapists
- 50.3 - Diagnostic Services Furnished to an Inpatient by an Independent Clinical Laboratory Under Arrangements With the Hospital
- 50.4 - Diagnostic Services Furnished a Hospital Inpatient Under Arrangement With the Laboratory of Another Participating Hospital
- 60 - Services of Interns or Residents-In-Training
- 70 - Inpatient Services in Connection With Dental Services
- 80 - Health Care Associated With Pregnancy
- 90 - Termination of Pregnancy
- 100 - Treatment for Infertility
- 110 - Inpatient Rehabilitation Facility (IRF) Services*
 - 110.1 - Documentation Requirements*
 - 110.1.1 - Required Preadmission Screening*
 - 110.1.2 - Required Post-Admission Physician Evaluation*
 - 110.1.3 - Required Individualized Overall Plan of Care*
 - 110.1.4 - Required Admission Orders*
 - 110.1.5 - Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)*
 - 110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria*
 - 110.2.1 - Multiple Therapy Disciplines*
 - 110.2.2 - Intensive Level of Rehabilitation Services*
 - 110.2.3 - Ability to Actively Participate in Intensive Rehabilitation Therapy Program*
 - 110.2.4 - Physician Supervision*
 - 110.2.5 - Interdisciplinary Team Approach to the Delivery of Care*
 - 110.3 - Definition of Measurable Improvement*
- 120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
- 130 - Religious Nonmedical Health Care Institution (RNHCI) Services
 - 130.1 - Beneficiary Eligibility for RNHCI Services
 - 130.2 - Election of RNHCI Benefits
 - 130.2.1 – Revocation of RNHCI Election

130.2.2 – RNHCI Election After Prior Revocation

130.3 – Medicare Payment for RNHCI Services and Beneficiary Liability

130.4 - Coverage of RNHCI Items Furnished in the Home

130.4.1 - Coverage and Payment of Durable Medical Equipment Under the RNHCI Home Benefit

130.4.2 - Coverage and Payment of Home Visits Under the RNHCI Home Benefit

1 – Definition of Inpatient Hospital Services

(Rev. 1, 10-01-03)

Inpatient hospital services are defined in Title XVIII of the Social Security Act (the Act) and in the regulations (42 CFR 409.10):

A. Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

1. Bed and board.
2. Nursing services and other related services.
3. Use of hospital or CAH facilities.
4. Medical social services.
5. Drugs, biologicals, supplies, appliances, and equipment.
6. Certain other diagnostic or therapeutic services.
7. Medical or surgical services provided by certain interns or residents-in-training.
8. Transportation services, including transport by ambulance.

B. Inpatient hospital services does not include the following types of services:

1. Posthospital SNF care, as described in 42 CFR 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.
2. Nursing facility services, described in 42 CFR 440.155 that may be furnished as a Medicaid service under title XIX of the Act in a swing- bed hospital that has an approval to furnish nursing facility services.
3. Physician services that meet the requirements of 42 CFR 415.102(a) for payment on a fee schedule basis.
4. Physician assistant services, as defined in §1861(s)(2)(K)(i) of the Act.
5. Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act.

6. Certified nurse mid-wife services, as defined in §1861(gg) of the Act.
7. Qualified psychologist services, as defined in §1861(ii) of the Act.
8. Services of an anesthetist, as defined in 42 CFR 410.69.

**10 - Covered Inpatient Hospital Services Covered Under Part A
(Rev. 1, 10-01-03)
A3-3101, HO-210**

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 remain at least overnight 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 a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. 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.

10.1 - Bed and Board

(Rev. 1, 10-01-03)

A3-3101.1, HO-210.1

10.1.1 - Accommodations - General

(Rev. 1, 10-01-03)

A3-3101.1.A, HO-210.1.A

The program will pay the same amount for routine accommodations services whether the patient has a private room not medically necessary, a private room medically necessary (Medicare does not pay for deluxe accommodations in any case), a semiprivate room (2-, 3-, or 4-bed accommodations), or ward accommodations, if its ward accommodations are consistent with program purposes (see §10.1.6 below).

A provider having both private and semiprivate accommodations may nevertheless charge the patient a differential for a private room if:

- The private room is not medically necessary; and
- The patient (or relative or other person acting on their behalf) has requested the private room, and the provider informs them of the amount of charge at the time of the request.

The private room differential may not exceed the difference between the customary charge for the accommodations furnished and the most prevalent semiprivate accommodation rate at the time of the patient's admission.

Where the provider bills for a private room as a covered service, i.e., shows the charge for the room as a covered charge on the Form CMS-1450, the intermediary will deem the private room to be medically necessary. Where the provider, on the other hand, shows a private differential as a noncovered charge, the intermediary will assume that the private room is not medically necessary.

If the beneficiary (or their representative) protests a charge for the private room on the grounds that the privacy was medically necessary, such protest will, if not in written form, be reduced to writing and forwarded to the intermediary. The intermediary will then develop the facts and make a specific determination regarding the medical necessity of the private room. (If an intermediary receives many protests of this kind, the provider may need guidance on what constitutes medical necessity for privacy). If the protest is received after the claim is processed, it will be treated as a request for reconsideration.

If at any time in the course of development (or thereafter within the period when the determination is not administratively final), the provider acknowledges that the private room was medically necessary; the intermediary will make an immediate finding to this effect.

Where it is necessary to develop the medical necessity of a private room, the guidelines in subsections §§10.1.2 and 10.1.3 below will apply.

10.1.2 - Medical Necessity - Need for Isolation **(Rev. 1, 10-01-03)** **A3-3101.1.B, HO-210.1.B**

A private room is medically necessary where isolation of a beneficiary is required to avoid jeopardizing their health or recovery, or that of other patients who are likely to be alarmed or disturbed by the beneficiary's symptoms or treatment or subjected to infection by the beneficiary's communicable disease. For example, communicable diseases, heart attacks, cerebra-vascular accidents, and psychotic episodes may require isolation of the patient for certain periods. (See §10.1.3 below concerning medical necessity not based on need for isolation).

In establishing the medical necessity for isolation, the date of the physician's written statement is not controlling, nor is the presence of a written statement. The crucial question is whether a private room was ordered by the physician because it is necessary for the health of the patient himself or herself or of other patients. In the absence of such an order, a patient who requested the room with knowledge of the amount of the charge may be charged appropriately, even though a physician subsequently submits a statement that the room was medically necessary. There may be cases in which the physician's written statement of medical necessity, though dated after admission or even after discharge, merely confirms an order made informally at or before the time the beneficiary was admitted to the private room (e.g., the physician made arrangements by phone for the patient's admission, gave the diagnosis, and stated the beneficiary would need a private

room). In such cases, assuming that the private room was medically necessary, the lack of a written statement by the physician, or the fact that the written statement was prepared after discharge, would not be controlling. The patient may not be charged.

10.1.3 - Medical Necessity - Admission Required and Only Private Rooms Available
(Rev. 1, 10-01-03)
A3-3101.1.C, HO-210.1.C

A private room is considered to be medically necessary even though the beneficiary's condition does not require isolation if he/she needs immediate hospitalization (i.e., the beneficiary's medical condition is such that hospitalization cannot be deferred) and the hospital has no semiprivate or ward accommodations available at the time of admission.

It need not be considered whether semiprivate or ward accommodations were available in some other accessible hospital. Where medical necessity exists, the provider may not charge the beneficiary a private room differential until semiprivate or ward accommodations become available. Thereafter the provider may transfer the patient to the nonprivate accommodations, or allow them to continue occupancy of the private room, subject to an appropriate differential charge (described in §10.1.1 above) if they request the private room with knowledge of the amount of the charge.

If the admission could be deferred until semiprivate or ward accommodations become available, the beneficiary should be informed of the amount of the differential he/she must pay for a private room if he/she wishes to be admitted immediately. The beneficiary may be charged the specified differential if he/she has been admitted to the private room at their request (or at the request of their representative) with knowledge of the amount of the charge.

10.1.4 - Charges for Deluxe Private Room
(Rev. 1, 10-01-03)
A3-3101.1.D, HO-210.1.D

Beneficiaries found to need a private room (either because they need isolation for medical reasons or because they need immediate admission when no other accommodations are available) may be assigned to any of the provider's private rooms. They do not have the right to insist on the private room of their choice, but their preferences should be given the same consideration as if they were paying all provider charges themselves. The program does not, under any circumstances, pay for personal comfort items. Thus, the program does not pay for deluxe accommodations and/or services. These would include a suite, or a room substantially more spacious than is required for treatment, or specially equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. If the beneficiary (or representative) requests such deluxe accommodations, the provider should advise that there will be a charge, not covered by Medicare, of a specified amount per day (not exceeding the differential defined in the next sentence); and may charge the beneficiary

that amount for each day he/she occupies the deluxe accommodations. The maximum amount the provider may charge the beneficiary for such accommodations is the differential between the most prevalent private room rate at the time of admission and the customary charge for the room occupied. Beneficiaries may not be charged this differential if they (or their representative) do not request the deluxe accommodations.

The beneficiary may not be charged such a differential in private room rates if that differential is based on factors other than personal comfort items. Such factors might include differences between older and newer wings, proximity to lounge, elevators or nursing stations, desirable view, etc. Such rooms are standard 1-bed units and not deluxe rooms for purposes of these instructions, even though the provider may call them deluxe and have a higher customary charge for them. No additional charge may be imposed upon the beneficiary who is assigned to a room that may be somewhat more desirable because of these factors.

10.1.5 - All Private Room Providers

(Rev. 1, 10-01-03)

A3-3101.E, HO-210.1.E

If the patient is admitted to a provider which has only private accommodations, and no semiprivate or ward accommodations, medical necessity will be deemed to exist for the accommodations furnished. Beneficiaries may not be subjected to an extra charge for a private room in an all-private room provider.

10.1.6 - Wards

(Rev. 1, 10-01-03)

A3-3101.1.F, HO-210.1.F

The law contemplates that Medicare patients should not be assigned to ward accommodations except at the patient's request or for a reason consistent with the purposes of the health insurance program.

When ward accommodations are furnished at the patient's request or for a reason determined to be consistent with the program's purposes, payment will be based on the average per diem cost of routine services (see §10.1.1 above). Where ward accommodations are assigned for other reasons, the law provides what may be a substantial penalty. (See §10.1.6.2 below).

Any request by the patient (or relative or other person responsible for his or her affairs) for ward accommodations must be obtained by the provider in writing and kept in its files.

10.1.6.1 - Assignment Consistent With Program Purposes

(Rev. 1, 10-01-03)

A3-3101.1.F.1, HO-210.1.F.1

It is considered to be consistent with the program's purposes to assign the patient to ward accommodations if all semiprivate accommodations are occupied, or the facility has no semiprivate accommodations. However, the patient must be moved to semiprivate accommodations if they become available during the stay.

Some hospitals have a policy of placing in wards all patients who do not have private physicians. Such a practice may be consistent with the purposes of the program if the intermediary determines that the ward assignment inures to the benefit of the patient. In making this determination, the principal consideration is whether the assignment is likely to result in better medical treatment of the patient (e.g., it facilitates necessary medical and nursing supervision and treatment). The intermediary should ask a provider having this policy to submit a statement describing how the assignments are made, their purpose, and the effect on the care of patients so assigned.

If the intermediary makes a favorable determination on a practice affecting all ward assignments of Medicare patients in the institution, a reference should be made on the appropriate billing form for patients to whom the hospital assigned a ward pursuant to such practice.

10.1.6.2 - Assignment Not Consistent With Program Purposes

(Rev. 1, 10-01-03)

A3-3101.1.F.2, HO-210.1.F.2

It is not consistent with the purposes of the law to assign a patient ward accommodation based on their social or economic status, their national origin, race, or religion, or their entitlement to benefits as a Medicare patient, or any other such discriminatory reason. It is also inconsistent with the purposes of the law to assign patients to ward accommodations merely for the convenience or financial advantage of the institution. Additionally, under DRGs, there no longer is a reduction to payment or an adjustment to the end of year settlement.

10.1.7 - Charges

(Rev. 1, 10-01-03)

A3-3101.1.G, HO-210.1.G

Customary charges means amounts which the hospital or skilled nursing facility is uniformly charging patients currently for specific services and accommodations. The most prevalent rate or charge is the rate that applies to the greatest number of semiprivate or private beds in the institution.

20 - Nursing and Other Services

(Rev. 1, 10-01-03)

A3-3101.2, HO-210.2

Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered under hospital insurance and included in the Prospective Payment system payment.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services.

Where the hospital acts on behalf of a patient, the services of the private-duty nurse or other attendant under such an arrangement are not inpatient hospital services regardless of the control which the hospital may exercise with respect to the services rendered by such private-duty nurse or attendant.

20.1 - Anesthetist Services

(Rev. 1, 10-01-03)

A3-3101.2.A, HO-210.2.A

If the hospital engages the services of a nurse anesthetist or other nonphysician anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital, the cost of the service when provided to an inpatient could be covered under Part A. (See the Medicare Claims Processing Manual for more information.)

20.2 - Medical Social Services to Meet the Patient's Medically Related Social Needs

(Rev. 1, 10-01-03)

A3-3101.2.B, HO-210.2.B

Medical social services are services which contribute meaningfully to the treatment of a patient's condition. Such services include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the facility;
- Appropriate action to obtain case work services to assist in resolving problems in these areas; and
- Assessment of the relationship of the patient's medical and nursing requirements to their home situation, financial resources, and the community resources available to them in making the decision regarding their discharge.

30 - Drugs and Biologicals

(Rev. 1, 10-01-03)
A3-3101.3, HO-210.3

Drugs and biologicals for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients, are covered.

Three basic requirements must be met for a drug or biological furnished by a hospital to be a covered hospital service:

1. The drug or biological must represent a cost to the institution in rendering services to the beneficiary;
2. The drug or biological must meet the statutory definition. Under the statute, payment may be made for a drug or biological only where it is included, or approved for inclusion, in the latest official edition of the United States Pharmacopoeia-National Formulary (USP-NF), the United States Pharmacopoeia Drug Information (USP DI), or the American Dental Association (ADA) Guide to Dental Therapeutics, except for those drugs and biologicals unfavorably evaluated in the ADA Guide to Dental Therapeutics. Combination drugs are also included in the definition of drugs if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the above drug compendia. Drugs and biologicals are considered approved for inclusion in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium; or be approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital for use in the hospital; and
3. Use of the drug or biological must be safe and effective and otherwise reasonable and necessary as specified in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.

Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this last requirement when used for indications specified in the labeling. Therefore, use of an FDA-approved drug or biological is covered if:

- It was administered on or after the date of the FDA's approval;
- It is reasonable and necessary for the individual patient; and
- All other applicable coverage requirements are met.

Drugs and biologicals, which have not received final marketing approval by the FDA, are not covered unless CMS instructs the intermediary to the contrary. However, FDA-approved drugs are used for indications other than those specified on the labeling. As long as the FDA has not specified such use as nonapproved, coverage is determined

taking into consideration the generally accepted medical practice in the community. For example, the labeling of certain chemotherapeutic drugs indicates their use in the therapy of specified types of cancer. However, based on experience and empirical evidence, physicians may prescribe these drugs for a wider range of cancer treatments than what is indicated in the labeling. Local medical review policy may or may not grant coverage, depending on the circumstances.

Determinations as to whether use of a drug or biological is reasonable and necessary for an individual patient are the responsibility of the Quality Improvement Organization (QIO), if this is part of the review for a PPS acute care admission. However, if this is an excluded service claim being reviewed by the intermediary, the intermediary reviews and makes a determination, unless it cannot and needs to refer it to the QIO for an initial determination.

A hospital stay solely for the purpose of use of a drug or biological that is determined not reasonable and necessary is not covered.

30.1 - Drugs Included in the Drug Compendia

(Rev. 1, 10-01-03)

A3-3101.2.A, HO-210.3.A

Medicare covers only those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia as previously listed.

Where a drug is excluded from coverage because it is unfavorably evaluated in either the AMA Drug Evaluations or Accepted Dental Therapeutics, the exclusion applies to all uses for which the drug or biological was so unfavorably evaluated.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the procedure established by the professional organization responsible for revision of the compendium.

30.2 - Approval by Pharmacy and Drug Therapeutics Committee

(Rev. 1, 10-01-03)

A3-3101.3.B, HO-210.3.B

A pharmacy and drug therapeutics or equivalent committee is a medical staff committee that confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Drugs and biologicals approved for use in the hospital by such a committee are covered only if the committee develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee but may also carry on other medical staff functions.

Drugs and biologicals are considered approved for use in the hospital if selected for inclusion in the hospital drug list of formulary under the procedure of the committee

established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital does not constitute approval.

Drugs and biologicals are covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. Approval by a pharmacy and drug therapeutics committee is an alternative to approval for inclusion of the drug or biological in an approved drug compendium (see §30.1 above); such approval does not preclude the need for a determination of medical necessity. An investigational drug is not considered to meet the reasonable and necessary test since its efficacy has not yet been established.

The decision of individual hospitals should not transcend the determinations of the Food and Drug Administration and Public Health Service in respect to the safety and effectiveness of drugs. Therefore, even if approved by an appropriate hospital committee, the reasonable cost of an investigational or other nonapproved drug or biological (e.g., Laetrile) cannot be reimbursed. This exclusion from payment applies whether or not the drug or biological is administered during the course of an otherwise covered hospital stay, since payment may not be made for items and services that are not reasonable and necessary. A hospital stay solely for the purpose of administering a drug or biological that is not reasonable and necessary, including an investigational drug or biological, is not covered and the drug or biological itself is not covered.

30.3 - Combination Drugs

(Rev. 1, 10-01-03)

A3-3101.3.C, HO-210-3.C

Combination drugs are covered if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. **Any** combination drug approved for use in the hospital by the pharmacy and drug therapeutics or equivalent committee is covered.

30.4 - Drugs Specially Ordered for Inpatients

(Rev. 1, 10-01-03)

A3-3101.3.D, HO-210.3.D

Coverage is not limited to drugs and biologicals routinely stocked by the hospital; a drug or biological not stocked by the hospital, which the hospital obtains for the patient from an outside source, such as a community pharmacy, can also be covered.

Drugs and biologicals not included in the drug list or formulary maintained by the hospital's pharmacy and drug therapeutics committee may be covered if the hospital has a policy which permits such drugs to be furnished to a patient at the special request of a physician. However, in order to be covered, such drugs and biologicals must be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a

combination drug, or all of its therapeutic ingredients, would have to be included or approved for inclusion in one of the compendia.)

30.5 - Drugs for Use Outside the Hospital

(Rev. 1, 10-01-03)

A3-3101.3.E, HO-210.3.E

Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service.

40 - Supplies, Appliances, and Equipment

(Rev. 1, 10-01-03)

A3-3101.4, HO-210.4

Supplies, appliances, and equipment, which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during the inpatient hospital stay, are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered under Part A even though the supplies, appliances and equipment leave the hospital with the patient upon discharge. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are:

- Items permanently installed in or attached to the patient's body while an inpatient, such as cardiac valves, cardiac pacemakers, and artificial limbs; and
- Items which are temporarily installed in or attached to the patient's body while an inpatient, and which are also necessary to permit or facilitate the patient's release from the hospital, such as tracheotomy or drainage tubes.

Hospital "admission packs" containing primarily toilet articles, such as soap, toothbrushes, toothpaste, and combs, are covered under Part A if routinely furnished by the hospital to all its inpatients. If not routinely furnished to all patients, the packs are not covered. In that situation, the hospital may charge beneficiaries for the pack, but only if they request it with knowledge of what they are requesting and what the charge to them will be.

Supplies, appliances, and equipment furnished to an inpatient for use **only** outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item, which is medically necessary to permit or facilitate the patient's

departure from the hospital and is required until the patient can obtain a continuing supply, is covered as an inpatient hospital service.

Oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

50 - Other Diagnostic or Therapeutic Items or Services
(Rev. 1, 10-01-03)
A3-3101.5, HO-210.5

Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services.")

Such services to hospital inpatients may be covered under Part A even when furnished off the hospital premises. For example, diagnostic or therapeutic services of an audiologist off the hospital premises are covered if billed for by the hospital under arrangements (see Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §10.3, for further information concerning "under arrangements"), if the services are furnished at a speech and hearing center, and if the audiologist meets the qualifications for an audiologist:

- Is licensed if applicable by the State in which practicing; and
- Is eligible for a certification of clinical competence in audiology granted by the American Speech and Hearing Association; or
- Meets the education requirements for certification and is in the process of accumulating the supervised experience required for certification.

50.1 - Therapeutic Items
(Rev. 1, 10-01-03)
A3-3101.5.A, HO-210.5

Therapeutic items, which are covered when ordinarily furnished by the hospital to its inpatients, or when ordinarily furnished to hospital inpatients by others under arrangements with them made by the hospital, include but are not limited to the following:

- Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ; and

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

With respect to items that leave the hospital with the patient upon discharge, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

50.2 - Diagnostic Services of Psychologists and Physical Therapists

(Rev. 1, 10-01-03)

A3-3101.5.B, HO-210.5

When a psychologist or physical therapist is a salaried member of the staff of a hospital, their diagnostic or therapeutic services to inpatients of that hospital are covered. See the Medicare Claims Processing Manual for information on distinguishing between professional and technical services, and for information about billing and payment for nonphysician practitioners.

50.3 - Diagnostic Services Furnished to an Inpatient by an Independent Clinical Laboratory Under Arrangements With the Hospital

(Rev. 1, 10-01-03)

A3-3101.5.C, HO-210.5

Diagnostic services furnished to an inpatient by an independent clinical laboratory under arrangements with the hospital are reimbursable under hospital insurance provided the lab is certified by CLIA to perform the services.

An independent laboratory is one which is independent both of an **attending** or **consulting** physician's office and also independent of any hospital which meets at least the requirements to qualify as an emergency hospital (e.g., maintains clinical records, has a utilization review plan, meets the health and safety requirements found necessary by the Secretary of Health and Human Services).

A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.

A laboratory operated by or under the supervision of a hospital (or the organized medical staff of the hospital) that does not meet at least the definition of an emergency hospital is considered to be an independent laboratory. However, a laboratory serving hospital patients and operated on the premises of a hospital that meets the definition of an emergency hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not an independent laboratory. A laboratory that a physician or group of physicians maintains for performing diagnostic tests in connection with their own or the group practice is also not considered to be an independent laboratory.

An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a hospital that meets at least the definition of an emergency hospital or of the organized medical staff of such a hospital. Refer to “The Conditions of Participation for Hospitals” found at [42 CFR 482](#) and below for a description of independent lab approval requirements when the hospital is participating.

Where a laboratory operated on hospital premises is claimed to be independent or where an out-of-hospital facility is designated as a hospital laboratory, the CMS regional office makes the determination concerning the laboratory's status.

A clinical laboratory is a laboratory where microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

The "Conditions of Participation for Hospitals (HIRM-1)" call for independent clinical laboratory services furnished under arrangements made by a hospital to be furnished only by a laboratory meeting the specified conditions for coverage under the program. These require that:

- Where State or applicable local law provides for licensing of independent clinical laboratories, the laboratory is either licensed under law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories; and
- Such laboratories also meet the health and safety requirements prescribed by the Secretary of Health and Human Services. (See “The Conditions of Participation for Hospitals” at [42 CFR 482](#)).

Where independent laboratory services are provided to patients of a participating hospital under arrangements with the hospital, the law does not require as a condition of payment in an individual case that the independent laboratory be approved under the program. In processing individual claims, the intermediary, therefore, need not verify that the services were obtained from an approved laboratory. The intermediary should make payment for laboratory services although it may know that the laboratory from which the hospital has obtained the service is not approved under the program. However, it should promptly refer this information to the appropriate regional office for review of the determination of the hospital's compliance with the conditions of participation and for whatever action the regional office deems appropriate. The above policy applies to PPS exempt hospitals. Note that under PPS, there is no separate payment for lab services furnished to inpatients.

50.4 - Diagnostic Services Furnished a Hospital Inpatient Under Arrangement With the Laboratory of Another Participating Hospital

(Rev. 1, 10-01-03)
A3-3101.5.D, HO-210.5

Diagnostic services furnished a hospital inpatient under arrangements with the laboratory of another participating hospital are reimbursable on a cost basis under Part A to the hospital obtaining the services if the hospital is PPS exempt. If the hospital is not exempt, there is not separate payment for lab services furnished to inpatients.

NOTE: Where a PPS exempt hospital obtains diagnostic laboratory services for inpatients under arrangements described in §§50.3 and 50.4 the cost to the hospital obtaining the services would be the reasonable charge for the laboratory's service.

60 - Services of Interns or Residents-In-Training

(Rev. 1, 10-01-03)
A3-3101.6, HO-210.6

Hospital insurance covers the reasonable cost of the services of medical or osteopathic interns or residents-in-training under a teaching program approved by the appropriate approving body.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The services of interns and residents-in-training in the field of podiatry who are in a residency program approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association are covered on the same basis as the services of other interns and residents in other approved residency programs.

70 - Inpatient Services in Connection With Dental Services

(Rev. 1, 10-01-03)
A3-3101.7, HO-210.7

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital. In addition, hospital inpatient services, which are necessary because of the patient's underlying medical condition and clinical status or the severity of a noncovered dental procedure, are covered.

When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services are not covered. The

services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

80 - Health Care Associated With Pregnancy

(Rev. 1, 10-01-03)

A3-3101.12, HO-210.13

Reasonable and necessary services associated with pregnancy are covered and reimbursable under the Medicare program. Because pregnancy is a condition sufficiently at variance with the usual state of health, it is appropriate for a pregnant woman to seek medical care. The increased possibility of illness or injury accompanying this condition is well recognized, and medical supervision is required throughout pregnancy and for a brief period beyond. Skilled medical management is appropriate throughout the events of pregnancy, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care. Similarly, if the pregnancy terminates, whether spontaneously or for therapeutic reasons (i.e., where the life of the mother would be endangered if the fetus were brought to term), the need for skilled medical management and/or medical services is equally as important as in those cases carried to full term. After the infant is delivered, items and services furnished to the infant cannot be covered and reimbursed under the program on the basis of the mother's eligibility.

90 - Termination of Pregnancy

(Rev. 1, 10-01-03)

B3-4276.1,.2

Effective for services furnished on or after October 1, 1998, Medicare will cover abortions procedures in the following situations:

1. If the pregnancy is the result of an act of rape or incest; or
2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

NOTE: The "G7" modifier must be used with the following CPT codes in order for these services to be covered when the pregnancy resulted from rape or incest, or the pregnancy is certified by a physician as life threatening to the mother:

59840 59841 59850

59851 59852 59855

59856 59857 59866

100 - Treatment for Infertility

(Rev. 1, 10-01-03)

A3-3101.13

Effective for services rendered on or after January 15, 1980, reasonable and necessary services associated with treatment for infertility are covered under Medicare. Like pregnancy (see §80 above), infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally would be expected to be fertile to seek medical consultation and treatment. Contractors should coordinate with QIOs to see that utilization guidelines are established for this treatment if inappropriate utilization or abuse is suspected.

110 - Inpatient Rehabilitation Facility (IRF) Services

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR §§412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR §412.23(b)(2)(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care.

110.1 - Documentation Requirements

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

110.1.1 - Required Preadmission Screening

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a

preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in this section. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified and qualified to perform the evaluation within their scopes of practice and training. Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information. The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not on how the process is organized.

The "rehabilitation physician" need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician".

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's medical record at the IRF.

"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient's admission to the IRF.

110.1.2 - Required Post-Admission Physician Evaluation

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A post-admission physician evaluation of the patient must be performed by a

rehabilitation physician. The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in section 110.1.3). The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

What to do if there are differences between the preadmission screening and the post-admission physician evaluation (within the first 24 hours of admission to the IRF):

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient since the clinicians fully expect the patient to be able to participate in the intensive rehabilitation program the next day. Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either, for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the 3rd day following the patient's admission to the IRF

(considering the day of admission to be the 1st day) are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim for not meeting the criteria in section 110.2 of this chapter, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case mix group (CMG) for IRF patient stays of 3 days or less.

110.1.3 - Required Individualized Overall Plan of Care

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first 4 days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

110.1.4 - Required Admission Orders

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

110.1.5 - Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

- 1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.*
- 2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.*
- 3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected*

to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time.

- 4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.*
- 5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.*

110.2.1 - Multiple Therapy Disciplines

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

110.2.2 - Intensive Level of Rehabilitation Services

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not

intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient’s need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient’s need for this program of intensive rehabilitation are well-documented in the patient’s IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient’s level of need or tolerance, or compromise the patient’s safety. See below for a brief exceptions policy for temporary and unexpected events.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient’s needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient’s medical record at the IRF.

Brief Exceptions Policy—While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient’s IRF stay because patients’ needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient’s IRF stay that limits the patient’s ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient’s IRF medical record. If these reasons are appropriately documented in the patient’s IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical

necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

110.2.3 - Ability to Actively Participate in Intensive Rehabilitation Therapy Program

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

The information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program that is defined in section 110.2.2.

110.2.4 - Physician Supervision

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least 3 times per week. The required rehabilitation physician visits must be documented in the patient's medical record at the IRF.

110.2.5 - Interdisciplinary Team Approach to the Delivery of Care

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals (as defined below).

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services;*
- A registered nurse with specialized training or experience in rehabilitation;*
- A social worker or a case manager (or both); and*
- A licensed or certified therapist from each therapy discipline involved in treating the patient.*

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals;*
- Considering possible resolutions to any problems that could impede progress towards the goals;*

- *Reassessing the validity of the rehabilitation goals previously established; and*
- *Monitoring and revising the treatment plan, as needed.*

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. Documentation of each team conference must include the names and professional designations of the participants in the team conference. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

110.3 - Definition of Measurable Improvement

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in Section 110.2.2). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient's

safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

(Rev. 1, 10-01-03)

A3-3101.14, HO-210.12, B3-2300.1, A3-3101.14, HO-210.12

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" noncovered services (e.g., cosmetic surgery, noncovered organ transplants, noncovered artificial organ implants, etc.), including services related to follow-up care and complications of noncovered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare. Services "not related to" noncovered services are covered under Medicare.

Following are examples of services "related to" and "not related to" noncovered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a noncovered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.
- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a noncovered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a noncovered transplant or implant, the services related to the admitting condition would be covered.
- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the noncovered transplant, the services would be "related to" noncovered services and would also be noncovered.

Following is an example of services received subsequent to a noncovered inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior noncovered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous noncovered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, repair of complications from transsexual surgery or from cosmetic surgery, removal of a noncovered bladder stimulator, or treatment of any infection at the surgical site of a noncovered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

130 – Religious Nonmedical Health Care Institution (RNHCI) Services (Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Section 1821 of the Social Security Act provides for coverage of services furnished in a Medicare qualified religious nonmedical health care institution (RNHCI), when the beneficiary meets specific coverage conditions. The beneficiary must have a valid election for RNHCI services and would otherwise qualify for care in a conventional hospital or post hospital extended care facility that was not a religious nonmedical health care institution.

The RNHCI benefit provides only for Part A inpatient services. The Medicare program will only pay for nonmedical health care services furnished in RNHCI, as defined in Section 1861(ss)(1) of the Act and 42 CFR 403 Subpart G. The program does not pay for supporting religious services or payment for the religious practitioner. The cost of religious items/services and the cost of using a religious practitioner is a personal financial responsibility and not covered by Medicare.

130.1 – Beneficiary Eligibility for RNHCI Services (Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

A beneficiary may elect to receive care in an RNHCI based on his or her own religious convictions or to revoke that election at any time if for any reason he or she decides to pursue medical care. Section 1821(a) of the Act requires that as a condition for Part A Medicare coverage, the beneficiary must have a condition that would qualify under Medicare Part A for inpatient hospital services or extended care services furnished in a hospital or skilled nursing facility that is not an RNHCI if it were not for their religious convictions.

When a beneficiary has an effective election on file with CMS but does not have a condition that would qualify for Medicare Part A inpatient hospital or posthospital extended care services if the beneficiary were an inpatient of a hospital or a resident of a SNF that is not an RNHCI, then services furnished in an RNHCI are not covered by Medicare. A Medicare claim for services that were furnished to that beneficiary would be treated as a claim for noncovered services. If the beneficiary only needs assistance with activities of daily living, then the beneficiary's condition could not be considered as meeting the Medicare Part A requirements. Prior to submitting a claim to Medicare it is the responsibility of the RNHCI's utilization review committee to determine that the beneficiary meets the Medicare Part A requirements.

If no valid election is filed or the election has been revoked and no new election is in effect, the beneficiary does not have Medicare coverage for services furnished in an RNHCI. Consequently, a Medicare claim for services furnished to such a beneficiary would also be treated as a claim for noncovered services.

In those cases where a beneficiary is admitted to an RNHCI with a valid election, the submission of prior claim for medical services to the Common Working File will revoke the election during the course of the RNHCI stay. If this is the first revocation, the beneficiary may make a new election without any disruption to the benefit. If this, however, is the second or subsequent revocation, the applicable waiting period applies and the remainder of the stay is not covered by Medicare (see 130.2.2).

130.2 – Election of RNHCI Benefits

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

Religious non-medical care or religious method of healing means health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets to fulfill a beneficiary's total health care needs.

Medical care or treatment means health care furnished by or under the direction of a licensed physician that can involve diagnosing, treating, or preventing disease and other damage to the mind and body. It may involve the use of pharmaceuticals, diet, exercise, surgical intervention, and technical procedures.

The signed and notarized election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. The election is

effective on the date it is signed, and it remains in effect until revoked in writing or by the receipt and filing of a claim for nonexcepted medical treatment.

The completed election form must be filed with the specialty contractor, a copy retained by the RNHCI provider and a copy provided to the beneficiary. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 170 for instructions on submission of elections to the specialty contractor.

Section 1821 defines “excepted” medical treatment as medical care or treatment that is received involuntarily or is required under Federal, State or local law. The term is intended to identify the kinds of medical services that can be provided to a beneficiary with an election for RNHCI services without revoking the election.

Examples of excepted medical care include, but are not limited to the following:

- A beneficiary that receives vaccinations required by a State or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services; or
- A beneficiary who is involved in an accident and receives medical attention at the accident scene, or in transport to the hospital, or at the hospital before being able to make their beliefs and wishes known; or
- A beneficiary who is unconscious and receives emergency care and is hospitalized before regaining consciousness or being able to locate his or her legal representative.

“Nonexcepted” medical treatment is defined as medical care or treatment other than excepted medical treatment. The term is intended to define the kinds of medical services that, if received by a beneficiary who has previously elected RNHCI services, would revoke the individual's election of services.

Examples of nonexcepted medical care could include but are not limited to the following:

- A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains.
- A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture.
- A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services.
- A beneficiary who has requested a physician to prescribe a wheelchair or other durable medical equipment item.

Note that the terms 'excepted' and 'nonexcepted' care represent mutually exclusive conditions under §1821 of the Social Security Act. Medicare contractors may use the examples above in making determinations of excepted and nonexcepted care.

130.2.1 - Revocation of RNHCI Election

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Revocation is the cancellation of the RNHCI election and can be achieved in two ways: either by submitting a written statement to the intermediary indicating the desire to cancel the election or by seeking nonexcepted medical care for which Medicare payment is sought.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 170 for instructions on submission of revocations to the specialty contractor. See section 180 of that manual for a description of how Medicare non-specialty contractors revoke elections upon billing for nonexcepted services.

130.2.2 - RNHCI Election After Prior Revocation

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

After an initial revocation, the individual may again file a written election to receive the religious nonmedical health care benefit. This second election takes effect immediately upon its execution. If an individual revokes a second election, the next (third) election cannot become effective until 1 year after the date of the most recent revocation. Subsequent elections are not effective until 5 years after the most recent revocation. Once an election is revoked, Medicare payment cannot be made to an RNHCI unless a valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage.

130.3 - Medicare Payment for RNHCI Services and Beneficiary Liability

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Medicare pays for RNHCI services under TEFRA payment rules (see Pub. 15-2, Provider Reimbursement Manual, chapter 30). RNHCI services are subject to the inpatient hospital cash deductible, when applicable. If services are for the 61st through 90th day of a benefit period or are for lifetime reserve days, RNHCI services are subject to coinsurance (see Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Sections 10.1 and 10.2).

Under normal Medicare rules, a provider of services may only bill a beneficiary deductible and coinsurance amounts. However, total Medicare payments to RNHCIs are subject to limits established in sections 1821(c)(2) (A) or (B) of the Act. In the event that the Medicare program reduces payments to RNHCIs based on these limits, RNHCIs may also bill beneficiaries an amount equal to any such reduction.

130.4 - Coverage of RNHCI Items Furnished in the Home

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Prior to the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare program's RNHCI benefit was limited to inpatient services provided in an RNHCI facility. The MMA revised sections 1821(a) and 1861 of the Social Security Act to extend coverage to RNHCI items and services that are provided in a beneficiary's home and that are comparable to items and services provided by a home health agency that is not an RNHCI.

Beneficiaries elect the RNHCI benefit if they are conscientiously opposed to accepting most medical treatment, since accepting such services would be inconsistent with their sincere religious beliefs. The Medicare home health benefit provides skilled nursing, physical therapy, occupational therapy, speech language pathology and home health aide services to eligible beneficiaries under a physician's plan of care. The home health benefit also provides medical supplies, a covered osteoporosis drug and durable medical equipment (DME) while under a plan of care (see chapter 7).

Medicare covers specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. These services comprise the RNHCI home benefit. The remainder of the services covered under the Medicare home health benefit are medical in nature and must be provided under the order of a physician. As such, these services conflict with RNHCI beneficiaries' conscientious opposition to medical care.

The RNHCI home benefit must exclude the same services that are excluded from the home health benefit, which include: drugs and biologicals; transportation; services that would not be covered as inpatient services; housekeeping services; services covered under the End Stage Renal Disease program; prosthetic devices; and medical social services provided to family members. These exclusions are defined at 42 CFR 409.49. Additionally, the RNHCI home benefit excludes the items or services provided by any HHA that is not an RNHCI; or any supplier, independent RNHCI nurse or aide that is working directly for a beneficiary rather than under arrangements with the RNHCI.

Medicare requires a brief letter of intent from the provider in order to determine the number of RNHCIs that will be implementing the home service benefit.

In the case where an RNHCI chooses to provide home services then only care on an intermittent basis, which is provided to an eligible beneficiary who is confined to their home for health reasons, will be covered under the home benefit. The home benefit is not to be confused with hospice care, which may involve more frequent visits and can involve institutional services. If for some reason the home serviced patient requires more than intermittent service, then institutional services may be required. However, the patient would need to meet the criteria for admission to a RNHCI, or the patient would require another institutional setting not necessarily covered by Medicare.

Similar to the inpatient RNHCI benefit, the physician role in certifying and ordering the home benefit is replaced with the use of the RNHCI utilization review committee to review the need for care and plan for initial and continued care in the home setting. The home benefit will also require a prompt review of admission to the home service, since the patient must be fully eligible (have a health condition that keeps them confined to the home (42CFR409.42(a), have health needs that can be met with intermittent care, and have a valid election) before billable services can be rendered and Medicare payment requested. Additionally the utilization review committee is responsible for review and approval of care plans and orders for DME items, and review of the need for the continuation of services.

As in the original RNHCI benefit, Medicare will only pay for nonmedical services in the home, but not for those religious items or services provided by the RNHCI.

Medicare covers these items and services for dates of service from January 1, 2005 through December 30, 2006. Total Medicare payments under this benefit for each calendar year during this period are limited to \$700,000.

130.4.1 - Coverage and Payment of Durable Medical Equipment Under the RNHCI Home Benefit

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Medicare covers a defined list of nonmedical DME items for RNHCI home services that are comparable to items used in the inpatient RNHCI setting and could be provided by an HHA. The DME items include canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals. Those RNHCIs offering home services may order these items without a physician order and without compromising the beneficiary election for RNHCI care. The need for each item of DME ordered must be supported by the RNHCI patient's plan of care for the home setting and the RNHCI nurses' notes for home services. It must be noted that the benefit is applicable only to what we shall refer to as "nonmedical DME items" and does not include any of the related services provided by RNHCI staff members.

The RNHCI shall establish a payment arrangement with one or more DME suppliers to obtain any of the items on the DME list (below) they may require for a beneficiary. The supplier will provide the items and related instructions on use to the beneficiary/family/care giver. The RNHCI will submit claims for these DME items to the RNHCI specialty FI.

The RNHCI must stress to suppliers that DME claims are not to be submitted to the DMERC because this will cause the beneficiary's election for RNHCI care to be revoked.

DME Items and HCPCS Codes for use by RNHCI Home Service Units Canes

E0100 Cane, includes canes of all materials, adjustable or fixed, with tip

E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed with tip

Crutches

E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips

E0113 Crutch underarm, wood, adjustable or fixed, pair, with pad, tip and handgrip

E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips

E0116 Crutch underarm, other than wood, adjustable or fixed, with pad, tip and handgrip

Walkers

E0130 Walker, rigid (pickup), adjustable or fixed height

E0135 Walker, folding (pickup), adjustable or fixed height

E0141 Walker, rigid, wheeled, adjustable or fixed height

E0143 Walker, folding, wheeled, adjustable or fixed height

Commodes

E0163 Commode chair, stationary, with fixed arms

E0167 Pail or pan for use with commode chair

Wheelchairs

K0001 Standard wheelchair

Hospital Beds & Accessories

E0250 Hospital bed, fixed height, with any type side rails, with mattress

E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress

E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress

E0275 Bed pan, standard, metal or plastic

E0276 Bed pan, fracture, metal or plastic

E0290 Hospital bed, fixed height, without side rails, with mattress

E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress

E0325 Urinal; male, jug-type, any material

E0326 Urinal; female, jug-type, any material

Payment to RNHCIs for these specified DME items will be made based on the DME fee schedule. Coinsurance applies to these items. Deductible does not apply to these items.

130.4.2 - Coverage and Payment of Home Visits Under the RNHCI Home Benefit

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06; Implementation: 05-11-06)

Medicare covers intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. The RNHCI nursing personnel may be skilled in ministering to a beneficiary's religious needs (not covered by Medicare), but do not have the training or nursing skill sets required of credentialed/licensed health care professionals (e.g., registered nurse). While RNHCI nurses may provide tender loving care, they are focused primarily on religious healing and meeting basic beneficiary needs for assistance with activities of daily living (e.g., bathing, toileting, dressing, ambulation), as part of creating a milieu for religious healing. The care provided by an RNHCI nurse is not at the level of either a registered nurse or a licensed practical nurse. The physical care provided by an RNHCI nurse is at a level that could be considered as supportive, but decidedly not "skilled" as defined by the Medicare program.

For purposes of payment for RNHCI nursing services in the home, the following services are comparable to the services of HHAs that are not RNHCIs (e.g., the RNHCI nurse and the home health aide share the following basic tasks):

- Assist with activities of daily living which include: ambulation, bed to chair transfer, and assist with range of motion exercises; bathing, shampoo, nail care and dressing; feeding and nutrition; and toileting;
- Light housekeeping, incident to visit
- Documenting visit

By comparison the home health aide will routinely perform additional medically oriented services (e.g., observation and reporting of existing medical conditions, taking and reporting vital signs, and using basic infection control procedures).

Due to the uniqueness of RNHCI nursing in the Medicare program, Medicare pays for RNHCI nursing visits at a percentage of the HHAs "low utilization payment adjustment"

(LUPA) rate for home health aides. Only a visit by an RNHCI nurse to a home will be considered as billable to Medicare. A visit is defined as an episode in which an RNHCI nurse will render physical care to an RNHCI beneficiary in the home setting. The visit is a single billable unit that is not influenced by the number of involved caregivers or the duration of the episode. The difference in skill levels and the incorporation of RNHCI religious activity (noncovered by Medicare) into a visit, resulted in a payment rate that is 80% of the home health aide rate adjusted by metropolitan service area (MSA) wage index rate for the involved RNHCI.

RNHCI nursing visits are paid using the LUPA system even in situations where the involved patient would not be classified as low utilization. The HHAs have moved to PPS, which is constructed on the medical model and therefore inappropriate for RNHCI use. The same “labor”/“non-labor” portions applied in the HHA PPS will be used for calculating the RNHCI nursing visit payments.

Example of LUPA Payment: An RNHCI in Baltimore, MD, provides twelve RNHCI nursing visits over the course of a 30 day period.

1. Home Health Aide Visit (National standardized rate for 2005)	\$44.76
2. RNHCI Nurse Visit(.80 * \$ 44.76)	35.81
3. Calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit.....(.76775 * \$35.81)	27.49
4. Apply wage index factor for Baltimore, MD.....(.9907 * \$ 27.49)	27.23
5. Calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit.....(.23225 * \$ 35.81)	8.32
6. Subtotal—Low Utilization Payment Adjustment (LUPA) wage for 1 RNHCI nurse visit.....(\$ 27.49 + \$ 8.32)	\$35.55
7. Total - Calculate total Low Utilization Payment Adjustment (LUPA) for 12 RNHCI nurse visits provided during the 30-day episode(12 * \$ 35.55)	\$426.60

Step 1. Take the HHA aide visit base rate (\$ 44. 76) for the involved year (2005), from the HHA update published annually each November in the **Federal Register**.

Step 2. To calculate the RNHCI nurse visit base rate, multiply the HHA base rate (\$ 44.76) by the allowed percentage for an RNHCI nurse visit (.80%) to allow for religious activity and reduced physical care skill level = (\$ 35.81)

Step 3. To calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the fixed allowance .76775 by the RNHCI nurse visit rate (\$ 35.81) = (\$ 27.49)

Step 4. Apply the wage index for the involved MSA from the HHA update published annually each November in the **Federal Register** (Baltimore, MD = .9907) multiplied by the labor portion of the RNHCI nurse visit (\$ 27.49) = (\$27.23).

Step 5. To calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the fixed allowance .23225 by the RNHCI nurse visit rate (\$ 35.81) = (\$ 8.32)

Step 6. To calculate the LUPA rate for 1 RNHCI nurse visit add the products from Step 4 (\$27.49) and Step 5 (\$ 8.32) = (\$ 35.55)

Step 7. To calculate the LUPA payment for RNHCI nurse visits to one beneficiary in a 30 day period, multiply the product of Step 6 (\$ 35.55) by the number of visits (12) = (\$ 426.60)

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R119BP	01/15/2010	Coverage of Inpatient Rehabilitation Services	01/04/2010	6699
R112BP	10/23/2009	Coverage of Inpatient Rehabilitation Services – Rescinded and replaced by Transmittal 119	01/04/2010	6699
R45BP	02/10/2006	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institution (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries with RNHCI Elections	05/11/2006	4218
R25BP	11/05/2004	Implementation of Coverage of Religious Nonmedical Health Care Institution (RNHCI) Items and Services Furnished in the Home, MMA section 706.	04/04/2005	3529
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

[Back to top of Chapter](#)