

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



REVISED product from the Medicare Learning Network® (MLN)

- **“Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs”** Fact Sheet (previously titled Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance) (ICN 006977), downloadable

MLN Matters® Number: MM8959

Related Change Request (CR) #: CR 8959

Related CR Release Date: November 6, 2014

Effective Date: October 1, 2013

Related CR Transmittal #: R3106CP

Implementation Date: February 10, 2015

## Implementing the Payment Policies Related to Patient Status from the CMS-1599-F

### Provider Types Affected

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This MLN Matters® Article is intended for hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### What You Need to Know

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Change Request (CR) 8959 incorporates changes to the "Medicare Claims Processing Manual" related to the payment policies regarding Patient Status from final rule CMS-1599-F. This includes payment of Medicare Part B inpatient services, and admission and medical review criteria for payment of hospital inpatient services under Medicare Part A. Make sure that your billing staffs are aware of these changes.

### Background

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When an inpatient admission is found to be not reasonable and necessary, Medicare will allow payment of all hospital services that were furnished and would have been reasonable

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and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, provided the allowed timeframe for submitting claims is not expired. Medicare will not allow payment for services that specifically require an outpatient status, such as outpatient visits, emergency department visits, and observation services that are, by definition, provided to hospital outpatients and not inpatients.

Specific changes to the "Medicare Claims Processing Manual" as a result of CR8959 involve Chapter 240 of that manual. Specifically, inpatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some providers established customary charging practice resulting in separate charges for these services following the "Provider Reimbursement Manual" (PRM-1) instructions. However, in order for a provider's customary charging practice to be recognized it must consistently follow those instructions for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for services rendered and documentation meet the definition of the Healthcare Common Procedure Coding System (HCPCS) in order to separately bill.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), hospitals paid under the Outpatient Prospective Payment System (OPPS), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, Critical Access Hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPSS would continue billing the OPSS for Part B inpatient services. Hospitals that are excluded from payment under the OPSS in 42 Code of Federal Regulations (CFR) 419.20(b) would be eligible to bill Part B inpatient services under their non-OPSS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. Beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the inpatient services they received, the beneficiary may face greater cost sharing.

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

Remember that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the "Medicare Benefit Policy Manual", Chapter 6, Section 10, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Note: You may view CMS-1599-F at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html> on the Centers for Medicare & Medicaid Services (CMS) website.

## Additional Information

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The official instruction, CR 8959, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3106CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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