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Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities

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PROVIDER TYPES AFFECTED

This article is intended for providers billing Medicare Administrative Contractors (MACs) under Medicare Part A for inpatient hospital services provided to Medicare beneficiaries and for acute-care hospitals providing outpatient services to beneficiaries who are inpatients of Long Term Care Hospitals (LTCHs) Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), and Critical Access Hospitals (CAHs). This article does not present any new or revised policy. Instead, it serves to remind hospitals of proper billing of services for beneficiaries in a covered Part A inpatient stay.

WHAT YOU NEED TO KNOW

Generally, Medicare should not pay an acute-care hospital for services (for example, outpatient surgery or lab work) furnished to a beneficiary at that facility when the beneficiary is still an inpatient of another facility. Acute-care hospitals, under arrangements with the LTCH, IRF, IPF, and/or CAH, should look to the LTCH, IRF, IPF, and/or CAH for payment for the outpatient services it provides to the beneficiary while an inpatient of that other facility. Additionally, acute care hospitals should not charge beneficiaries for outpatient deductibles and coinsurance payments as a result of such services.

Medicare system edits examine claims history for the presence of a covered Part A inpatient stay when also processing an outpatient claim for a date of service when the beneficiary was an inpatient. If Medicare paid for an inpatient stay for the same date of service as the incoming outpatient claim, Medicare edits will appropriately deny payment for the outpatient services. There are occasions when Medicare may get an outpatient claim before getting an inpatient claim. In these cases, after paying the inpatient claim, the MACs will recover the outpatient

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payment from the provider and direct the provider to refund to the beneficiary any inappropriately collected coinsurance and/or deductible for the outpatient services. Hospitals should review the policies restated in this article to bill correctly in these situations.

BACKGROUND

Section 1812 of the Social Security Act (the Act) states that inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A. These include inpatient stays at LTCHs, IPFs, IRFs, and CAHs (the Act § 1861). All items and non-physician services provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with another provider and billed to Medicare by the inpatient hospital through its Part A claim. Specifically, subject to the conditions, limitations, and exceptions set forth in 42 CFR 409.10, 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:

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

These services include all inpatient hospital services, which do not include certain physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified nurse midwife services, qualified psychologist services, and the services of an anesthetist (42 CFR 409.10(a) and (b)). This provision applies to all hospitals, regardless of whether they are subject to a Prospective Payment System (PPS).

Federal regulations state that Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR 412.50(b). In addition, 42 CFR 412.509(b) states that Medicare does not pay any provider or supplier other than the LTCH for inpatient hospital services furnished to a Medicare beneficiary who is an inpatient of the LTCH. Likewise, 42 CFR 412.604(e) informs IRFs that in furnishing services either directly or under arrangement, the Medicare payments are payment in full for all inpatient services.

As stated in Federal requirements, all items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. Federal regulations define “arrangements” as those “which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services” (42 CFR 409.3).

These requirements are clearly stated in the Medicare Claims Processing Manual, Chapter 3, Section 10.4, which states that "All items and non-physician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS." The following medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services)
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips
- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic
- Total parenteral nutrition (TPN) services
- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient

The hospital must include the cost of these services in the appropriate ancillary service cost center, that is, in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540. The following are exceptions:

- Pneumococcal Vaccine - is payable under Part B only and is billed by the hospital using the ASC X12 837 institutional claim format or on the Form CMS-1450.
- Ambulance Service - For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted. It does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately using the ASC X12 837 institutional claim format or on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the A/B MAC (B) by the ambulance operator or beneficiary, as appropriate. If an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment, the ambulance trip is considered part of the Diagnosis Related Group (DRG), and not separately billable, if the resident hospital is under PPS.
- Part B Inpatient Services - Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services.
- Anesthetist Services "Incident to" Physician Services - If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of the hospital's most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that

practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist's service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ Certified Registered Nurse Anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital's cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

Another major exception is that the pneumococcal vaccine (as noted above), influenza virus vaccine, and hepatitis B vaccine and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. See the Medicare Claims Processing Manual, Chapter 18, Section 10.1.

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient as noted in the Medicare Benefit Policy Manual, Chapter 15, Section 250. This section of the manual also notes other services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are (in addition to those already mentioned previously):

- Qualified clinical psychologist services furnished after December 31, 1990
- Screening mammography services
- Screening pap smears and pelvic exams
- Screening glaucoma services
- Colorectal screening
- Bone mass measurements
- Prostate screening

The Medicare Benefit Policy Manual, Chapter 6, Section 10 states that payment may be made under Part B for physician services and for the nonphysician medical and other health services as provided in this section when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. The same manual section also states that in all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

The Centers for Medicare & Medicaid Services (CMS) has edits to detect these situations and requires the MACs to recover inappropriate payments and to have the acute care hospitals refund to beneficiaries any inappropriately collected deductible or coinsurance payments.

ADDITIONAL INFORMATION

A recent report by the Office of the Inspector General, *Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities*, found Medicare overpaid acute-care hospitals for certain outpatient services. Review the entire report: https://oig.hhs.gov/oas/reports/region9/91602026.pdf.

The Acute Care Hospital IPPS Fact Sheet is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf. This fact sheet includes information on what is covered for beneficiaries in an inpatient stay. On page 3 of this fact sheet (Basis for IPPS Payment), CMS points out that the claim for the patient's inpatient stay must include all outpatient diagnostic services and admission-related outpatient nondiagnostic services. Further, this portion of the fact sheet notes that providers must not bill these services separately to Medicare Part B.

The MLN booklet, Items and Services not Covered by Medicare, (available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf) provides more details and states that in general, non-physician services furnished to Part A and Part B hospital inpatients and Part A SNF inpatients not provided directly or under arrangement are not covered by Medicare. This booklet also provides details on exceptions to this policy.

The Medicare Claims Processing Manual, Chapter 3, Section 10.4, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. Chapter 18, Section 10.1 of that manual is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf.

The Medicare Benefit Policy Manual, Chapter 15, Section 250 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf. Chapter 6, Section 10 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
December 13, 2017	The article was revised to include a reference and link to a recent report from the Office of the Inspector General on this issue in the Additional Information section of this article. All other information remains the same.
December 6, 2017	Initial article released