DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

Provider Types Affected

This MLN Matters® Article is intended for hospitals and Critical Access Hospitals (CAHs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8666, which implements revised policies related to payment of hospital Part B inpatient services from the Fiscal Year 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule, CMS-1599-F. This includes several conforming changes to the "Medicare Benefit Policy Manual" for payment of Part B inpatient services in skilled nursing facilities (SNFs). CR8666 is a companion piece to the recently issued CR 8445 (see the related MLN Matters® Article, MM8445, available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf** on the CMS website.). Be sure your billing staffs are aware of these changes.

Background

When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, such as

outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients. Part B payment may only be made if the beneficiary is enrolled in Part B, the allowed timeframe for submitting claims is not expired, and waiver of liability payment is not made.

The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospitals services furnished by nonparticipating hospitals. In this article, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

This policy applies when a hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit).

- If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B services.
- Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a "no pay" Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services.
- The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

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

When payment cannot be made under Medicare Part A, Medicare continues to pay for Part B services included in the 3-day (1-day for hospitals not paid under the Inpatient Prospective Payment System (IPPS)) payment window preceding the inpatient admission, including services requiring an outpatient status.

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

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the IPPS, hospitals paid under the OPPS, LTCHs, inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, CAHs, children's hospitals, cancer hospitals, Maryland waiver hospitals, and other facilities as provided by the Centers for

Medicare & Medicaid Services (CMS). Hospitals paid under the OPPS must continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

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

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

CMS notes that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of ancillary Part B inpatient services specified in the "Medicare Benefit Policy Manual," Chapter 6, Section 10.2, attached as part of CR8666.

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see the "Medicare Claims Processing Manual," Chapter 4, Section 10.12, available at), including services requiring an outpatient status.

The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see the "Medicare Claims Processing Manual", Chapter 16,Section 40.1, “Laboratories Billing for Referred Tests” available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf** on the CMS website).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or one calendar year after the date of service.

Other Circumstances in Which Payment Cannot Be Made Under Part A

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

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

- The patient was not otherwise eligible for or entitled to coverage under Part A (See Chapter 16 section 180 of the "Medicare Claims Processing Manual" for services received as a result of non-covered services).

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

The following inpatient services are payable under the OPPS:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Acute dialysis of a hospital inpatient with or without End Stage Renal Disease. The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, "Medicare Claims Processing Manual", Chapter 4, section 200.2, "Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)."
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Prostate screening;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO) that is not covered under the End-Stage Renal Disease benefit.

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

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the

applicable rate under the “Medicare Claims Processing Manual” Chapter 4 section 240.3, “Inpatient Part B Hospital Services - Implantable Prosthetic Devices”);

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient’s physical condition (DMEPOS fee schedule);
- Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15 Sections 220 and 230 of the "Medicare Benefit Policy Manual", “Covered Medical and Other Health Services”) (applicable rate based on the Medicare Physician Fee Schedule);
- Ambulance services (ambulance fee schedule); and
- Screening mammography services (Medicare Physician Fee Schedule).

Additional Information

The official instruction, CR 8666, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R182BP.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-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.