**COST PLAN POLICY ISSUE**
**03-004**

**QUESTION:**

Per the HMO/CMP Manual, when a cost plan chooses billing option 1, it has CMS (through the intermediary) pay hospitals and SNFs on its behalf for covered items and services furnished to its Medicare enrollees. What provider types are included under billing option 1 – just hospitals and SNFs or hospitals, SNFs and other provider types. Please specify the other provider types in the answer, if applicable.

**ANSWER**:

The regulation - 42 CFR 417.532(c) - mentions only "payment for hospital and SNF services." However, the Medicare Managed Care Manual, Chapter 17, subchapter B - Payment Principles for Cost-Based HMOs/CMPs - section 300, clarifies this issue as follows:

All HMOs/CMPs (both billing options 1 and 2) are required to process all non-provider Part B bills, with some exceptions. These exceptions, which are to be processed by the fee-for-service carrier, include:

1. Claims for services by an independent physical therapist and/or for physical, occupational or speech therapy subject to the fee-for-service payment limitation imposed by section 4541 of the Balanced Budget act of 1997. This payment limit (and special billing process for Cost HMOs/CMPs) applies only to therapy services provided in other than a hospital outpatient department setting.

2. Claims for outpatient blood transfusions.

3. Claims from physicians for dialysis and related services provided through an approved dialysis facility.

4. Hospice care by Medicare participating hospices, except:
- Services of the enrollee's attending physician, if the physician is an employee or contractor of the Cost HMO/CMP and is not employed by or under contract to the hospice elected by the member.
- Services not related to the treatment of, or a condition related to, the terminal condition.