



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 10: Coverage of Hospital Inpatient Services

I. Inpatient Admission Order

A. Inpatient Order Requirement

1. A patient is only considered an inpatient when they are formally admitted pursuant to an order for inpatient admission by a qualifying admitting practitioner. <See 42 C.F.R. 412.3(a), see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>
 - a. For orders written prior to the patient presenting to the hospital (e.g., pre-surgery orders), the time of admission occurs when hospital care services are provided to the patient. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.4>
 - b. For orders written after hospital care has started, including initial orders and verbal orders as discussed below, the time of admission is the time the inpatient order is documented. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.d, B.4>

B. Qualifications of the Admitting Practitioner

1. The admitting practitioner must be licensed by the state, have privileges to admit to the hospital and be knowledgeable about the patient's hospital course, medical plan of care and condition at the time of admission. <See 42 C.F.R. 412.3(b), see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2>

Caution: A mid-level practitioner may be an admitting/ordering practitioner OR a proxy practitioner (discussed below) OR may be restricted from acting in either capacity depending on applicable state law and hospital by-laws and privileging standards. The QIO KEPRO recommends sending copies of by-laws regarding mid-level practitioners when submitting requested records for short stay reviews involving mid-level practitioner orders.

2. The admitting practitioner must be knowledgeable about the patient's care and condition at the time of admission. <See 42 C.F.R. 412.3(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.3>

CMS specifies the following practitioners to have sufficient knowledge of the patient's hospital course to be the admitting practitioner:

- The admitting ("attending") physician of record (or physician on call)
- Primary or covering hospitalist caring for the patient
- Patient's primary care practitioner (or physician on call)
- Surgeon responsible for major surgical procedure (or physician on call)
- Emergency or clinic practitioner caring for the patient at admission
- Practitioner qualified to admit patients and actively treating the patient at admission

3. Practitioners acting as a "Proxy" for the Admitting Practitioner
 - a. Individuals, such as residents, physician assistants, nurse practitioners, or emergency department physicians, may write initial inpatient admission orders (e.g., "bridge orders", "initial orders") on behalf of an admitting practitioner if:
 - i. The individual is authorized under state law to admit patients;
 - ii. The individual is allowed by hospital by-laws or policies to make initial admission decisions; and
 - iii. The admitting practitioner approves and accepts responsibility for the admission decision by countersigning the order. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.a>

C. Verbal Orders

1. An individual (e.g., registered nurse) may receive and document a verbal order for admission, in accordance with their scope of practice, hospital policies and medical staff bylaws, rules and regulations. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.b>
 - a. A verbal order for admission must be documented at the time it is received, identify the ordering practitioner, and be countersigned by the ordering practitioner. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.b>

D. Clarification of Ambiguous Orders

1. If an admission order is ambiguous, a hospital may obtain a clarification order from the ordering practitioner before billing to Medicare. A clarification should, but does not need to be, completed before discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5>
2. Orders that specify typically outpatient services (e.g., admit to observation or admit to same day surgery) are not considered ambiguous. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5>

E. Signature or Authentication of Orders

1. An inpatient order, including an initial or verbal order, should be authenticated (i.e., signed or countersigned) prior to discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>
 - a. The time of discharge does not always coincide with the order for discharge. Discharge occurs when the ordering practitioner's discharge orders are effectuated, including activities specified as having to occur prior to discharge (e.g., discharge after supper, discharge after patient voids). <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>

Caution: The Benefit Policy Manual indicates if the order, including an initial or verbal order, is not signed before discharge, the patient is not considered an inpatient and the provider should not submit an inpatient Part A claim. This guidance appears to have been superseded by regulatory amendments and policy statements in the FY2019 IPPS Final Rule, effective October 1, 2018, discussed below. The applicable Benefit Policy Manual sections have not been updated or replaced at the time of publishing.

F. Missing or Defective Orders

1. Technical discrepancies in the inpatient order, such as signature after discharge or missing signatures, co-signatures or authentications, do not necessarily prevent inpatient Part A payment. <See 83 *Fed. Reg.* 41507>
 - a. Documentation such as progress notes or the medical records as a whole must support that coverage criteria have been met, including medical necessity, and the hospital must be operating in accordance with Conditions of Participation, such as delivery of the Important Message from Medicare. <See 83 *Fed. Reg.* 41507>

2. If the inpatient admission order is missing or defective, but the intent, decision, and recommendation of the qualifying ordering practitioner to admit the patient as an inpatient is clear, review contractors have the discretion to determine the information in the record constructively satisfies the requirement for an inpatient order. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5; 83 *Fed. Reg.* 41508-510>
3. Constructive satisfaction of inpatient admission order requirements should be extremely rare and may only be applied at the discretion of the contractor. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5; 83 *Fed. Reg.* 41507-510>

II. Inpatient Certification

A. Certification at Prospective Payment System (PPS) Hospitals

1. Timing

- a. For stays 20 days or greater, a physician certification must be documented and signed no later than the 20th day. <See 42 *C.F.R.* 424.13(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2>
- b. For cost outlier cases, a physician certification must be documented and signed no later than the date the hospital requests outlier payment, unless certification was made by day 20. <See 42 *C.F.R.* 424.13(b) and (f)(2)>

Caution: Inpatient Psychiatric Facilities (IPFs) have additional inpatient certification requirements. See 42 *C.F.R.* 424.14.

2. Content of Certification

- a. There are three elements to the PPS certification:
 - i. The reason for continued hospitalization of the patient for inpatient medical treatment or diagnostic testing, OR the special or unusual services for cost outlier cases. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.a; see 42 *C.F.R.* 424.13(a)(1)>
 - ii. The estimated time the patient requires hospitalization if completed before discharge or the actual time in the hospital if completed at discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.b; see 42 *C.F.R.* 424.13(a)(2)>

- a) Documentation of the estimated or actual length of stay is commonly reflected in the physician's assessment and plan or as part of routine discharge planning but may also appear in a separate certification form. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.b>
- iii. The plans for post discharge care, if appropriate. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.c; see 42 *CFR* 424.13(a)(3)>
- b. Documentation of Inpatient Rehabilitation Facility (IRF) coverage criteria (preadmission screening, post admission evaluation and admission orders) may be used to satisfy certification requirements for IRF patients. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.e.>

B. Certification at Critical Access Hospitals

1. Timing

- a. For a CAH, all certification requirements must be completed and signed no later than 1 day before the date on which the claim for payment for the inpatient service is submitted. <See 42 *C.F.R.* 424.15(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2>

2. "Good faith" certification in a CAH

- a. Medicare only pays for inpatient admissions at a CAH if a physician certifies in good faith that the patient may reasonably be expected to be discharged from the CAH or transferred to another hospital within 96 hours after admission to the CAH, even if an unforeseen event occurs that causes the patient to stay longer at the CAH. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.d>
 - (i) A problem will not occur regarding the CAH's designation if a stay longer than 96 hours does not cause the CAH to exceed the 96-hour annual average length of stay.
 - (ii) Time spent as an outpatient or time spent in a CAH's swing bed does not count towards the 96-hour certification requirement.
- b. If a physician cannot in good faith certify that a patient is expected to be discharged from the CAH or transferred to another hospital within 96 hours after inpatient admission, the CAH will not receive Medicare reimbursement for any portion of the admission. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.d>

- (i) NOTE: For medical record reviews conducted on or after October 1, 2017, CMS has directed Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractor (SMRC), and Recovery Auditors to make the 96-hour certification requirement a low priority during medical record reviews. This non-enforcement will only be applied absent any concerns of probable fraud, waste, or abuse. <82 Fed. Reg. 38296>
- (ii) CMS also stated that reviews by other entities, including Zone Program Integrity Contractors (ZPICs), the Office of Inspector General, and the Department of Justice will continue, as appropriate. <82 Fed. Reg. 38296>

Caution: The 96-hour certification requirement is statutory and cannot be amended or changed by CMS. Even though CMS will direct its contractors to make the certification a low priority during medical record review, failure to comply with CMS' provider screening and revalidation requirements or other medical review issues, may initiate additional documentation requests.

C. Qualifications of the Certifying Physician

1. The certifying practitioner must be a physician (i.e., MD/DO), or a dentist or podiatrist in limited circumstances, who has knowledge of the case. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.3>

CMS specifies the following physicians to have sufficient knowledge of the patient's hospital course to make the inpatient certification:

- The admitting ("attending") physician of record (or a physician on call)
- Surgeon responsible for major surgical procedure (or a physician on call)
- Hospital staff physician, on behalf of non-physician admitting

D. Format of the Certification

1. The elements of the certification may be entered on forms, notes or records signed by the physician or on a separate form, as long as the method of documentation permits verification. <See 42 CFR 424.11(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4; *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.5>

2. There must be a separate signed statement that inpatient services are, were or continue to be medically necessary for each certification. <See 42 CFR 414.11(b); see *Medicare Benefit Policy Manual*, Chapter 1 § Section 10.2 A.4; *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.5>
 - a. The provider does not need to repeat the elements or state the location of the information supporting the separate signed statement if the supporting information can be verified in signed provider records such as progress notes or the discharge summary. <See 42 C.F.R. 424.11(b); *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4>

E. Certification if No SNF Bed is Available

1. If an inpatient could be treated at a skilled nursing facility (SNF) but no SNF bed is available at a participating SNF, continued hospitalization is covered if the physician certifies the need for continued hospitalization on that basis. <See 42 C.F.R. 424.13(c); *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.6>
2. Alternate placement days certified as necessary because no SNF bed is available are covered days and are counted toward the three-day stay requirement for SNF coverage. <*Medicare Benefit Policy Manual*, Chapter 8 § 20.1>
3. Coverage of additional hospitalization days certified by a physician as necessary when no SNF bed is available continues until:
 - a. A bed becomes available in a participating SNF;
 - b. The patient no longer needs SNF level of care; or
 - c. The patient exhausts their Part A inpatient hospital benefits. <*Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.6>

III. Requirements for Part A Payment of an Inpatient Admission

Two requirements for Part A payment of an inpatient admission:

- Certification
 - At a PPS hospital, if
 - Cost outlier; or
 - Length of stay of 20 days or greater
 - OR
 - “Good faith” certification at a CAH
- Appropriate for Part A payment:
 - An inpatient only procedure; or
 - Physician’s expectation the patient will require medically necessary hospital care for two midnights or longer; or
 - Physician’s case-by-case determination to admit the patient based on their clinical judgment, supported in the medical record

- A. CMS published an algorithm entitled “BFCC QIO 2 Midnight Claim Review Guideline” that provides helpful guidance on application of the 2 Midnight Rule to determine whether cases are appropriate for payment under Part A. Handout 15 is the “BFCC QIO 2 Midnight Claim Review Guideline”.

Link: Inpatient Hospital Reviews under Medicare-Related Sites - Hospital

IV. Inpatient-Only Procedures

- A. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them “inpatient only” procedures. <Medicare Claims Processing Manual, Chapter 4 § 180.7>
- B. Inpatient admission and Part A payment is appropriate if a medically necessary inpatient-only procedure is performed and documented in the medical record. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.A>
1. Inpatient admission is appropriate based on the presence of an inpatient-only procedure, regardless of the patient’s expected length of stay. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.E.1>

V. Two Midnight Benchmark

- A. The physician should order inpatient care if the physician has a reasonable expectation that the patient will require two midnights of medically necessary hospital care. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A, A.I.B; 78 *Fed. Reg.* 50946>

CMS has indicated they do not expect a patient receiving medically necessary hospital care to pass a second midnight without an order for inpatient care.

1. The physician should consider time the patient spent receiving medically necessary outpatient services (e.g., in the ED, observation, outpatient surgery) prior to the order for admission. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
 - a. Hospitals may report Occurrence Span Code (OSC) 72 to indicate a contiguous outpatient day prior to an inpatient admission for one midnight to demonstrate compliance with the two-midnight benchmark. <One Time Notification Transmittal 1334>
2. Care that is Not Medically Necessary Hospital Care
 - a. The physician should not consider time the patient spent or will spend receiving care that is not medically necessary hospital care (e.g., skilled nursing, nursing or custodial care) or extensive delays in care. <See BFCC QIO 2 Midnight Claim Review Guideline algorithm; see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B; 78 *Fed. Reg.* 50947-48>

VI. Admission on a Case-by-Case Basis

- A. Inpatient admission may be appropriate when the admitting physician expects less than a two midnight stay, but determines admission is appropriate on a case-by-case basis, based on their clinical judgment, supported by the medical documentation. <See 42 *C.F.R.* 412.3(d)(3), 80 *Fed. Reg.* 70545>
1. Effective January 1, 2016, this exception expanded the former sub-regulatory rare and unusual exception policy under the Two-Midnight Rule, which formerly only included newly initiated mechanical ventilation. <80 *Fed. Reg.* 70541, 70545; *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.2>
- B. CMS has stated that rarely would a stay of less than 24 hours qualify for a case-by-case exception to the two-midnight benchmark. <*Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.3>

VII. Inpatient Utilization Review

A. The UR Committee

1. The *Conditions of Participation* require the UR committee consist of at least two Doctors of Medicine or osteopathy and other specified practitioners. <See 42 C.F.R. 482.30(b)>

Non-physician practitioners that may be on the UR committee, include:

- Doctor of Dental Surgery or dental medicine
- Doctors of podiatric medicine
- Doctor of Optometry
- Chiropractors
- Clinical psychologists

B. Four Requirements for Determinations by the UR Committee

1. The UR committee must offer the attending physician or NPP an opportunity to present their views prior to making a determination an admission is not medically necessary. <See 42 C.F.R 482.30(d)(2)>
2. One member of the UR committee may make the determination an admission is not medically necessary if the patient's attending physician or NPP concurs with the determination or does not present their views. <See 42 C.F.R. 482.30(d)(1)(i), see *MLN Matters Article SE0622, Background*>
3. Two members of the UR committee must make the determination an admission is not medically necessary if the patient's attending physician does not concur with the determination. <See 42 C.F.R. 482.30(d)(1)(ii), see *MLN Matters Article SE0622, Background*>
4. If the UR committee determines a patient's admission was not medically necessary, notice must be provided to the patient, the hospital, and the attending physician within 2 days of the determination. <See 42 C.F.R. 482.30(d)(3)>

C. Role of Non-physician Hospital Staff

1. CMS has clarified that case managers, who are not licensed practitioners authorized under state law to admit patients to the hospital, do not have the authority to make a determination an admission is not medically necessary or change a patient's status from inpatient to outpatient. <See *MLN Matters Article SE0622, Q.3*>

CMS encourages and expects hospitals to employ case managers to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in decision making processes.

D. Timing of UR Determination

1. Determination Prior to Discharge

- a. If the determination an admission is not medically necessary is made prior to the patient's discharge, the hospital may retroactively convert the patient to an outpatient if the following conditions are met:

- i. The change in status is made while the patient is still in the hospital to allow the hospital to provide notice of the determination to the patient prior to discharge. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; see *MLN Matters Article SE0622*, Q.8>

Although the UR CoP allows 2 days to provide notice to the patient, in order to retroactively change the patient's status to outpatient, notice must be provided before discharge.

- ii. The attending physician concurs with the UR committee's decision. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
 - iii. The physician's concurrence is documented in the medical record. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
- b. If all conditions are met, the claim for the case should be submitted as an outpatient claim (bill type 13X) with condition code 44. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>
 - i. When billing observation services following conversion to outpatient status with condition code 44, an order for observation is required prior to counting time for observation. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2 and 290.5.2>
 - ii. The hospital may include charges representing the cost of all resources utilized in the care of the patient during the encounter, including monitoring and nursing care prior to an order for observation. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

- a) Hours of monitoring and nursing care prior to a written order for observation may be reported on a line with revenue code 0762 (Observation Hours) without a HCPCS code. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

2. Determination After Discharge

- a. If the determination an admission is not medically necessary is made by the UR committee after the patient's discharge (i.e., self-denial), the patient remains an inpatient and the case should be submitted as an inpatient Part B claim (bill type 12X) with condition code W2. <78 *Fed. Reg.* 50914; *MLN Matters Article SE1333*

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

VIII. Inpatient Part B (TOB 012X) Payment

Medicare covers and makes payment under Part B for inpatient services in three separate circumstances:

- An inpatient admission denied as not reasonable and necessary by a contractor or through self-denial (UR determination)
- The patient has no entitlement to Part A or has exhausted their Part A benefits
- Preventative services only covered under Part B

A. Admission Denied as Not Reasonable and Necessary

1. Inpatient Part B payment is available if:

- a. The inpatient admission is denied as not reasonable and necessary through contractor or self-denial; and
- b. The services would have been reasonable and necessary as outpatient services; and
- c. The services meet all applicable Part B coverage and payment conditions. <See 42 CFR 414.5, 78 Fed. Reg. 50914, See Medicare Benefit Policy Manual, Chapter 6 § 10.1>

2. Payment is available for:

- a. Services payable under OPPS and certain ancillary services payable under other payment systems (e.g., therapy, DME, laboratory services). <See 42 CFR 414.5(a)(1), 78 Fed. Reg. 50914, see Medicare Benefit Policy Manual, Chapter 6 § 10.1, MLN Matters SE1333>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.1, attached, has a list of the ancillary services payable when the inpatient admission is denied as not reasonable and necessary.
 - ii. Exceptions:
 - a) Services that by their nature are outpatient services (e.g., ED visits and observation services). <See Medicare Benefit Policy Manual, Chapter 6 § 10.1; MLN Matters SE1333>

Tip: These services should be submitted on a standard outpatient (131) claim.

- b) Inpatient nursing services (e.g., infusions, injections, transfusions, and nebulizer treatments) that the hospital treats as routine (i.e., billed as part of their inpatient room rate). <See Medicare Claims Processing Manual, Chapter 4 § 240>
 - 1) Routine services are services included in the provider's daily room and board charges and the provider does not separately charge for them. <Program Reimbursement Manual, Chapter 22 § 2202.6>

- (a) The provider must follow all instructions in the Provider Reimbursement Manual and the principles of cost apportionment for Medicare to “recognize” their treatment of the services as routine or ancillary. <Medicare Claims Processing Manual, Chapter 4 § 240>

Note: Ancillary nursing services for which the provider customarily makes a separate charge to inpatients may be billed for inpatient Part B payment if all documentation and coverage requirements are met.

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>
- ii. The three-day payment window, which requires inclusion of certain outpatient services on a subsequent inpatient claim, does not apply when no Part A inpatient payment is made. <MLN SE1333; See Medicare Benefit Policy Manual, Chapter 6 § 10.1; See Medicare Claims Processing Manual, Chapter 4 § 10.12>

Tip: If significant surgical or emergency department services are provided before the admission order and billed on an outpatient 131 claim triggering C-APC payment, no inpatient Part B claim will be needed because the C-APC provides payment in full for the encounter.

b. Inpatient Part A Non-covered Claim

- i. To bill for inpatient Part B payment, the provider must first submit a Part A “provider liable” claim on a type of bill 110, unless the claim has already been denied by the contractor. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 § 240.6, Medicare Claims Processing Manual, Transmittal 2877>
 - a) The “provider liable” claim must process and the remittance advice must be issued prior to billing for inpatient Part B payment. <MLN Matters SE1333; See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; Medicare Claims Processing Manual, Transmittal 2877>

- b) The provider must report the Occurrence Span Code M1 to indicate the period of provider liability on the Part A claim. <MLN Matters SE1333, Medicare Claims Processing Manual, Transmittal 2877>
 - c) The provider must refund any inpatient deductible or copay to the patient. <See Medicare Claims Processing Manual, Chapter 4 §§ 240.1, 240.6; MLN Matters SE1333>
- c. Inpatient Part B Claim
 - i. After receiving the remittance advice for the “provider liable” claim, the provider may submit a claim on type of bill 12X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240; MLN Matters SE1333>
 - a) The provider must submit the following on the 12X claim:
 - 1) A treatment authorization code “A/B Rebilling”.
 - 2) Condition code W2 attesting that the claim is a rebill and no appeal is in process.
 - 3) A remark code with the document control number (DCN) of the denied inpatient Part A claim in the format ABREBILL followed by the DCN of the denied inpatient claim. <Medicare Claims Processing Manual, Transmittal 2877>
 - b) Medicare Claims Processing Manual, Chapter 6 § 240.1, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the inpatient stay was denied as not reasonable and necessary.
 - c) Hospitals must report the HCPCS codes they would report on an outpatient Part B claim, including for implantable prosthetic devices. <See Medicare Claims Processing Manual, Chapter 4 § 240.1, 240.3>
 - d) The claim for Part B inpatient payment must be submitted within 1 year of the date of service in compliance with normal timely filing requirements. <See 42 CFR 414.5 (c)>
 - ii. The patient is liable for the normal Part B deductible and co-payment for services billed on an inpatient Part B claim. <See Medicare Claims Processing Manual, Chapter § 240.6>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e., there was no reasonable expectation of a two midnight stay) and would not be covered under Part A. On what bill type should the hospital submit the pacemaker procedure?

B. No Part A Entitlement or Exhaustion of Part A Benefits

1. Limited inpatient Part B payment is available if:

- a. No Part A payment is made at all for the case because the patient had exhausted his or her benefit days *before* or during the admission, OR
- b. The patient was otherwise not eligible for or entitled to coverage under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>

2. Payment is available for:

- a. Specified services payable under OPPS or other payment systems, including diagnostic tests, therapy, radiation therapy, acute dialysis, specified screening tests and preventative services, specified covered drugs, specified DME, and ambulance services. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>
 - i. Medicare Benefit Policy Manual, Chapter 6 § 10.2, attached, has a list of the services payable when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.
 - ii. If one of these services is packaged under the OPPS and the service it would package to is not payable on the inpatient Part B claim, it is excluded from OPPS packaging and paid separately. <See Medicare Benefit Policy Manual, Chapter 6 § 10.2>

Example: An inpatient, who has exhausted their Part A benefits, has a surgical service and related lab tests. The lab tests would normally package and only the surgical service would pay, but on an inpatient Part B claim the surgical service is not payable and the lab test will be excluded from packaging and pay separately.

3. Billing Requirements

a. Outpatient Part B Claim

- i. Services prior to the inpatient order for admission are outpatient services and should be submitted on an outpatient type of bill 13X for payment under Part B as noted above. <See Medicare Claims Processing Manual, Chapter 4 § 10.12>

b. Inpatient Part B Claim

- i. The provider submits a claim with type of bill 012X for payment of inpatient services under Part B. <See Medicare Claims Processing Manual, Chapter 4 § 240>
 - a) Medicare Claims Processing Manual, Chapter 6 § 240.2, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.
 - b) Hospitals must report the HCPCS codes they would report on an outpatient Part B claim. <See Medicare Claims Processing Manual, Chapter 4 § 240.2>

1) Special instructions for implantable prosthetic devices

- (a) Hospitals should bill implantable prosthetic devices with HCPCS code C9899 (“Implantable prosthetic device, payable only for inpatients who do not have inpatient coverage”). <See Medicare Claims Processing Manual, Chapter 4 § 240.3>
- (b) The provider should report the HCPCS code for the device, if one exists, or a narrative description of the device in the remarks section. <Medicare Claims Processing Manual Transmittal 1628, IV. Supporting Information>
- (c) The MAC prices the device according to its pass-through amount, DME fee schedule amount or the device offset amount for packaged devices and the beneficiary co-insurance is set at 20% of the payment amount determined by the MAC. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>

- (d) This code should not be used on inpatient Part B claims for inpatient cases denied as not reasonable and necessary because the surgical service that includes payment for the device is payable. <See Medicare Claims Processing Manual, Chapter 4 § 240.3>

C. Services Covered Only Under Part B

1. Inpatient Part B payment is available for a limited number of preventative services and vaccines only covered under Part B and not covered under Part A when provided to an inpatient directly or under arrangement by a hospital. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3>
 - a. Medicare Benefit Policy Manual, Chapter 15 § 250, attached, contains a list of the services only covered under Part B and not covered under Part A. <See Medicare Benefit Policy Manual, Chapter 6 § 10.3 and Chapter 15 § 250>
2. Billing Requirements
 - a. The hospital submits a 12X claim for these services. <See Medicare Claims Processing Manual, Chapter 4 § 240>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care. May the hospital change the patient's status to outpatient and bill with condition code 44?

Analysis: No, in order to bill with condition code 44 the UR committee determination must be made prior to the patient's discharge and notice provided to the patient. The stay may be billed to Medicare as a self-denial for inpatient Part B payment. <Medicare Claims Processing Manual, Chapter 1 § 50.3; MLN Matters Article SE1333; 42 C.F.R 414.5>

Case Study 2

Facts: A patient presented to City Hospital's surgery department for a pacemaker procedure on Monday at 8 am. At 4 pm the physician ordered inpatient care and the patient stayed overnight and was discharge on Tuesday after a normal course of care for a pacemaker patient.

Upon utilization review, the hospital's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e. there was no reasonable expectation of a two midnight stay) and would not be covered under Part A. On what bill type should the hospital submit the pacemaker procedure?

Analysis: The hospital should submit the pacemaker on a 13X (outpatient) bill type because the surgery was an outpatient service provided prior to a non-covered inpatient stay. The three-day window is inapplicable when the inpatient stay is non-covered. Note that full payment for the encounter will be made under the C-APC for the pacemaker procedure on the 131 claim and no inpatient Part B claim will be necessary in this case. <Medicare Claims Processing Manual, Chapter 4 § 10.12>

ELECTRONIC CODE OF FEDERAL REGULATIONS

SEE AMENDED VERSION ON NEXT PAGE - THIS VERSION PROVIDED FOR EDUCATIONAL PURPOSES ONLY RELATED TO INPATIENT ORDERS

[Title 42](#) → [Chapter IV](#) → [Subchapter B](#) → [Part 412](#) → [Subpart A](#) → §412.3

Title 42: Public Health

[PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES](#)

[Subpart A—General Provisions](#)

§412.3 Admissions. Deleted text represents the amendment effective October 1, 2018.

[Link to an amendment published at 83 FR 41700, Aug. 17, 2018.](#)

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. ~~This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.~~ In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in §412.622 of this chapter.

(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.

(c) The physician order must be furnished at or before the time of the inpatient admission.

(d)(1) Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.

(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under §419.22(n) of this chapter is generally appropriate for payment under Medicare Part A, regardless of the expected duration of care.

(3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015]

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 412 - Prospective Payment Systems for Inpatient Hospital Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

§ 412.3 Admissions.

- (a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. In addition, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622.
- (b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.
- (c) The physician order must be furnished at or before the time of the inpatient admission.
- (d)
 - (1) Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.
 - (i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.
 - (ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.
 - (2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under § 419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

- (i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.
 - (ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.
- (3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015; 83 FR 41700, Aug. 17, 2018; 85 FR 86300, Dec. 29, 2020; 86 FR 63992, Nov. 16, 2021]

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 424 - Conditions for Medicare Payment

Subpart B - Certification and Plan Requirements

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities.

- (a) **Content of certification and recertification.** Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) for cases that are 20 inpatient days or more, or are outlier cases under subpart F of part 412 of this chapter, only if a physician certifies or recertifies the following:
 - (1) The reasons for either -
 - (i) Continued hospitalization of the patient for medical treatment or medically required diagnostic study; or
 - (ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).
 - (2) The estimated time the patient will need to remain in the hospital.
 - (3) The plans for posthospital care, if appropriate.
- (b) **Timing of certification.** For outlier cases under subpart F of part 412 of this chapter, the certification must be signed and documented in the medical record and as specified in paragraphs (e) through (h) of this section. For all other cases, the certification must be signed and documented no later than 20 days into the hospital stay.
- (c) **Certification of need for hospitalization when a SNF bed is not available.**
 - (1) The physician may certify or recertify need for continued hospitalization if he or she finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.
 - (2) If this is the basis for the physician's certification or recertification, the required statement must so indicate; and the certifying physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.
- (d) **Signatures -**
 - (1) **Basic rule.** Except as specified in paragraph (d)(2) of this section, certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

- (2) **Exception.** If the intermediary requests certification of the need to admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.
- (e) **Timing of certifications and recertifications: Outlier cases not subject to the prospective payment system (PPS).**
 - (1) For outlier cases that are not subject to the PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories.
 - (2) The first recertification is required no later than as of the 18th day of hospitalization.
 - (3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.
- (f) **Timing of certification and recertification: Outlier cases subject to PPS.** For outlier cases subject to the PPS, certification is required as follows:
 - (1) For day outlier cases, certification is required no later than 1 day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.
 - (2) For cost outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).
- (g) **Recertification requirement fulfilled by utilization review.**
 - (1) At the hospital's option, extended stay review by its UR committee may take the place of the second and subsequent recertifications required for outlier cases not subject to PPS and for PPS day-outlier cases.
 - (2) A utilization review that is used to fulfill the recertification requirement is considered timely if performed no later than the seventh day after the day the recertification would have been required. The next recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this recertification, the review could be performed as late as the seventh day following the 30th day.
- (h) **Description of procedures.** The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all outlier cases not subject to PPS and of PPS day outlier cases.

[78 FR 50969, Aug. 19, 2013, as amended at 79 FR 67033, Nov. 10, 2014]

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 424 - Conditions for Medicare Payment

Subpart B - Certification and Plan Requirements

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.11 General procedures.

- (a) **Responsibility of the provider.** The provider must -
 - (1) Obtain the required certification and recertification statements;
 - (2) Keep them on file for verification by the intermediary, if necessary; and
 - (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.
- (b) **Obtaining the certification and recertification statements.** No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be a separate signed statement for each certification or recertification. If supporting information for the signed statement is contained in other provider records (such as physicians' progress notes), it need not be repeated in the statement itself.
- (c) **Required information.** The succeeding sections of this subpart set forth specific information required for different types of services.
- (d) **Timeliness.**
 - (1) The succeeding sections of this subpart also specify the timeframes for certification and for initial and subsequent recertifications.
 - (2) A hospital or SNF may provide for obtaining a certification or recertification earlier than required by these regulations or vary the timeframe (within the prescribed outer limits) for different diagnostic or clinical categories.
 - (3) Delayed certification and recertification statements are acceptable when there is a legitimate reason for delay. (For instance, the patient was unaware of his or her entitlement when he or she was treated.) Delayed certification and recertification statements must include an explanation of the reasons for the delay.
 - (4) A delayed certification may be included with one or more recertifications on a single signed statement.
 - (5) For all inpatient hospital services, including inpatient psychiatric facility services, a delayed certification may not extend past discharge.

- (e) **Limitation on authorization to sign statements.** A certification or recertification statement may be signed only by one of the following:
- (1) A physician who is a doctor of medicine or osteopathy.
 - (2) A dentist in the circumstances specified in § 424.13(d).
 - (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under State law.
 - (4) A nurse practitioner or clinical nurse specialist as defined in paragraph (e)(5) or (e)(6) of this section, or a physician assistant as defined in section 1861(aa)(5)(A) of the Act, in the circumstances specified in § 424.20(e).
 - (5) For purposes of this section, to qualify as a nurse practitioner, an individual must -
 - (i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a nurse practitioner in accordance with State law; and have a master's degree in nursing;
 - (ii) Be certified as a nurse practitioner by a professional association recognized by CMS that has, at a minimum, eligibility requirements that meet the standards in paragraph (e)(5)(i) of this section; or
 - (iii) Meet the requirements for a nurse practitioner set forth in paragraph (e)(5)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.
 - (6) For purposes of this section, to qualify as a clinical nurse specialist, an individual must -
 - (i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a clinical nurse specialist in accordance with State law; and have a master's degree in a defined clinical area of nursing;
 - (ii) Be certified as a clinical nurse specialist by a professional association recognized by CMS that has at a minimum, eligibility requirements that meet the standards in paragraph (e)(6)(i) of this section; or
 - (iii) Meet the requirements for a clinical nurse specialist set forth in paragraph (e)(6)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

[53 FR 6634, Mar. 2, 1988, as amended at 56 FR 8845, Mar. 1, 1991; 60 FR 38272, July 26, 1995; 78 FR 47968, Aug. 6, 2013; 78 FR 50969, Aug. 19, 2013; 79 FR 50359, Aug. 22, 2014; 83 FR 41706, Aug. 17, 2018]

- (2) **Exception.** If the intermediary requests certification of the need to admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.
- (e) **Timing of certifications and recertifications: Outlier cases not subject to the prospective payment system (PPS).**
- (1) For outlier cases that are not subject to the PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories.
 - (2) The first recertification is required no later than as of the 18th day of hospitalization.
 - (3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.
- (f) **Timing of certification and recertification: Outlier cases subject to PPS.** For outlier cases subject to the PPS, certification is required as follows:
- (1) For day outlier cases, certification is required no later than 1 day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.
 - (2) For cost outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).
- (g) **Recertification requirement fulfilled by utilization review.**
- (1) At the hospital's option, extended stay review by its UR committee may take the place of the second and subsequent recertifications required for outlier cases not subject to PPS and for PPS day-outlier cases.
 - (2) A utilization review that is used to fulfill the recertification requirement is considered timely if performed no later than the seventh day after the day the recertification would have been required. The next recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this recertification, the review could be performed as late as the seventh day following the 30th day.
- (h) **Description of procedures.** The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all outlier cases not subject to PPS and of PPS day outlier cases.

[78 FR 50969, Aug. 19, 2013, as amended at 79 FR 67033, Nov. 10, 2014]

completed a cost reporting period under the demonstration payment methodology beginning in FY 2013 are available. The actual costs of the demonstration as determined from these finalized cost reports fell short of the estimated amount that was finalized in the FY 2013 IPPS final rule by \$5,398,382.

We note that the amounts identified for the actual cost of the demonstration for each of FYs 2011, 2012, and 2013 (determined from finalized cost reports) is less than the amount that was identified in the final rule for the respective year. Therefore, in keeping with previous policy finalized in situations when the costs of the demonstration fell short of the amount estimated in the corresponding year's final rule, we are including this component as a negative adjustment to the budget neutrality offset amount for the current fiscal year.

e. Total Final Budget Neutrality Offset Amount for FY 2019

For this FY 2019 IPPS/LTCH PPS final rule, we are incorporating the following components into the calculation of the total budget neutrality offset for FY 2019:

Step 1: The amount determined under section IV.L.4.c.(3) of the preamble of this final rule, representing the difference applicable to FY 2018 between the sum of the estimated reasonable cost amounts that would be paid under the demonstration to participating hospitals for covered inpatient hospital services and the sum of the estimated amounts that would generally be paid if the demonstration had not been implemented. The determination of this amount includes prorating to reflect for each participating hospital the fraction of the number of months for the cost report year starting in FY 2018 falling into the overall 12 months of the fiscal year. This estimated amount is \$31,070,880.

Step 2: The amount, determined under section IV.L.4.c.(4) of the preamble of this final rule representing the corresponding difference of these estimated amounts for FY 2019. No prorating is applied in the determination of this amount. This estimated amount is \$70,929,313.

Step 3: The amount determined under section IV.L.4.d. of the preamble of this final rule according to which the actual costs of the demonstration for FY 2011 for the 16 hospitals that completed a cost reporting period beginning in FY 2011 differ from the estimated amount that was incorporated into the budget neutrality offset amount for FY 2011 in the FY 2011 IPPS/LTCH PPS final rule.

Analysis of this set of cost reports shows that the actual costs of the demonstration fell short of the estimated amount finalized in the FY 2011 IPPS/LTCH PPS final rule by \$29,971,829.

Step 4: The amount determined under section IV.L.4.d. of the preamble of this final rule, according to which the actual costs for the demonstration for FY 2012 for the 23 hospitals that completed a cost reporting period beginning in FY 2012 differ from the estimated amount in the FY 2012 final rule. Analysis of this set of cost reports shows that the actual costs of the demonstration for FY 2012 fell short of the estimated amount finalized in the FY 2012 IPPS/LTCH PPS final rule by \$8,500,373.

Step 5: The amount, also determined under section IV.L.4.d. of the preamble of this final rule, according to which the actual costs of the demonstration for FY 2013 for the 22 hospitals that completed a cost reporting period beginning in FY 2013 differ from the estimated amount in the FY 2013 final rule. Analysis of this set of cost reports shows that the actual costs of the demonstration for FY 2013 fell short of the estimated amount finalized in the FY 2013 IPPS/LTCH PPS final rule by \$5,398,382.

In keeping with previously finalized policy, we are applying these differences, according to which the actual costs of the demonstration for each of FYs 2011, 2012, and 2013 fell short of the estimated amount determined in the final rule for each of these fiscal years, by reducing the budget neutrality offset amount to the national IPPS rates for FY 2019 by these amounts.

Thus, the total budget neutrality offset amount that we are applying to the national IPPS rates for FY 2019 is: The amount determined under Step 1 (\$31,070,880) plus the amount determined under Step 2 (\$70,929,313) minus the amount determined under Step 3 (\$29,971,829) minus the amount determined under Step 4 (\$8,500,373) minus the amount determined under Step 5 (\$5,398,382). This total is \$58,129,609.

In addition, in accordance with the policy finalized in the FY 2018 IPPS/LTCH PPS final rule, we will incorporate the actual costs of the demonstration for the previously participating hospitals for cost reporting periods starting in FYs 2015, 2016, and 2017 into a single amount to be included in the calculation of the budget neutrality offset amount to the national IPPS rates in a future final rule after such finalized cost reports become available. We expect to do this in FY 2020 or FY 2021.

In response to the FY 2019 IPPS/LTCH PPS proposed rule, we received one public comment in support of continuing the demonstration. We appreciate the commenter's support.

M. Revision of Hospital Inpatient Admission Orders Documentation Requirements Under Medicare Part A

1. Background

In the CY 2013 OPPI/ASC final rule with comment period (77 FR 68426 through 68433), we solicited public comments for potential policy changes to improve clarity and consensus among providers, Medicare, and other stakeholders regarding the relationship between hospital admission decisions and appropriate Medicare payment, such as when a Medicare beneficiary is appropriately admitted to the hospital as an inpatient and the cost to hospitals associated with making this decision. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50938 through 50942), we adopted a set of policies widely referred to as the "2 midnight" payment policy. Among the finalized changes, we codified through regulations at 42 CFR 412.3 the longstanding policy that a beneficiary becomes a hospital inpatient if formally admitted pursuant to the order of a physician (or other qualified practitioner as provided in the regulations) in accordance with the hospital conditions of participation (CoPs). In addition, we required that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment. In response to public comments that the requirement of a written admission order as a condition of payment is duplicative and burdensome on hospitals, we responded that the physician order reflects affirmation by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and the "order serves the unique purpose of initiating the inpatient admission and documenting the physician's (or other qualified practitioner as provided in the regulations) intent to admit the patient, which impacts its required timing." Therefore, we finalized the policy requiring a written inpatient order for all hospital admissions as a specific condition of payment. We acknowledged that in the extremely rare circumstance the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review

contractors are provided with discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record.

2. Revisions Regarding Admission Order Documentation Requirements

As discussed in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20447 and 20448), despite the discretion granted to medical reviewers to determine that admission order information derived from the medical record constructively satisfies the requirement that a written hospital inpatient admission order is present in the medical record, as we have gained experience with the policy, it has come to our attention that some medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders. Common technical discrepancies consist of missing practitioner admission signatures, missing co-signatures or authentication signatures, and signatures occurring after discharge. We have become aware that, particularly during the case review process, these discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim. In looking to reduce unnecessary administrative burden on physicians and providers and having gained experience with the policy since it was implemented, we have concluded that if the hospital is operating in accordance with the hospital CoPs, medical reviews should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay. It was not our intent when we finalized the admission order documentation requirements that they should by themselves lead to the denial of payment for medically reasonable and necessary inpatient stays, even if such denials occur infrequently.

Therefore, in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20447 and 20448), we proposed to revise the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment. Specifically, we proposed to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.

Hospitals and physicians are still required to document relevant orders in the medical record to substantiate medical necessity requirements. If other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met, and the hospital is operating in accordance with the hospital conditions of participation (CoPs), we stated that we believe it is no longer necessary to also require specific documentation requirements of inpatient admission orders as a condition of Medicare Part A payment. We stated that the proposal would not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission. While this continues to be a requirement, as indicated earlier, technical discrepancies with the documentation of inpatient admission orders have led to the denial of otherwise medically necessary inpatient admission. To reduce this unnecessary administrative burden on physicians and providers, we proposed to no longer require that the specific documentation requirements of inpatient admission orders be present in the medical record as a condition of Medicare Part A payment.

Accordingly, we proposed to revise the regulations at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A. We note that we did not propose any changes with respect to the “2 midnight” payment policy.

Comment: Numerous commenters supported CMS’ proposal. One commenter conveyed that there are instances where medical records clearly indicate inpatient intent but the associated claim is denied only because the inpatient admission order was missing a signature. Another commenter agreed with CMS’ proposal because the requirement for an inpatient admission order to be present in the medical record is duplicative in nature. One commenter explained that alleviating this requirement will result in significant burden reduction for physicians and providers.

Response: We appreciate the commenters’ support.

Comment: Some commenters were concerned that the proposal may render the inpatient admission order completely insignificant and not required for any purpose. In addition,

and in further context, the commenters referenced previous CMS subregulatory guidance from January 2014 which explained that if a practitioner disagreed with the decision to admit a patient to inpatient status, the practitioner could simply refrain from authenticating the inpatient admission order and the patient would remain in outpatient status. The commenters were concerned that if CMS no longer requires a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment, CMS would not be able to distinguish between orders that were simply defective and orders that were intentionally not signed.

Other commenters believed that the proposal would make the payment process even more difficult, especially in instances where patients were not registered by the hospital admissions staff, did not receive the required notice of their inpatient status, and there was no valid admission order related to their visit. The commenters were concerned that these particular cases would prevent patients from being knowledgeable of their appeal rights and financial liability.

Some commenters believed that, without an inpatient admission order, Medicare coverage of SNF services would be at risk due to issues such as lack of clarity in the medical record or a MAC’s misinterpretation of physician intent, and stated that denial of such needed services would negatively impact patients’ health.

Response: Our proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. The physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the process for inpatient admission.

Regarding the concerns of some commenters regarding orders that were intentionally not signed because the practitioner responsible for signing disagreed with the decision to admit, it should never have been the case that the only evidence in the medical record regarding this uncommon situation was the absence of the physician’s or other qualified practitioner’s signature. The medical record as a whole should reflect whether there was a decision by a physician or other qualified practitioner to admit the beneficiary as an inpatient or not. This fact is precisely why, under our current guidance, we acknowledged



that in the extremely rare circumstance where the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review contractors have discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record. We disagree with these commenters that reliance only on the absence of the signature in these uncommon situations reflected good medical documentation practice.

Regarding the commenters who were concerned that our proposal would remove the requirement for an order altogether, affecting patient appeal rights, or increase financial liability, as stated earlier, the physician order remains a requirement for purposes of reflecting a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, initiating the inpatient admission. Additionally, regardless of this proposal and other physician order requirements described earlier, the hospital CoPs include the requirement that all Medicare inpatients must receive written information about their hospital discharge appeal rights.



Comment: Commenters inquired about situations where a patient in outpatient status under observation spent two medically necessary midnights and was subsequently discharged. The commenters stated that, in these situations, providers are allowed to obtain an admission order at any time prior to formal discharge. The commenters inquired whether providers can review this stay after discharge, determine the 2-midnight benchmark was met, and submit a claim for inpatient admission.

Response: Again, the proposal would not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. As noted previously, the physician order reflects the determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the inpatient admission. With respect to the question about reviewing an outpatient stay after discharge and submitting an inpatient claim for that stay, we refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50942) in our response to comments where we stated that “The physician order cannot

be effective retroactively. Inpatient status only applies prospectively, starting from the time the patient is formally admitted pursuant to a physician order for inpatient admission, in accordance with our current policy.”

Comment: Some commenters asked whether condition code 44 was still required to change a patient's status from inpatient to outpatient. Other commenters asked whether condition code 44 could still be used by hospitals without the presence of an inpatient admission order.

Response: We consider these comments regarding the use of condition code 44 to be outside the scope of the proposed rule because we did not make a proposal regarding changing patient status from inpatient to outpatient. Therefore, we are not responding to these comments in this final rule.

Comment: Some commenters wanted to know how the proposed policy changes the process for moving a patient from observation status to inpatient status and the timing of inpatient billing related to this process. Some commenters stated that the proposed policy change appears to suggest that the completion of admission orders would now be optional and other available documentation could be used to create retroactive orders.

Response: As stated earlier, the proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. In addition, this proposal does not change the fact that hospitals are required to operate in accordance with appropriate CoPs.

Regarding the comment about retroactive orders, it has been and continues to be longstanding Medicare policy to not permit retroactive orders. The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (for example, for a prescheduled surgery), but the inpatient admission does not occur until hospital services are provided to the beneficiary.

Comment: Commenters also discussed how the proposed policy may affect procedures on the inpatient only list. Specifically, the commenters wanted to know how this policy proposal applies to patients who receive procedures on the inpatient only list when the patient is an outpatient. In instances when a patient's status changes to inpatient prior to an inpatient order being placed, the commenters questioned whether hospitals would be able to determine the inpatient only procedure was

performed and submit a bill for Medicare Part A payment.


Response: The proposed revision does not include revisions to the policy for processing payment for inpatient only list procedures. As noted previously, our proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. The physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the process for inpatient admission. We did not understand the comment regarding a patient's status changing prior to an order being placed. Therefore, we are unable to specifically respond to that comment.

Comment: Commenters inquired if the proposal would change the requirements regarding which practitioners are allowed to furnish inpatient admission orders.

Response: The proposed revision relating to hospital inpatient admission order documentation requirements under Medicare Part A does not include revisions to the requirements regarding which practitioners are allowed furnish inpatient admission orders.

Comment: A number of commenters had specific questions regarding technical discrepancies. Specifically, the commenters wanted to know if CMS will be publishing a list of acceptable and unacceptable technical discrepancies considered by medical review contractors for the purposes of approving or denying Medicare Part A payment for inpatient admissions. In addition, the commenters wanted to know if CMS will require a specific error rate for compliance with inpatient physician orders, such as for provider technical errors that may be deemed excessive or unacceptable. The commenters also inquired whether providers will be required to document in the medical record whether technical discrepancies occurred in order for Medicare Part A payment to be considered. For example, the commenters wanted to know if an inpatient order for a medically necessary inpatient admission is not signed prior to the patient's discharge, will the facility need to document why the technical discrepancy occurred.

Response: We have not considered developing a list of acceptable or unacceptable technical discrepancies nor have we considered requiring a technical discrepancy error rate.

 In regards to the comment regarding whether this proposed policy would require documentation of how a technical discrepancy occurred, we refer readers to the following subregulatory guidance from the Medicare Benefits Policy Manual (MBPM), Chapter 1, Section 10.2.: “The order to admit may be missing or defective (that is, illegible, or incomplete, for example ‘inpatient’ is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these situations, contractors have been provided with discretion to determine that this information provides acceptable evidence to support the hospital inpatient admission. However, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.” This guidance will remain in effect after this rule is finalized.

Comment: Some commenters recommended that CMS change the audit requirements for contractors so that claims are not denied solely on technical issues found in the inpatient admission order. The commenters also suggested that CMS amend its Medicare Manual to clarify if an inpatient admission order is deemed defective.

Response: We thank the commenters for their recommendations and suggestions. In carrying out their work, medical review contractors are required to follow CMS regulations and policy guidance. If necessary, we may revise our manuals and/or issue additional subregulatory guidance as appropriate with respect to the finalized regulation.

Comment: Some commenters submitted information to demonstrate that CMS had indeed at one point intended to require orders and deny payment based on the absence of orders. As such, the commenters indicated that CMS’ FY 2019 proposed policy would institute a change in language that may confuse hospitals due to lack of clarity. The commenters stated that any change should be accompanied with further changes to relevant CoPs and codified through provider education mechanisms.


The commenters stated that because of perceived uncertainty and lack of clarity in comparing previous CMS guidance and rulemaking language to the language in the policy proposal, providers are going to need assistance in how to proceed in determining how to document inpatient admission orders

and ensure proper processing of Medicare Part A payment. The commenters requested that the proposed policy be incorporated into hospital’s post-discharge review in addition to the audits performed by Medicare contractors.

In addition, commenters believed that the 2-midnight rule amended the Medicare CoPs to require an inpatient admission order. The commenters explained that if CMS proceeds with its proposal, the Agency would have to revise the CoPs to clarify that an order is no longer a condition for Medicare Part A payment.

Response: In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50938 through 50942), we adopted a set of policies widely referred to as the “2-midnight” payment policy, as well as codified the requirement that a physician order for inpatient admission was a specific condition for Part A payment. In that rulemaking, we acknowledged that, in the extremely rare circumstance that the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review contractors are provided with discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record.

However, as we have gained experience with the policy, it has come to our attention that, despite the discretion granted to medical reviewers to determine that admission order information derived from the medical record constructively satisfies the requirement that a written hospital inpatient admission order is present in the medical record, some medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders.

Particularly during the case review process, these discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim. We note that when we finalized the admission order documentation requirements in past rulemaking and guidance, it was not  intent that admission order documentation requirements should, by themselves, lead to the denial of payment for medically reasonable and necessary inpatient stay, even if such denials occur infrequently. It is our intention that this revised policy will properly adjust the focus of the medical review process towards determining

whether an inpatient stay was medically reasonable and necessary and intended by the admitting physician rather than towards occasional inadvertent signature or documentation issues unrelated to the medical necessity of the inpatient stay or the intent of the physician.

Regarding whether CMS would also need to make revisions to the CoPs in order to support this finalized revised regulation, we note that CMS did not make any amendments to the CoPs when we adopted the 2-midnight payment policy or our current inpatient admission order policy; therefore, there is no need to revise the CoPs as a result of the regulatory change we are now finalizing.

Comment: Commenters also asked if the proposal includes any changes to physician certification policy or regulations and whether physician certification will still be required to support payment for an inpatient Medicare Part A claim. Commenters believed CMS’ preamble language that “(i)f other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole . . .” implied that physician certification statements were not always required.

Response: The proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A did not include any changes to physician certification requirements. Not all types of covered services provided to Medicare beneficiaries require physician certification. Physician certification of inpatient services is required for cases that are 20 inpatient days or more (long-stay cases), for outlier cases of hospitals other than inpatient psychiatric facilities, and for cases of CAHs. We refer readers also to the CY 2015 OPPS/ASC final rule with comment period (79 FR 66997), and 42 CFR part 412, subpart F, 42 CFR 424.13, and 42 CFR 424.15.

Comment: Commenters wanted to know if the proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A has an effective date or whether the guidance will be retroactive.

Response: The proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A will be effective for dates of admission occurring on or after October 1, 2018. Previous guidance in our manual regarding constructive satisfaction of hospital inpatient admission order requirements still applies to dates of admission before

October 1, 2018, and will continue to apply after the effective date of this final rule.

Comment: Commenters were concerned that the proposal to revise 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A, will not reduce the administrative burden to providers. The commenters expressed that inpatient admissions will still be denied based solely on timeliness or completion of the attending physician's order and that other Medicare regulations will be referenced as the source of denial.

Response: We will continue to stay engaged with medical review contractors, as we have historically, so that there is awareness and understanding of this revision. As indicated earlier, if necessary, we may revise our manuals and/or issue additional subregulatory guidance as needed.

Comment: Commenters also suggested alternative options to address CMS' concerns regarding hospital inpatient admission order documentation requirements under Medicare Part A, including policy proposals that would substantively change the 2-midnight rule.

Response: We did not propose changes to the 2-midnight rule with this proposal to revise hospital inpatient admission orders documentation requirements. However, we will continue to monitor this policy and may propose additional changes in future rulemaking, or issue further clarifications in subregulatory guidance, as necessary.

Comment: Some commenters believed that removing the hospital inpatient admission order documentation requirement will have negative effects on both the cost and quality of care by losing the assurance that a qualified physician has close involvement in the decision to admit the patient, that they are involved early in the patients care, and that admitting physicians are free from postdischarge financial pressures from the hospital.

Response: We refer readers to our impact discussion regarding this proposal in Appendix A—Economic Analyses, Section I.H.10. of the preamble of this final rule where we state, “our actuaries estimate that any increase in Medicare payments due to the change will be negligible, given the anticipated low volume of claims that will be payable under this policy that

would not have been paid under the current policy.” Furthermore and as stated earlier, this policy proposal would not change the requirement that a beneficiary becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission (nor that the documentation must still otherwise meet medical necessity and coverage criteria); only that the documentation requirement for inpatient orders to be present in the medical record will no longer be a specific condition of Part A payment.

Comment: Some commenters expressed concern that the proposal to revise the inpatient admission order policy presents a problem for the capture of specific data elements necessary for compliance with electronic clinical quality measures.

Response: As indicated earlier, this proposal would not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission. The physician order reflects affirmation by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and serves the purpose of initiating the inpatient admission and documenting the physician's (or other qualified practitioner's, as provided in the regulations) intent to admit the patient. Accordingly, inpatient admission order documentation information should continue to be available in electronic health records.

Comment: Commenters pointed out that this policy proposal only applies to the inpatient prospective payment system and that to encourage consistency across payment systems and reduce documentation burden, CMS should make the same change to documentation requirements at other sites where there will be an inpatient admission, such as in psychiatry and rehabilitation. The commenters acknowledged that this will require rulemaking and encourages CMS to make these changes as soon as possible.

Response: We appreciate the recommendations made by the commenters and will take these comments into consideration in future rulemaking.

After consideration of the public comments we received, we are finalizing our proposal to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment. Specifically, we are finalizing our proposal to revise the regulation at 42 CFR 412.3(a) to

remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.

V. Changes to the IPPS for Capital-Related Costs

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services in accordance with a prospective payment system established by the Secretary. Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the FY 1992 IPPS final rule (56 FR 43358). In that final rule, we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based payment methodology to a prospective payment methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period that was established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.)

The basic methodology for determining capital prospective payments using the Federal rate is set forth in the regulations at 42 CFR 412.312. For the purpose of calculating capital payments for each discharge, the standard Federal rate is adjusted as follows:

$$(\text{Standard Federal Rate}) \times (\text{DRG Weight}) \times (\text{Geographic Adjustment Factor (GAF)}) \times (\text{COLA for hospitals located in Alaska and Hawaii}) \times (1 + \text{Capital DSH Adjustment Factor} + \text{Capital IME Adjustment Factor, if applicable}).$$

In addition, under § 412.312(c), hospitals also may receive outlier payments under the capital IPPS for extraordinarily high-cost cases that

Caution: Portions have been superseded by discussion
in the FY2019 IPPS Final Rule

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 A/B MAC (A) 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 A/B MAC (A) 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 A/B MAC (A) 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.



10.2 – Hospital Inpatient Admission Order and Certification

(Rev. 234, Issued: 03-10-17, Effective: 01-01-16, Implementation: 06-12-17)

The order to admit as an inpatient (“practitioner order”) is a critical element in clarifying when an individual is considered an inpatient of a hospital, including a critical access hospital (CAH), and is therefore required for all hospital inpatient cases for hospital inpatient coverage and payment under Part A. As a condition of payment for hospital inpatient services under Medicare Part A, according to section 1814(a) of the Social Security Act, CMS is requiring, only for long-stay cases and outlier cases, separate physician certification of the medical necessity that such services be provided on an inpatient basis. The signed physician certification is considered, along with other documentation in the medical record, as evidence that hospital inpatient service(s) were reasonable and necessary.

The following guidance applies to all inpatient hospital and CAH services unless otherwise specified. For the remainder of this guidance, references to hospitals includes CAHs. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B, and requirements for admission orders are found at 42 CFR 412.3.

A. Physician Certification. Physician certification of inpatient services is required for cases that are 20 inpatient days or more (long-stay cases), for outlier cases of hospitals other than inpatient psychiatric facilities and for cases of CAHs. (See CY 2015 Outpatient Prospective Payment System Final Rule, 79 FR 66997 and 42 CFR 412 Subpart F, 42 CFR 424.13 and 42 CFR 424.15):

1. Content: The physician certification includes the following information:

- a.** Reason for inpatient services: The physician certifies the reasons for either— (i) Continued hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.
- b.** The estimated (or actual) time the beneficiary requires or required in the hospital: The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge). Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, the regulations at 42

CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

- c. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.
- d. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hour certification requirement. The clock for the 96 hour certification requirement only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour certification requirement.

The 96-hour certification requirement is based on an expectation at the time of admission. If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH, and something unforeseen occurs that causes the individual to stay longer at the CAH, the CAH would be paid for that unforeseen extended inpatient stay as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay. This would be determined based on a medical review of the case.

All certification requirements must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted, as provided in the FY15 IPPS Final Rule and 42 CFR 424.11 and 42 CFR 424.15.

- e. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Outlier cases must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. For all other long stay cases, the certification must be signed and documented no later than 20 days into the inpatient portion of the hospital stay.
3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:
 - (1) A physician who is a doctor of medicine or osteopathy.
 - (2) A dentist in the circumstances specified in 42 CFR 424.13(d).
 - (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff (or by the dentist as provided in 42 CFR 424.11 and 42 CFR 424.13). CMS considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record ("attending") or a physician on call for him or her; a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above. The admitting physician of record may be an emergency department physician or hospitalist. CMS does not require the certifying physician to have inpatient admission privileges at the hospital.

4. **Format:** As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

B. Inpatient Order: A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by an ordering practitioner. As stated in the FY 2014 IPPS Final Rule, 78 FR 50908 and 50941, and as conveyed in 42 CFR 482.24, if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment. Meeting the two midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in Medicare regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by an ordering practitioner.

With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the ordering practitioner as having to occur prior to discharge (e.g., “discharge after supper” or “discharge after voids”). Thus, discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the ordering practitioner’s order for discharge is effectuated.

1. **Content:** The ordering practitioner’s order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) must adhere to the admission requirements specified in 42 CFR 412.622. The two midnight benchmark does not apply in IRFs.
2. **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. See section (B)(3) for a discussion of the requirements to be knowledgeable about the patient’s hospital course. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must authenticate (sign, or in the case of an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)), countersign) the order reflecting that he or she has made the decision to admit the patient for inpatient services.

The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff. However, a medical resident, physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met (FY 14 IPPS Final Rule and 42 CFR 412.3(b)).

- a. **Residents and non-physician practitioners authorized to make initial admission decisions** - Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by authenticating (countersigning) the order prior to discharge. (See (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient's hospital course). In authenticating (countersigning) the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for practitioners (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.

- b. **Verbal orders-** At some hospitals, individuals who lack the authority to admit inpatients under state laws and hospital by-laws (such as a registered nurse) may nonetheless enter the inpatient admission order as a verbal order. In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including; scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. In this case, the staff receiving the verbal order must document the verbal order in the medical record at the time it is received. The order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. Example: "Admit to inpatient per Dr. Smith" would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge.

- c. **Standing orders and protocols** - The inpatient admission order cannot be a standing order. While Medicare's rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section

(B)(2)(a) can make and take responsibility for the inpatient admission decision.

- d. Commencement of inpatient status** - Inpatient status begins at the time of formal admission by the hospital pursuant to the order, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is authenticated (countersigned) timely, by authorized individuals, as required in this section. If the practitioner responsible for authenticating (countersigning) an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an unauthorized verbal order), he or she should not authenticate (countersign) the order and the beneficiary is not considered to be an inpatient. The hospital stay may be billed to Part B as a hospital outpatient encounter.
- 3. Knowledge of the patient's hospital course:** CMS considers only the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record ("attending") or a physician on call for him or her, primary or covering hospitalists caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision. A utilization review committee physician functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee physician may only write the order to admit if he or she is not acting in a utilization review capacity and fulfills one of the direct patient care roles, such as the attending physician. Utilization review may not be conducted by any individual who was professionally involved in the care of the patient whose case is being reviewed (42 CFR 482.30(d)(3)).
- 4. Timing:** The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until hospital care services are provided to the beneficiary. Conversely, in the unusual case in which a patient is admitted as an inpatient prior to an order to admit and there is no documented verbal order, the inpatient stay should not be considered to commence until the inpatient admission order is documented. CMS does not permit retroactive orders. Authentication by the ordering practitioner of the order (either by signature or, in the case of an initial order

under (B)(2)(a) or a verbal order under (B)(2)(b), countersignature) is required prior to discharge for all inpatient cases.

5. **Specificity of the Order:** The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 states, “the order must specify the admitting practitioner’s recommendation to admit ‘to inpatient,’ ‘as an inpatient,’ ‘for inpatient services,’ or similar language specifying his or her recommendation for inpatient care. While CMS does not require specific language to be used on the inpatient admission order, it is in the interest of the hospital that the ordering practitioner use language that clearly expresses intent to admit the patient as inpatient that will be commonly understood by any individual who could potentially review documentation of the inpatient stay. CMS does not recommend using language that may have specific meaning only to individuals that work in a particular hospital (e.g., “admit to 7W”) that will not be commonly understood by others outside of the hospital.

If admission order language used to specify inpatient or outpatient status is ambiguous, the best course of action would be to obtain and document clarification from the ordering practitioner before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit “to ER,” “to Observation,” “to Recovery,” “to Outpatient Surgery,” “to Day Surgery,” or “to Short Stay Surgery”) as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

The admission order is evidence of the decision by the ordering practitioner to admit the beneficiary to inpatient status. In extremely rare circumstances, the order to admit may be missing or defective (that is, illegible, or incomplete, for example “inpatient” is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these extremely rare situations, contractors have been provided with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the order, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.

This narrow and limited alternative method of satisfying the requirement for documentation of the inpatient admission order in the medical record should be extremely rare, and may only be applied at the discretion of the contractor.

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;

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 414 - Payment for Part B Medical and Other Health Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

Source: 55 FR 23441, June 8, 1990, unless otherwise noted.

Editorial Note: Nomenclature changes to part 414 appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

- (a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:
- (1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.
 - (2) Physical therapy services, speech-language pathology services, and occupational therapy services.
 - (3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.
 - (4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.
 - (5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.
 - (6) Clinical diagnostic laboratory services.
 - (7)
 - (i) Effective December 8, 2003, screening mammography services; and
 - (ii) Effective January 1, 2005, diagnostic mammography services.
 - (8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

- (b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).
- (c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

Excerpt from Medicare Benefit Policy Manual, Chapter 6**10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals****(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

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. This 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 hospital services furnished by nonparticipating hospitals. In this section, the term “hospital” includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements (see chapter 16, §170 of this manual, “Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider”). A nonphysician service is one which does not meet the criteria defining physicians’ services specifically provided for in regulation at 42 CFR 415.102. Services “incident to” physicians’ services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

10.1 - Reasonable and Necessary Part A Hospital Inpatient Claim Denials**(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary’s inpatient admission was not reasonable and necessary, and if waiver of liability payment is not made, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

- 1) Part B services paid under the outpatient prospective payment system (OPPS), excluding observation services and hospital outpatient visits that require an outpatient status. Hospitals that are excluded from payment under the OPPS are instead paid under their alternative payment methodology (e.g., reasonable cost, all inclusive rate, or Maryland waiver) for the services that are otherwise payable under the OPPS.
- 2) The following services excluded from OPPS payment, that are instead paid under the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients:

- a. Physical therapy services, speech-language pathology services, and occupational therapy services (see chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services,”).
- b. Ambulance services.
- c. Prosthetic devices, prosthetic supplies, and orthotic devices paid under the DMEPOS fee schedule (excludes implantable 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) and replacement of such devices).
- d. Durable medical equipment supplied by the hospital for the patient to take home, except durable medical equipment that is implantable.
- e. Certain clinical diagnostic laboratory services.
- f. Screening and diagnostic mammography services.
- g. Annual wellness visit providing personalized prevention plan services.

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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), 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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

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 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.2 - Other Circumstances in Which Payment Cannot Be Made Under Part A

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

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, §180 of this 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 (ESRD). 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, §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 ESRD 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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §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, §§220 and 230 of this 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).

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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), 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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for these services must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70, “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.3 - Hospital Inpatient Services Paid Only Under Part B (Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The services listed in Chapter 15, §250 of this manual, “Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities,” when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

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.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

20 - Outpatient Hospital Services (Rev. 157, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The rules in this section pertaining to the coverage of outpatient hospital services are not applicable to the following services.

- Physical therapy, speech-language pathology or occupational therapy services when they are furnished “as therapy” meaning under a therapy plan of care. See chapter 15, sections 220 and 230 of this manual, for coverage and payment rules for these services, which are paid at the applicable amount under the physician fee schedule.
- Services that are covered and paid under the End Stage Renal Disease Prospective Payment System. See Chapter 11, “End Stage Renal Disease (ESRD)” of this manual, for rules on the coverage of these services.

Excerpt from Medicare Benefit Policy Manual, Chapter 15

fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an “intensive care” concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

There are several 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:

- Physicians’ services (including the services of residents and interns in unapproved teaching programs);

- Physician assistant services, furnished after December 31, 1990;

- Certified nurse-midwife services, as described in §180, furnished after December 31, 1990; and

- Qualified clinical psychologist services, as defined in §160, furnished after December 31, 1990;

- Screening mammography services;

- Screening pap smears and pelvic exams;

- Screening glaucoma services;

- Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations;

- Colorectal screening;

- Bone mass measurements; and

- Prostate screening;

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. The other

services listed are not subject to bundling but, because they are excluded from the statutory definition of inpatient hospital services, may be covered only under Part B.

Payment may be made under Part B to a hospital (or critical access hospital) for certain medical and other health services furnished to its inpatients as provided in Chapter 6, §10 of this manual, “Medical and Other Health Services Furnished to Inpatients of Participating Hospitals.”

Payment may be made under Part B for certain medical and other health services if the beneficiary is an inpatient of a skilled nursing facility (SNF) as provided in chapter 8, §§ 70ff of this manual.

260 - Ambulatory Surgical Center Services

(Rev. 77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and change requests. The ASC must accept Medicare’s payment for such procedures as payment in full with respect to those services defined as ASC facility services.

Where services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services; however, the “professional” rate is then adjusted since the ASC incurs the facility costs.

260.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 104; Issued: 03-13-09; Effective Date: 04-01-09; Implementation Date: 04-06-09)

An ASC for purposes of this benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, a facility elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise. This provision is intended to prohibit such an entity from switching from one payment method to another to maximize its revenues (47 FR 34082, 34099, Aug. 5, 1982). For other general conditions and requirements, see 42 CFR 416.25-416.49. If the hospital based surgery center is certified as an ASC it is considered an ASC and is subject to rules for ASCs. Related survey requirements are published in the State Operations Manual, Pub. 100-07, Appendix L. Claims processing and payment requirements for ASCs are published in Pub. 100-04, the Medicare Claims Processing Manual, chapter 14.

Excerpt from Medicare Claims Processing Manual, Chapter 4

furnished. See Pub. 100-04, chapter 3, §90.3.1 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

Effective January 1, 2017, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0815 (Other Organ Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same claim as the transplant procedure in order to be appropriately packaged for payment purposes. Revenue code 0815 charges for allogeneic stem cell acquisition costs are reported on Worksheet D Part V, column 2, line 77, cost center 0077 of the hospital Medicare cost report (Form CMS-2552-10).

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by A/B MACs (A) under the OPPS is available at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>

240 - Inpatient Part B Hospital Services

(Rev. 3106, Issued: 11-06-14, Effective: 10-01-13, Implementation: 02-10-15)

Medicare pays for hospital (including CAH) inpatient Part B services in the circumstances provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, § 10 ("Medical and Other Health Services Furnished to Inpatients of Participating Hospitals"). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient

claim is subject to the statutory time limit for filing Part B claims described in chapter 1, §70 of this manual.

Inpatient Part B services include inpatient ancillary services that do not require an outpatient status and are not strictly provided in an outpatient setting. Services that require an outpatient status and are provided only in an outpatient setting are not payable inpatient Part B services, including Clinic Visits, Emergency Department Visits, and Observation Services (this is not a complete listing).

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 provider's customary charging practice has established separate charges for these services following the PRM-1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed 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 service rendered and documentation meet the definition of the HCPCS in order to separately bill.

240.1 - Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

(Rev.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)

When inpatient services are denied as not medically necessary or a provider submitted medical necessity denial utilizing occurrence span code "M1", and the services are furnished by a participating hospital, Medicare pays under Part B for physician services and the non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.1, "Reasonable and Necessary Part A Hospital Inpatient Claim Denials."

A hospital may also be paid for Part B inpatient services if it 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 would be required to adjust its Part A claim (to make the provider liable) prior to submitting a claim for payment of Part B inpatient services. Whether or not the hospital had submitted a claim to Part A for payment, we require the hospital to submit a 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 could 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.

A hospital part B inpatient services claim billed when a reasonable and necessary part A hospital inpatient was denied must be billed with:

- A condition code “W2” attesting that this is a rebilling and no appeal is in process,
- “A/B REBILLING” in the treatment authorization field, and
- The original, denied inpatient claim (CCN/DCN/ICN) number.

NOTE: Providers submitting an 837I are instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*A/B REBILLING~ For DDE or paper Claims, "A/B Rebilling" will be added in FL 63.

NOTE: Providers submitting an 837I are instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~ For DDE or paper Claims, Providers are instructed to use the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234". (The numeric string (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.)

Not Allowed Revenue Codes

The claims processing system shall set edits to prevent payment on Type of Bill 012x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	029x	0390
0399	045x	050x	051x	052x	054x	055x	056x
057x	058x	059x	060x	0630	0631	0632	0633
0637	064x	065x	066x	067x	068x	072x	0762
082x	083x	084x	085x	088x	089x	0905	0906
0907	0912	0913	093x	0941	0943	0944	0945
0946	0947	0948	095x	0960	0961	0962	0963
0964*	0969	097x	098x	099x	100x	210x	310x

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
 CARC: 96
 RARC: M28

MSN: 21.21

CWF shall edit to ensure that DSMT services are not billed on a 012x claim.

Hospitals are required to report HCPCS codes that identify the services rendered.

ort HCPCS codes that identify the services rendered.

240.2 - Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A *(Rev.:11685, Issued:11-09-22, Effective: 07-01-22, Implementation: 12-12-22)*

When Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 012x for claims containing the revenue codes listed in the table below with exceptions as noted. For the exceptions noted, contractors shall ensure that only the exceptions identified are allowed to process with the revenue code.

Not Allowed Revenue Codes

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	026x	0270
0271	0272	0273	0277	0279	028x	029x	036x
0370	0374	0379	038x	039x	041x	045x	0470
0472	0479	0480	0481	0489	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	056x	057x	058x	059x	060x
0620	0624	063x	064x	065x	066x	067x	068x
069x	070x	071x	072x	075x	076x	079X	081x
082x	083x	084x	085x	087x	088x	089x	090x
091x	093x	0940	0941	0942*	0943	0944	0945
0946	0947	0948	0949	095x	0960	0961	0962
0963	0964*	0969	097x	098x	099x	100x	210x
310x							

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
 CARC: 96
 RARC: M28
 MSN: 21.21

Hospitals are required to report HCPCS codes that identify the services rendered.

Allowed Revenue Codes

0240	0274	0275	0276	0278	030x	031x	032x
0333	034x	035x,	040x,	042x	043x	044x	046x
0471	0482	0483	054x	061x	0623	073x	074x
0771	078x*	080x	086x	092x	0942*	0964*	

*Billed prior to admission or on the day of discharge.

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

* In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.

Additional Allowed services that are be identified by HCPCS, not identified by Revenue Codes

Other Diagnostic services: (A MAC maintained)

Preventive services:

COVID-19, Influenza, pneumococcal pneumonia, and hepatitis B vaccines

Colorectal screening

Screening glaucoma services

Bone mass measurements

Prostate screening

Covered drugs:

Hemophilia clotting factors

Immunosuppressive drugs

Oral anti-cancer drugs

Oral anti-emetic

Non-ESRD Epoetin Alfa (EPO)

240.3 - Implantable Prosthetic Devices

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

Under 42 CFR 419.2(b)(11), implantable 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 these devices, are paid under the OPPS, and are therefore packaged with the surgical implantation procedure unless the device has pass-through payment status. This payment provision applies when such a device is billed as a Part B outpatient service, or as a Part B inpatient service when the inpatient admission is determined not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.1). In these circumstances, hospitals should submit the usual HCPCS code for Part B payment of the device.

In the other circumstances in which a beneficiary does not have Part A coverage of inpatient services on the date that such a device is implanted (that is, when furnished by a participating hospital to an inpatient who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), hospitals paid under the OPPS should report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, that is effective for services furnished on or after January 1, 2009. This code allows an alternative Part B inpatient payment methodology for the device as discussed in this section, and may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage under Part A because he or she is not entitled to Part A benefits, has exhausted his or her Part A benefits, or receives services not covered under Part A. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting C9899, the hospital is reporting that the item is eligible for separate OPPS payment because the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”).

If C9899 is a separately payable Part B inpatient service, the contractor shall determine the payment amount as follows. If the device has pass through status under the OPPS, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS

fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPS webpage, select “Device, Radiolabeled Product, and Procedure Edits” from the list on the left side of the page. Open the file “Procedure to Device edits” to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file “FB/FC Modifier Procedures and Devices”. Select the applicable year’s file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy”). Select the “Full offset reduction amount” that pertains to the APC that is most applicable to the device described by C9899. It would be reasonable to set this amount as payment for the device.

For example, if C9899 is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in “remarks”) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single chamber pacemaker to \$4881.77. In this case the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or

the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

When a hospital that is not paid under the OPPTS furnishes an implantable prosthetic device other than dental), which replaces all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such a device, to an inpatient who has coverage under Part B but does not have Part A coverage, and the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”), payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

240.4 - Indian Health Service/Tribal Hospital Inpatient Social Admissions

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

There may be situations when an American Indian/Alaskan Native (AI/AN) beneficiary is admitted to an IHS/Tribal facility for social reasons. These social admissions are for patient and family convenience and are not billable to Medicare. There are also occasions where IHS/Tribal hospitals elect to admit patients prior to a scheduled day of surgery, or place a patient in a room after an inpatient discharge. These services are also considered to be social admissions as well.

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, Type of Bill (TOB) 12X during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13X or 72X. The Common Working File (CWF) returns an A/B crossover edit and creates an unsolicited response (IUR) in this situation.

The CWF also creates an IUR when a line item date of service on TOB 12X is equal to or one day following the discharge date on TOB 11X for the same provider.

The CWF bypasses both of these edits when the beneficiary is not entitled to Medicare Part A at the time the services on TOB 12X are rendered.

240.5 - Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10 (“Medical and Other Health Services Furnished to Inpatients of Participating Hospitals”) and Pub 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12 (“Payment Window for Outpatient Services Treated as Inpatient Services”) regarding services bundled into the

original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission, that may be billed to Part B when Part A payment cannot be made. Hospitals should use the following type of bill to report these services:

- 13X TOB (85X for a CAH)- Hospital outpatient services included in the payment window for outpatient services treated as inpatient services
- 14X TOB- Laboratory tests that are paid under the clinical laboratory fee schedule (see chapter 16, §40.3 of this manual), and included in the payment window for outpatient services treated as inpatient services

240.6 - Submitting Provider-Liable “No-Pay” Part A Claims and Beneficiary Liability

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

When Part A payment cannot be made for a hospital inpatient admission and the hospital, not the beneficiary, is liable under section 1879 of the Act for the cost of the Part A items and services, the hospital must submit a provider-liable “no pay” Part A claim (110 TOB) (see chapter 3 §40.2.2, “Charges to Beneficiaries for Part A Services” of this manual). Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A. When a Medicare review contractor denies a Part A claim for medical necessity, the claims system converts the originally submitted 11X claim to a 110 TOB on behalf of the hospital.

When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary’s Medicare utilization record is not charged for the services and items furnished. The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, “Beneficiary Determined to Be Without Liability” and 30.2.2, “Provider/Practitioner/Supplier is Determined to Be Liable” of this manual).

Medicare beneficiaries are liable for their usual Part B financial liability for services covered under Part B when Part A payment cannot be made, including Part B copayments for each payable Part B inpatient or Part B outpatient service. The beneficiary is also liable for the cost of services not covered under Part B.

250 - Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in §250.1. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee