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Acute Care Hospitals - Billing Medicare After the COVID-19 Public Health Epidemic Ends

2023 Spring Virtual Conference

5/17/2023

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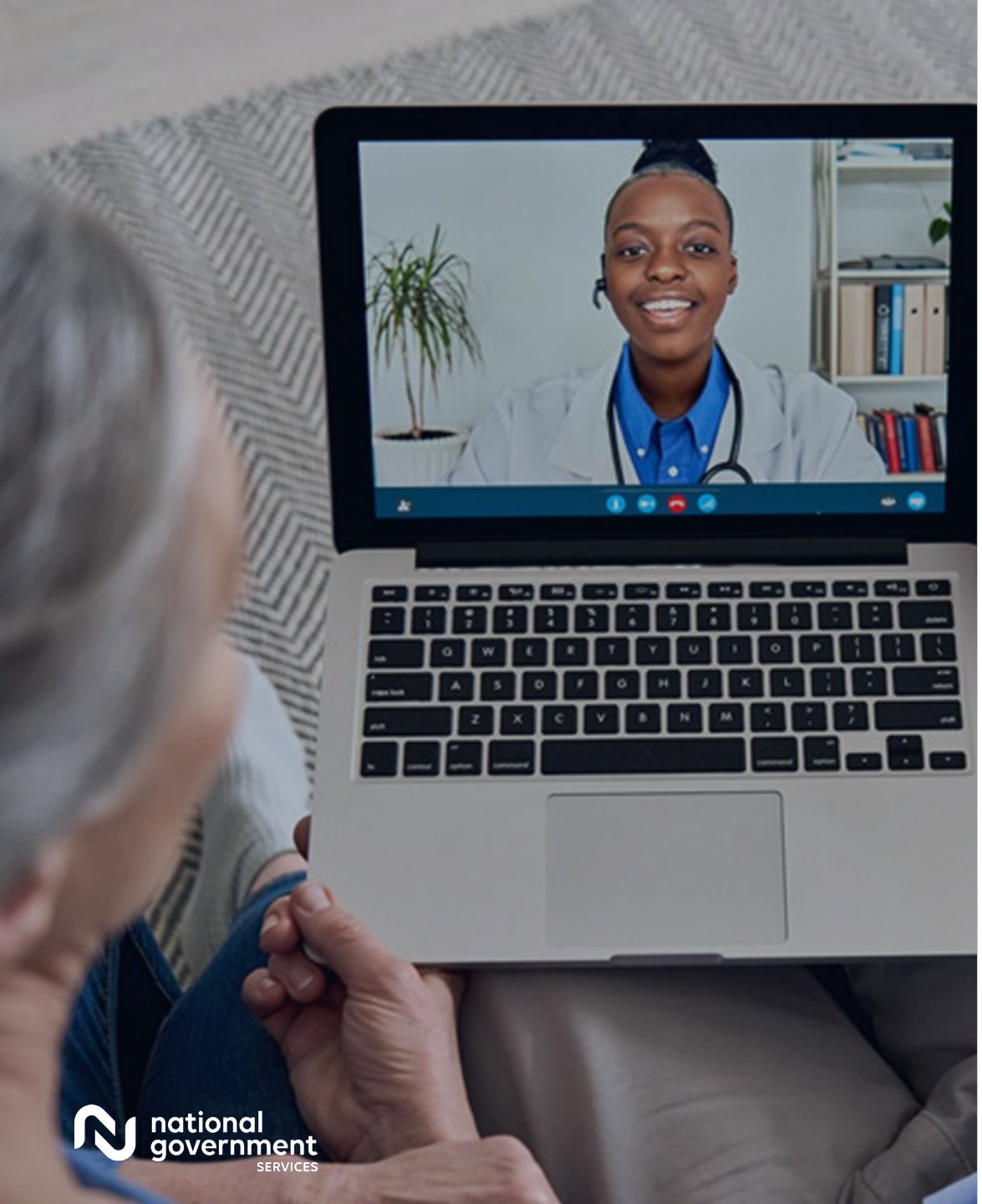

Recording

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Objectives

Review for ACHs

- Impacts of end of PHE on Medicare billing
- Various Medicare billing policies

Today's Presenters

- Provider Outreach and Education Consultants
  - Christine Janiszcak
  - Jean Roberts

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Agenda

- End of PHE Reminders
- End of PHE on Hospitals
- ACH Billing Reminder – TOB 12X
- ACH Billing Reminder – Under Arrangement Policy
- Resources
- Questions and Answers

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End of PHE Webinars 1 and 2 Reminders (5/10/2023)

Suggested Provider Actions

- Vital to ensure you receive latest information/updates
  - During COVID-19 PHE, and after, information and instructions may change
  - Many waivers and flexibilities going away and will return to pre-COVID-19 instructions while others may be extended
- Ensure you are subscribed to list serve messaging
  - CMS Medicare Email Updates at CMS.gov
  - ASPR: HHS Office of the Assistance Secretary for Preparedness and Response
  - National Government Services Email Updates
- Periodically check
  - CMS Medicare Current Emergencies
  - CMS Medicare Coronavirus Waivers & Flexibilities

Periodically Check CMS Roadmap and More

- What Do I Need to Know? CMS Waivers, Flexibilities, and Transition Forward from COVID-19 Public Health Emergency
- Fact Sheet: CMS Waivers, Flexibilities, and Transition Forward from COVID-19 Public Health Emergency (2/27/2023)
- Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap (2/9/2023)
- Creating a Roadmap for End of COVID-19 Public Health Emergency (8/18/2022)

Periodically Check

- Provider-specific fact sheets: Information about COVID-19 Public Health Emergency (PHE) waivers and flexibilities
- Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19
- Telehealth Policy Updates
- CMS List of Telehealth Services
- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

End of PHE: Overview

- 5/11/2023
  - End of national emergency and PHE declarations related to COVID-19 pandemic
    - ✓ Expired at end of day
- During PHE, CMS
  - Used emergency waiver and various regulatory authorities to enable flexibilities
  - Added and terminated flexibilities and waivers as needed
- In preparing for future, CMS
  - Continues to evaluate PHE blanket waivers and flexibilities
  - Assesses which flexibilities would be most useful in a future PHE
  - Collaborates with federal partners and health care industry to ensure health care system is prepared for future emergencies

End of PHE: Overview (2)

- Expired 5/11/2023
  - Certain blanket waivers and flexibilities
  - Blanket waivers generally apply to all entities in provider category
    - ✓ CMS typically issues standard group of such waivers
    - ✓ These waivers were made available to several categories of providers
    - ✓ Blanket waivers
- At PHE end
  - These waivers ended unless legislation made permanent
- Extended by Consolidated Appropriations Act (CAA) for FY (H.R. 2716)
  - Major telehealth flexibilities/waivers
  - Acute Hospital Care at Home (AHCaH)

Topics Covered

- Payment adjustments for domestic NIOSH-approved surgical N95 respirators
- COVID-19 testing
- COVID-19 specimen collection
- COVID-19 vaccinations
- COVID-19 treatments and add-on payments
- COVID-19 antibody diagnostic tests
- Monoclonal antibodies
- Acute Hospital At Home (AHCaH)
- Hospitals without walls
- OPPS remote behavioral health update
- Opioid Treatment Program (OTP)
- Telehealth

End of PHE for Acute Care Hospitals

Deactivated Billing Codes

- Deactivated effective for DOS on/after 5/12/2023
  - CR modifier
    - ✓ Catastrophe/disaster related, mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned on presence of a "formal waiver" to allow bypass for co-pay and deductible for disaster or emergency-related services
  - DR condition code
    - ✓ Disaster-related, only used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster

Extended Through 12/31/2024

- During PHE
  - CMS implemented AHCaH initiative, a flexibility that allowed hospitals to expand their capacity to provide IP care in beneficiary's home
    - ✓ Many hospitals and individuals participated in this initiative
    - ✓ Individual hospital waiver required
- After PHE
  - AHCaH individual waiver extended under CAA 2023
    - ✓ Hospitals can continue to apply to participate in initiative
    - ✓ If beneficiary is receiving care in participating hospital and meets requirements to receive IP care at home, he/she can continue to do so
    - ✓ CMS continues to accept waiver requests from individual hospitals
    - ✓ Acute Hospital Care at Home
    - ✓ CR12540

Expired 5/11/2023

- During PHE
  - HOPDs were separately paid for COVID-19 related symptom assessment and specimen collection when billed using HCPCS code C9803 and when not billed with another covered HOPD service
    - ✓ As of CY 2023, national base payment rate for HCPCS code C9803 slightly under $25
- At PHE end
  - Payments to HOPDs for specimen collection related to COVID-19 testing not separately paid
  - CMS discontinued HCPCS code C9803

Expired 5/11/2023

- During PHE
  - CMS allowed hospitals to set up temporary expansion sites and remote locations such as hotels and community facilities
    - ✓ Example: Waivers to allow acute care patients to be housed in other facilities such as ASCs, IRFs, hotels, dorms to temporarily expand capacity)
- At PHE end
  - ACHs required to provide services to patients within their hospital departments in accordance with Medicare's hospital CoP

Expired 5/11/2023

- During PHE
  - CMS waived requirements at 42 CFR S482.58, subsections (a)(1)-(4) Eligibility
  - Provided additional options for hospitals with patients who no longer required acute LOC but are unable to find placement in SNF
    - ✓ Hospitals could offer long-term care services (Swing Beds) for inpatients who did not require acute LOC but did meet SNF LOC criteria at 42 CFR S409.31
- At PHE end
  - ACHs cannot bill for SNF PPS payment using Swing Beds

Expired 5/11/2023

- During PHE
  - CMS waived requirements to allow ACHs to house acute care inpatients n DPUs, where DPU's beds are appropriate
    - ✓ ACH could bill for care and annotate beneficiary's medical record to indicate he/she is acute care inpatient being housed in DPU due to capacity issues
- At PHE end
  - ACHs cannot bill for acute care inpatients housed in excluded DPUs

Expired 5/11/2023

- During PHE
  - CMS waived requirements to allow ACHs with IP psychiatric DPUs that needed to relocate inpatients from such DPUs to acute care bed and unit
    - ✓ Hospital could continue to bill for inpatient psychiatric services under IPF PPS for such patients and annotate medical record to indicate patient is psychiatric inpatient being housed in acute care bed
    - ✓ Only when hospital's acute care beds are appropriate for patients and staff/environment are conducive to safe care
- At PHE end
  - Inpatients receiving psychiatric services paid under IPF PPS and furnished by excluded psychiatric DPU of ACH cannot be housed in acute care beds and unit
    - ✓ ACHs cannot bill for IP psychiatric DPU inpatients housed in acute care beds and unit

Expired 5/11/2023

- During PHE
  - CMS waived requirements to allow ACHs with IP rehabilitation DPUs that needed to relocate inpatients from such DPUs to acute care bed and unit
    - ✓ Hospital could continue to bill for IP rehabilitation services under IRF PPS for such patients and annotate medical record to indicate patient is rehabilitation inpatient being housed in acute care bed
    - ✓ Only when hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continued to receive intensive rehabilitation services
- At PHE end
  - Inpatients receiving rehabilitation services paid under IRF PPS and furnished by excluded rehabilitation DPU of ACH cannot be housed in acute care beds and unit
    - ✓ ACHs cannot bill for IP rehabilitation DPU inpatients housed in acute care beds and unit

Expired 5/11/2023

- Use of hospital PBD as temporary expansion site and hospital temporary extraordinary circumstances relocation policy
  - PBDs that relocated during PHE should relocate back to their original location unless PBD decides to permanently relocate off-campus
    - ✓ PBDs that permanently relocate are new off-campus PBDs; must bill with PN modifier and are paid PFS-equivalent rate
    - ✓ Temporarily relocated off-campus PBDs that do not go back to their original location are non-excepted PBDs and paid PFS-equivalent rate
- Resources:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4
    - ✓ Section 20.6.11 - Modifier PO & Section 20.6.12 - Modifier PN & 20.6.18 – Modifier ER
  - MLN Matters® *SE18002: Billing Requirements for OPPS Providers with Multiple Service Locations*

Off Campus Provider Based Facility

- Service facility address of off-campus, OP, PBD of a hospital facility is used to determine the locality
- Ensures accuracy: MPFS and OPPS payments
- CMS implementing edits to ensure address is an exact match to address in PECOS
  - MLN Matters® *SE19007 Revised: Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update*

Reporting Service Facility Location For Off Campus OP PBD of Hospital

- Electronic submitters
  - 2310E loop of 837 institutional claim transaction
- DDE submitters
  - MAP171F
- Paper Claim submitters
  - Form Locator (FL) “01” of claim form

Modifier Reminders

- PN Modifier
  - Definition
    - ✓ Non-excepted service provided at off-campus, OP, PBD of a hospital
  - Report
    - ✓ On each claim line with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services

Modifier Reminders

- PO Modifier
  - Definition
    - ✓ Services, procedures, and/or surgeries furnished at excepted off-campus provider-based OP Departments
    - ✓ Grandfathered
  - Report
    - ✓ With every HCPCS code for all OP hospital items and services furnished in excepted off-campus PBD of a hospital

Modifier Reminders

- ER Modifier
  - Definition
    - ✓ Items and services furnished by a provider-based off-campus emergency department (ED)
  - Report
    - ✓ With every claim line for OP hospital services furnished in an off-campus provider based ED
  - Provider-based off-campus EDs that meet definition of a "dedicated emergency department"
    - ✓ Defined in 42 CFR 489.24 under Emergency Medical Treatment and Labor Act (EMTALA) regulations
    - ✓ CR11099

Provider Practice Address Query

- The purpose of the Provider Practice Address Query screen is to display the additional practice addresses for a facility, this includes off-campus, OP, or PBD of a hospital

Reason Codes

- 34977
  - Claim service facility address doesn't match provider practice file address
- 34978
  - Off-campus provider claim line that contains a HCPCS must have a PN or PO modifier

Exceptions

- Exceptions to hospital claims where the service facility location will not be at a hospital owned location
  - MLN Matters® *MM11470: Updating FISS Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home*
- Services rendered at:
  - Mobile Facility and/or Portable Units
  - Patient's home

Exceptions Coding

- NUBC approved condition code "A7"
  - Claims with hospital services provided in a Mobile Facility or with Portable Unit
  - Effective 4/1/2020
- Edit will be bypassed when service facility address matches beneficiary's permanent or temporary address

Multiple Service Locations Resources

- MLN Matters® *SE18002: Billing Requirements for OPPS Providers with Multiple Service Locations*
- MLN Matters® *SE18023: Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations*
- MLN Matters® *SE19007 Revised: Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update*
- MLN Matters® *MM9613: Implementing Provider File Updates and PECOS to FISS Interface Via Extract File Updates to Accommodate Section 603 Bipartisan Budget Act of 2015*
- MLN Matters® *MM9907: Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2*
- CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 170 " Payment Bases for Institutional Claims"

ACH Billing Reminder – Type of Bill 12X

Submit Claims for Inpatient Hospital Stays

- Submit claims to us for all IP hospital stays
  - Even if not expecting Medicare payment
    - ✓ Except if beneficiary not entitled to Part A, then not required
    - ✓ Includes services rendered to MAO plan enrollees
- Use TOB 11X
  - Processed by Part A
    - ✓ TOB 110 for noncovered stays (do not include OP services rendered within three-day payment window)

Did You Know…

- The three-day payment window does not apply when Medicare Part A cannot pay for a beneficiary's IP hospital stay
  - Part A payment cannot be made for IP stay when
    - ✓ Beneficiary is not entitled to Part A or has Part A but has exhausted IP hospital benefits (BE)
    - ✓ IP stay is not covered by Medicare (i.e., not R&N) per decision made by MAC or Medicare review contractor (MRC) or ACH's self-audit (Part A to B rebilling rules apply)

Submit Inpatient Ancillary Claim When No Part A or Part A Benefits Previously Exhausted

- Submit claims to us for IP ancillary hospital services when
  - We cannot pay for IP stay under Part A because
    - ✓ Beneficiary does not have Medicare Part A entitlement (IP claim not required)
    - ✓ Beneficiary has Part A but IP hospital BE before admission (IP claim required but rejected)
- Use TOB 12X
  - Processed by Part B of A

Billable on TOB 12X When No Part A or Part A Benefits Previously Exhausted

- Billable services payable under OPPS (based on HCPCS codes):
  - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
  - X-ray, radium, radioactive isotope therapy, including technician materials/services
  - Acute dialysis of hospital inpatient with/without ESRD (Review references)
  - Vaccines: COVID-19, Influenza, pneumococcal pneumonia, and hepatitis B
  - Bone mass measurements
  - Screenings: colorectal, glaucoma, pap smears, prostate
  - Drugs:
    - ✓ Hemophilia clotting factors for hemophilia patients competent to use without supervision;
    - ✓ Immunosuppressive drugs
    - ✓ Oral anti-cancer drugs
    - ✓ Oral drug prescribed as acute anti-emetic used as part of anti-cancer chemotherapeutic regimen
    - ✓ Epoetin Alfa (EPO) not covered under ESRD benefit

Billable on TOB 12X When No Part A or Part A Benefits Previously Exhausted – 2

- Billable services payable under other methods (based on HCPCS codes):
  - Surgical dressings, splints, casts, other devices for reduction of fractures/dislocations
  - Prosthetic devices (other than dental) which replace all or part of internal body organ, including replacement of such devices
  - Leg, arm, back, neck braces, trusses, artificial legs, arms, eyes including replacements if required because of change in physical condition
  - PT, SLP and OT services
  - Ambulance services
  - Screening mammography services
- References:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18

Billable on TOB 12X When No Part A or Part Benefits Previously Exhausted – 3

- Billable 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
    - ✓ 078x billed prior to admission or on day of discharge
  - 080x, 086x
  - 092x, 0942, 0964
    - ✓ 0942 used by Rural hospitals for KDE services
    - ✓ 0964 used by hospitals with CRNA exception
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2

Not Billable on TOB 12X When No Part A or Part A Benefits Previously Exhausted

- Revenue codes not billable:
  - 010x, 011x, 012x, 013x, 014x, 015x, 016x, 017x, 018x, 019x
  - 020x, 021x, 022x, 023x, 0250-0253, 0256-0259, 026x, 0270-0273, 0277, 0279, 028x, 029x
  - 036x, 0370, 0374, 0379, 038x, 039x
  - 041x, 045x, 0470, 0472, 0479-0481, 0489, 049x
  - 050x, 051x, 052x, 053x, 0541-0544, 0546-0549, 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, 0940-0949, 095x, 0960-0964, 0969, 097x, 098x, 099x
  - 100x, 210x, 310x
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2

Submit Claims for Inpatient Ancillary Hospital Services When Inpatient Stay Denied

- Submit claims to us for IP ancillary hospital services when
  - We cannot pay for IP stay under Part A
    - ✓ IP hospital claim denied not R&N by provider (self audit); IP claim required per CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.6
    - ✓ IP hospital claim denied not R&N by MAC or MRC; IP claim required but we adjust previously submitted claim to provider liable
- Use TOB 12X
  - Processed by Part B of A
  - Submit once IP no-payment claim or adjustment claim is finalized

Submit Claims for Inpatient Ancillary Hospital Services When Inpatient Stay Denied – 2

- When IP hospital claim is denied
  - TOB 12X claim may include services that would have R&N if beneficiary had been treated as hospital OP
    - ✓ Except for services that require OP status such as OP visits, ED visits and observation services
- TOB 12X requires Part A to B rebilling claim coding:
  - CC = W2
  - Treatment authorization code = A/B Rebilling
  - Remarks = ABREBILL12345678901234 (numbers represent IP claim's DCN)

Billable on TOB 12X When IP Stay Denied

- Billable Part B services paid under OPPS, except observation services and hospital OP visits that require OP status
- Services excluded from OPPS payment:
  - PT, SLP, and OT services (see C15, §§220 and 230 of this manual).
  - Ambulance services
  - Prosthetic devices, prosthetic supplies, orthotic devices paid under DMEPOS fee schedule (see IOM for certain exclusions)
  - DME equipment supplied by hospital for patient to take home, except implantable DME
  - Certain clinical diagnostic laboratory services
  - Screening and diagnostic mammography services
  - AWV providing personalized prevention plan services
- Reference:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1

Not Billable on TOB 12X When IP Stay Denied

- Revenue codes not billable:
  - 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, 0630-0633, 0637, 064x, 065x, 066x, 067x, 068x
  - 072x, 0762
  - 082x, 083x, 084x, 085x, 088x, 089x
  - 0905-0907, 0912-0913, 093x, 0941, 0943-0948, 095x, 0960-0964, 0969, 097x, 098x, 099x
  - 100x, 210x, 310x
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.1

Submit Claims for Inpatient Ancillary Hospital Services in Other Situations

- Submit claims to us for IP ancillary hospital services
  - When we pay in Part for IP claim under Part A
    - ✓ For services rendered after TOB 11X claim's BE date and such claim was paid including part of outlier (VC 17) (TOB 12X claim's from date greater than TOB 11X claim's last paid day)
    - ✓ For certain days not paid and no waiver of liability payment made for such days (TOB 12X claim's from/through dates can fall within TOB 11X claim's OSC 76, 77 or 79 from/through dates)
    - ✓ Review CR7849
- Use TOB 12X
  - Processed by Part B of A

Coding Reminders

- IP hospital BE date shown with OC A3, B3 or C3
- Outlier payment shown with VC 17
- OSCs:
  - 76 = Patient liability (From/through dates of a period of non-covered care for which the hospital/ SNF is permitted to charge beneficiary)
  - 77 = Provider liability period/utilization charged (From/through dates of a period of noncovered care for which provider is liable)
  - 79 = Payer code (This code is set aside for payer use only. Providers do not report this code)

Submit Claims for Inpatient Ancillary Hospital Services in Other Situations – 2

- Hospitals may submit TOB 12x claim for certain services covered under Part B even when beneficiary has Part A coverage for IP hospital stay
  - Includes:
    - ✓ Screening mammography services
    - ✓ Screening pap smears and pelvic exams
    - ✓ Screening glaucoma services
    - ✓ COVID-19, Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations
    - ✓ Colorectal screening
    - ✓ Bone mass measurements
    - ✓ Prostate screening
- References
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.3
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 250
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18

TOB 12X Services – Requirements for Payment Under Part B

- If submitting TOB 12X for IP ancillary hospital services
  - Such services
    - ✓ Must be billable
    - ✓ Must meet all Part B coverage and payment conditions
    - ✓ Must be rendered after formal admission as hospital IP
    - ✓ Must be recoded to Part B services (revenue, CPT/HCPCS coding)
    - ✓ Are payable under Part B (OPPS, fee schedule or prospectively determined rate) if beneficiary has Part B and waiver of liability payment is not made
    - ✓ Must have been furnished directly by hospital or under arrangement with hospital
    - ✓ Must be submitted within one year timely filing
    - ✓ Must contain Part A to B Rebilling coding when Part A stay denied

ACH Billing Reminder – Inpatient Under Arrangement Policy

Services Furnished to Your Inpatients

- All items and nonphysician services furnished to hospital inpatients must be
  - Furnished directly by IP hospital or
  - Billed through IP hospital under arrangement
    - ✓ CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 10.4
- What is meant by under arrangement?
  - ACH that admitted beneficiary as an inpatient
    - ✓ May not be able to furnish certain ancillary services during stay
    - ✓ Arranges for beneficiary to receive services at another provider as OP (returns by midnight)
    - ✓ Pays other provider for such services and pays transportation provider for any transportation
    - ✓ Reports costs (total paid to other providers) on its IP claim

All Items and NonPhysician Services

- When furnished to inpatients, following covered under Part A PPS rate
  - Laboratory services, excluding anatomic pathology services and certain clinical pathology services
  - Pacemakers/other prosthetic devices including lenses, artificial limbs, knees, hips
  - Radiology services including CT scans furnished to inpatients by physician's office, other hospital, or radiology clinic
  - Total parenteral nutrition (TPN) services
  - Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at hospital where beneficiary is inpatient
    - ✓ Hospital must include cost of these services in appropriate ancillary service cost center, i.e., in cost of diagnostic or therapeutic service; it must not show them separately under revenue code 0540

All Items and Nonphysician Services

- If IP hospital sends beneficiary to physician's office for services
  - IP hospital is responsible for any service that is not physician professional service
  - Part B pays physician for professional services, such as E/M or injection administration, even if beneficiary is registered hospital inpatient
    - ✓ Physician must bill Part B with POS = 21
    - ✓ Physician professional service (PC/TC = 0) on PFS
    - ✓ Physician Fee Schedule Look Up Tool
    - ✓ MLN Booklet® *How to Use the MPFS Look-Up Tool*

Under Arrangement Policy – Billing and Example

- ACH that admitted beneficiary as IP reports
  - Revenue code for OP ancillary service provided by other providers
    - ✓ But not 0540 for transportation
  - All associated costs including transportation (amount paid to other providers)
- Example
  - Beneficiary
    - ✓ Admitted as IP to hospital A and needs MRI (revenue code 0612) only hospital B can provide
  - Hospital A
    - ✓ Arranges for beneficiary to receive OP MRI at hospital B and for transportation to/from each hospital
    - ✓ Submits IP claim including revenue code 0612 with total paid to hospital B and transportation provider
  - Hospital B
    - ✓ Charges hospital A for MRI done as OP
  - Transportation provider
    - ✓ Charges hospital A for transportation provided

ACH Provides OP Services to Inpatients of Other Hospitals

- Since under arrangement policy applies to all hospitals
  - If your ACH renders OP services to beneficiary who is in a covered Part A stay at another hospital (CAH, IPF, IRF or LTCH)
    - ✓ Submit your OP services to that hospital who must pay under arrangement
      - Do not submit claim to Medicare

Resources

CMS Resources

- Acute Hospital Care at Home
  - Acute Hospital Care at Home Individual Waiver Only (not a blanket waiver)
  - Acute Hospital Care at Home Reporting Measures
  - Acute Hospital Care at Home Resources
    - ✓ Includes list of approved facilities
- ASPR: HHS Office of the Assistance Secretary for Preparedness and Response
- Billing and Coding Medicare Fee-for-Service Claims
- Blanket waivers
- CMS 1135 Waiver/Flexibility Request and Inquiry Form
- CMS Emergencies Page
- CMS List of Telehealth Services
- CMS Medicare Coronavirus Waivers & Flexibilities
- CMS Medicare Current Emergencies

CMS Resources – 2

- MLN Matters® *SE20011 Revised: Medicare FFS Response to the PHE on COVID-19*
- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
  - Blanket Waivers Only
  - Unless otherwise noted, these waivers terminate at the end of the COVID-19 PHE
- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing
- Creating a Roadmap for the End of the COVID-19 Public Health Emergency (8/18/2022)
- Fact Sheet: CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency (2/27/2023)
- Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap (2/9/2023)
- Health Care System Resiliency

CMS Resources – 3

- Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19
- MLN Fact Sheet® MLN901705, *Telehealth Services*
- Provider-specific fact sheets: Information about COVID-19 Public Health Emergency (PHE) waivers and flexibilities
- Social Security Act: Title XV111 Health Insurance for the Aged and Disabled
- Telehealth: Billing and coding Medicare Fee-for-Service claims
- Telehealth policy changes after the COVID-19 public health emergency
- Telehealth Policy Updates
- What Do I Need to Know? CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency

CMS Resources – Under Arrangement

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 3, Section 10.4, "Payment of Nonphysician Services For Inpatients" (exceptions noted in reference)
- MLN Matters® *SE17033 Revised: Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities*
  - This reference includes links to many other references

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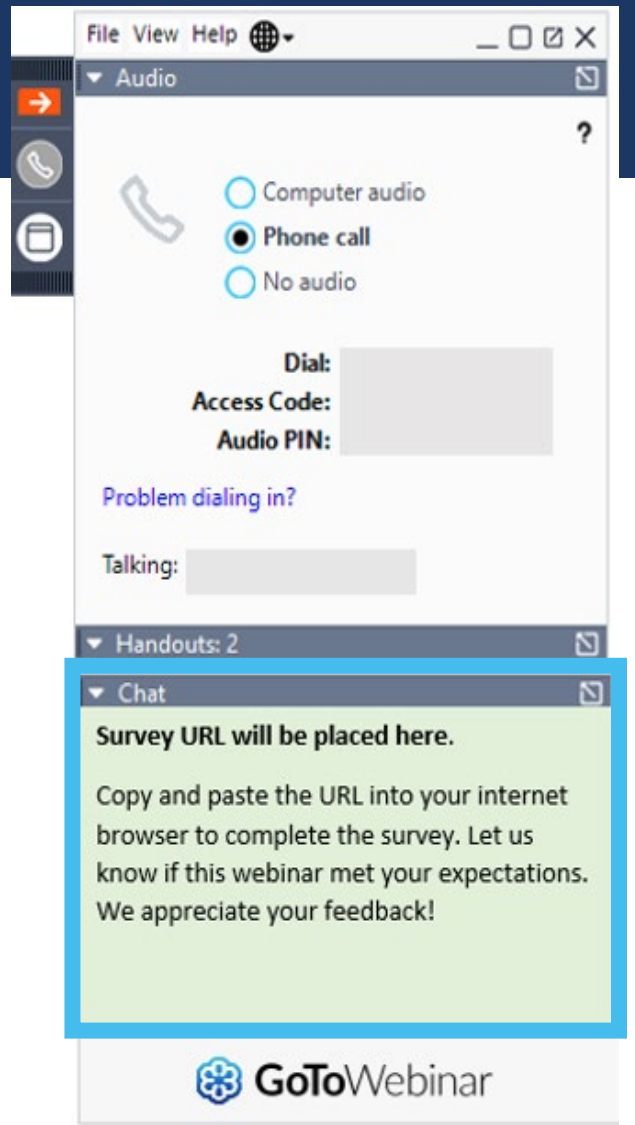

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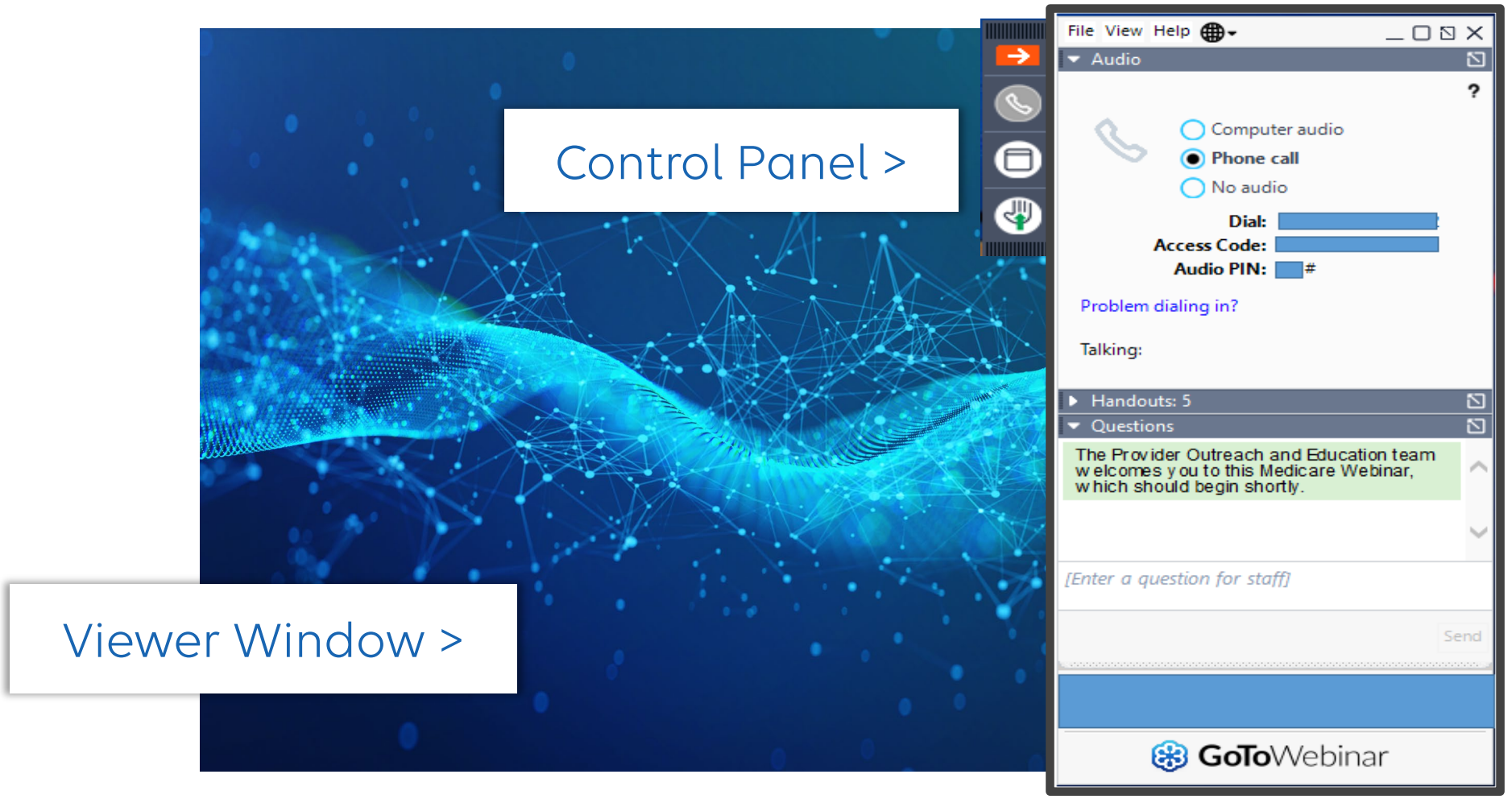

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