Medicare Benefit Policy Manual
Chapter 1 - Inpatient Hospital Services Covered Under Part A

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(Rev. 45, 02-10-06)

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1 – Definition of Inpatient Hospital Services

(Rev. 1, 10-01-03)

Inpatient hospital services are defined in Title XVIII of the Social Security Act (the Act) and in the regulations (42 CFR 409.10):

A. Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

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

B. Inpatient hospital services does not include the following types of services:

1. Posthospital SNF care, as described in 42 CFR 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.
2. Nursing facility services, described in 42 CFR 440.155 that may be furnished as a Medicaid service under title XIX of the Act in a swing- bed hospital that has an approval to furnish nursing facility services.
3. Physician services that meet the requirements of 42 CFR 415.102(a) for payment on a fee schedule basis.
4. Physician assistant services, as defined in §1861(s)(2)(K)(i) of the Act.
5. Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act.
6. Certified nurse mid-wife services, as defined in §1861(gg) of the Act.
7. Qualified psychologist services, as defined in §1861(ii) of the Act.

8. Services of an anesthetist, as defined in 42 CFR 410.69.

10 - Covered Inpatient Hospital Services Covered Under Part A

(Rev. 1, 10-01-03)

A3-3101, HO-210

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals. See Pub. 100-1, Chapter 8, §10.1, "Hospital Providers of Extended Care Services."). However, both inpatient hospital and inpatient SNF benefits are provided under Part A - Hospital Insurance Benefits for the Aged and Disabled, of Title XVIII).

Additional information concerning the following topics can be found in the following manual chapters:

- Benefit periods is found in Chapter 3, "Duration of Covered Inpatient Services";
- Copayment days is found in Chapter 2, "Duration of Covered Inpatient Services";
- Lifetime reserve days is found in Chapter 5, "Lifetime Reserve Days";
- Related payment information is housed in the Provider Reimbursement Manual.

Blood must be furnished on a day which counts as a day of inpatient hospital services to be covered as a Part A service and to count toward the blood deductible. Thus, blood is not covered under Part A and does not count toward the Part A blood deductible when furnished to an inpatient after the inpatient has exhausted all benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the patient is discharged on their first day of entitlement or on the hospital's first day of participation, the hospital is permitted to submit a billing form with no accommodation charge, but with ancillary charges including blood.

The records for all Medicare hospital inpatient discharges are maintained in CMS for statistical analysis and use in determining future PPS DRG classifications and rates.

Non-PPS hospitals do not pay for noncovered services generally excluded from coverage in the Medicare Program. This may result in denial of a part of the billed charges or in denial of the entire admission, depending upon circumstance. In PPS hospitals, the following are also possible:

1. In appropriately admitted cases where a noncovered procedure was performed, denied services may result in payment of a different DRG (i.e., one which excludes payment for the noncovered procedure); or

2. In appropriately admitted cases that become cost outlier cases, denied services may lead to denial of some or all of an outlier payment.

The following examples illustrate this principle. If care is noncovered because a patient does not need to be hospitalized, the intermediary denies the admission and makes no Part A (i.e., PPS) payment unless paid under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider **and** the beneficiary were **not** aware the services were not necessary and could not reasonably be expected to know that he services were not necessary. For detailed instructions, see the Medicare Claims Processing Manual, Chapter 30,"Limitation on Liability." If a patient is appropriately hospitalized but receives (beyond routine services) only noncovered care, the admission is denied.

NOTE: The intermediary does not deny an admission that includes covered care, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for **only** the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided.

If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If noncovered procedures are elevating costs into the cost outlier category, outlier payment is denied in whole or in part.

When the hospital is included in PPS, most of the subsequent discussion regarding coverage of inpatient hospital services is relevant only in the context of determining the appropriateness of admissions, which DRG, if any, to pay, and the appropriateness of payment for any outlier cases.

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program. If the items or services were requested by the patient, the hospital may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other

patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Renal Dialysis - Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Patients staying at home, who are ambulatory, whose conditions are stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. On the other hand, patients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only

after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Refer to Parts 4 and 7 of the QIO Manual with regard to initial determinations for these services. The QIO will review the swing bed services in these PPS hospitals as well.

NOTE: When patients requiring extended care services are admitted to beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services.

10.1 - Bed and Board

(Rev. 1, 10-01-03)

A3-3101.1, HO-210.1

10.1.1 - Accommodations - General

(Rev. 1, 10-01-03)

A3-3101.1.A, HO-210.1.A

The program will pay the same amount for routine accommodations services whether the patient has a private room not medically necessary, a private room medically necessary (Medicare does not pay for deluxe accommodations in any case), a semiprivate room (2-, 3-, or 4-bed accommodations), or ward accommodations, if its ward accommodations are consistent with program purposes (see §10.1.6 below).

A provider having both private and semiprivate accommodations may nevertheless charge the patient a differential for a private room if:

- The private room is not medically necessary; and
- The patient (or relative or other person acting on their behalf) has requested the private room, and the provider informs them of the amount of charge at the time of the request.

The private room differential may not exceed the difference between the customary charge for the accommodations furnished and the most prevalent semiprivate accommodation rate at the time of the patient's admission.

Where the provider bills for a private room as a covered service, i.e., shows the charge for the room as a covered charge on the Form CMS-1450, the intermediary will deem the private room to be medically necessary. Where the provider, on the other hand, shows a

private differential as a noncovered charge, the intermediary will assume that the private room is not medically necessary.

If the beneficiary (or their representative) protests a charge for the private room on the grounds that the privacy was medically necessary, such protest will, if not in written form, be reduced to writing and forwarded to the intermediary. The intermediary will then develop the facts and make a specific determination regarding the medical necessity of the private room. (If an intermediary receives many protests of this kind, the provider may need guidance on what constitutes medical necessity for privacy). If the protest is received after the claim is processed, it will be treated as a request for reconsideration.

If at any time in the course of development (or thereafter within the period when the determination is not administratively final), the provider acknowledges that the private room was medically necessary; the intermediary will make an immediate finding to this effect.

Where it is necessary to develop the medical necessity of a private room, the guidelines in subsections §§10.1.2 and 10.1.3 below will apply.

10.1.2 - Medical Necessity - Need for Isolation

(Rev. 1, 10-01-03)

A3-3101.1.B, HO-210.1.B

A private room is medically necessary where isolation of a beneficiary is required to avoid jeopardizing their health or recovery, or that of other patients who are likely to be alarmed or disturbed by the beneficiary's symptoms or treatment or subjected to infection by the beneficiary's communicable disease. For example, communicable diseases, heart attacks, cerebra-vascular accidents, and psychotic episodes may require isolation of the patient for certain periods. (See §10.1.3 below concerning medical necessity not based on need for isolation).

In establishing the medical necessity for isolation, the date of the physician's written statement is not controlling, nor is the presence of a written statement. The crucial question is whether a private room was ordered by the physician because it is necessary for the health of the patient himself or herself or of other patients. In the absence of such an order, a patient who requested the room with knowledge of the amount of the charge may be charged appropriately, even though a physician subsequently submits a statement that the room was medically necessary. There may be cases in which the physician's written statement of medical necessity, though dated after admission or even after discharge, merely confirms an order made informally at or before the time the beneficiary was admitted to the private room (e.g., the physician made arrangements by phone for the patient's admission, gave the diagnosis, and stated the beneficiary would need a private room). In such cases, assuming that the private room was medically necessary, the lack of a written statement by the physician, or the fact that the written statement was prepared after discharge, would not be controlling. The patient may not be charged.

10.1.3 - Medical Necessity - Admission Required and Only Private Rooms Available

(Rev. 1, 10-01-03)

A3-3101.1.C, HO-210.1.C

A private room is considered to be medically necessary even though the beneficiary's condition does not require isolation if he/she needs immediate hospitalization (i.e., the beneficiary's medical condition is such that hospitalization cannot be deferred) and the hospital has no semiprivate or ward accommodations available at the time of admission.

It need not be considered whether semiprivate or ward accommodations were available in some other accessible hospital. Where medical necessity exists, the provider may not charge the beneficiary a private room differential until semiprivate or ward accommodations become available. Thereafter the provider may transfer the patient to the nonprivate accommodations, or allow them to continue occupancy of the private room, subject to an appropriate differential charge (described in §10.1.1 above) if they request the private room with knowledge of the amount of the charge.

If the admission could be deferred until semiprivate or ward accommodations become available, the beneficiary should be informed of the amount of the differential he/she must pay for a private room if he/she wishes to be admitted immediately. The beneficiary may be charged the specified differential if he/she has been admitted to the private room at their request (or at the request of their representative) with knowledge of the amount of the charge.

10.1.4 - Charges for Deluxe Private Room

(Rev. 1, 10-01-03)

A3-3101.1.D, HO-210.1.D

Beneficiaries found to need a private room (either because they need isolation for medical reasons or because they need immediate admission when no other accommodations are available) may be assigned to any of the provider's private rooms. They do not have the right to insist on the private room of their choice, but their preferences should be given the same consideration as if they were paying all provider charges themselves. The program does not, under any circumstances, pay for personal comfort items. Thus, the program does not pay for deluxe accommodations and/or services. These would include a suite, or a room substantially more spacious than is required for treatment, or specially equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. If the beneficiary (or representative) requests such deluxe accommodations, the provider should advise that there will be a charge, not covered by Medicare, of a specified amount per day (not exceeding the differential defined in the next sentence); and may charge the beneficiary that amount for each day he/she occupies the deluxe accommodations. The maximum

amount the provider may charge the beneficiary for such accommodations is the differential between the most prevalent private room rate at the time of admission and the customary charge for the room occupied. Beneficiaries may not be charged this differential if they (or their representative) do not request the deluxe accommodations.

The beneficiary may not be charged such a differential in private room rates if that differential is based on factors other than personal comfort items. Such factors might include differences between older and newer wings, proximity to lounge, elevators or nursing stations, desirable view, etc. Such rooms are standard 1-bed units and not deluxe rooms for purposes of these instructions, even though the provider may call them deluxe and have a higher customary charge for them. No additional charge may be imposed upon the beneficiary who is assigned to a room that may be somewhat more desirable because of these factors.

10.1.5 - All Private Room Providers

(Rev. 1, 10-01-03)

A3-3101.E, HO-210.1.E

If the patient is admitted to a provider which has only private accommodations, and no semiprivate or ward accommodations, medical necessity will be deemed to exist for the accommodations furnished. Beneficiaries may not be subjected to an extra charge for a private room in an all-private room provider.

10.1.6 - Wards

(Rev. 1, 10-01-03)

A3-3101.1.F, HO-210.1.F

The law contemplates that Medicare patients should not be assigned to ward accommodations except at the patient's request or for a reason consistent with the purposes of the health insurance program.

When ward accommodations are furnished at the patient's request or for a reason determined to be consistent with the program's purposes, payment will be based on the average per diem cost of routine services (see §10.1.1 above). Where ward accommodations are assigned for other reasons, the law provides what may be a substantial penalty. (See §10.1.6.2 below).

Any request by the patient (or relative or other person responsible for his or her affairs) for ward accommodations must be obtained by the provider in writing and kept in its files.

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 intermediary 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 intermediary 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 intermediary 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.

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;

- Appropriate action to obtain case work services to assist in resolving problems in these areas; and

- Assessment of the relationship of the patient's medical and nursing requirements to their home situation, financial resources, and the community resources available to them in making the decision regarding their discharge.

30 - Drugs and Biologicals

(Rev. 1, 10-01-03)

A3-3101.3, HO-210.3

Drugs and biologicals for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients, are covered.

Three basic requirements must be met for a drug or biological furnished by a hospital to be a covered hospital service:

1. The drug or biological must represent a cost to the institution in rendering services to the beneficiary;

2. The drug or biological must meet the statutory definition. Under the statute, payment may be made for a drug or biological only where it is included, or approved for inclusion, in the latest official edition of the United States Pharmacopoeia-National Formulary (USP-NF), the United States Pharmacopoeia Drug Information (USP DI), or the American Dental Association (ADA) Guide to Dental Therapeutics, except for those drugs and biologicals unfavorably evaluated in the ADA Guide to Dental Therapeutics. Combination drugs are also included in the definition of drugs if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the above drug compendia. Drugs and biologicals are considered approved for inclusion in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium; or be approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital for use in the hospital; and

3. Use of the drug or biological must be safe and effective and otherwise reasonable and necessary as specified in the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §50.

   Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this last requirement when used for indications specified in the labeling. Therefore, use of an FDA-approved drug or biological is covered if:

   - It was administered on or after the date of the FDA's approval;

- It is reasonable and necessary for the individual patient; and
- All other applicable coverage requirements are met.

Drugs and biologicals, which have not received final marketing approval by the FDA, are not covered unless CMS instructs the intermediary to the contrary. However, FDA-approved drugs are used for indications other than those specified on the labeling. As long as the FDA has not specified such use as nonapproved, coverage is determined taking into consideration the generally accepted medical practice in the community. For example, the labeling of certain chemotherapeutic drugs indicates their use in the therapy of specified types of cancer. However, based on experience and empirical evidence, physicians may prescribe these drugs for a wider range of cancer treatments than what is indicated in the labeling. Local medical review policy may or may not grant coverage, depending on the circumstances.

Determinations as to whether use of a drug or biological is reasonable and necessary for an individual patient are the responsibility of the Quality Improvement Organization (QIO), if this is part of the review for a PPS acute care admission. However, if this is an excluded service claim being reviewed by the intermediary, the intermediary reviews and makes a determination, unless it cannot and needs to refer it to the QIO for an initial determination.

A hospital stay solely for the purpose of use of a drug or biological that is determined not reasonable and necessary is not covered.

30.1 - Drugs Included in the Drug Compendia

(Rev. 1, 10-01-03)

A3-3101.2.A, HO-210.3.A

Medicare covers only those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia as previously listed.

Where a drug is excluded from coverage because it is unfavorably evaluated in either the AMA Drug Evaluations or Accepted Dental Therapeutics, the exclusion applies to all uses for which the drug or biological was so unfavorably evaluated.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the procedure established by the professional organization responsible for revision of the compendium.

30.2 - Approval by Pharmacy and Drug Therapeutics Committee

(Rev. 1, 10-01-03)

A3-3101.3.B, HO-210.3.B

A pharmacy and drug therapeutics or equivalent committee is a medical staff committee that confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Drugs and biologicals approved for use in the hospital by such a committee are covered only if the committee develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee but may also carry on other medical staff functions.

Drugs and biologicals are considered approved for use in the hospital if selected for inclusion in the hospital drug list of formulary under the procedure of the committee established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital does not constitute approval.

Drugs and biologicals are covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. Approval by a pharmacy and drug therapeutics committee is an alternative to approval for inclusion of the drug or biological in an approved drug compendium (see §30.1 above); such approval does not preclude the need for a determination of medical necessity. An investigational drug is not considered to meet the reasonable and necessary test since its efficacy has not yet been established.

The decision of individual hospitals should not transcend the determinations of the Food and Drug Administration and Public Health Service in respect to the safety and effectiveness of drugs. Therefore, even if approved by an appropriate hospital committee, the reasonable cost of an investigational or other nonapproved drug or biological (e.g., Laetrile) cannot be reimbursed. This exclusion from payment applies whether or not the drug or biological is administered during the course of an otherwise covered hospital stay, since payment may not be made for items and services that are not reasonable and necessary. A hospital stay solely for the purpose of administering a drug or biological that is not reasonable and necessary, including an investigational drug or biological, is not covered and the drug or biological itself is not covered.

30.3 - Combination Drugs

(Rev. 1, 10-01-03)

A3-3101.3.C, HO-210-3.C

Combination drugs are covered if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. **Any** combination drug approved for use in the hospital by the pharmacy and drug therapeutics or equivalent committee is covered.

30.4 - Drugs Specially Ordered for Inpatients

(Rev. 1, 10-01-03)

A3-3101.3.D, HO-210.3.D

Coverage is not limited to drugs and biologicals routinely stocked by the hospital; a drug or biological not stocked by the hospital, which the hospital obtains for the patient from an outside source, such as a community pharmacy, can also be covered.

Drugs and biologicals not included in the drug list or formulary maintained by the hospital's pharmacy and drug therapeutics committee may be covered if the hospital has a policy which permits such drugs to be furnished to a patient at the special request of a physician. However, in order to be covered, such drugs and biologicals must be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a combination drug, or all of its therapeutic ingredients, would have to be included or approved for inclusion in one of the compendia.)

30.5 - Drugs for Use Outside the Hospital

(Rev. 1, 10-01-03)

A3-3101.3.E, HO-210.3.E

Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service.

40 - Supplies, Appliances, and Equipment

(Rev. 1, 10-01-03)

A3-3101.4, HO-210.4

Supplies, appliances, and equipment, which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during the inpatient hospital stay, are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered under Part A even though the supplies, appliances and equipment leave the hospital with the patient upon discharge. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are:

- Items permanently installed in or attached to the patient's body while an inpatient, such as cardiac valves, cardiac pacemakers, and artificial limbs; and

- Items which are temporarily installed in or attached to the patient's body while an inpatient, and which are also necessary to permit or facilitate the patient's release from the hospital, such as tracheotomy or drainage tubes.

Hospital “admission packs” containing primarily toilet articles, such as soap, toothbrushes, toothpaste, and combs, are covered under Part A if routinely furnished by the hospital to all its inpatients. If not routinely furnished to all patients, the packs are not covered. In that situation, the hospital may charge beneficiaries for the pack, but only if they request it with knowledge of what they are requesting and what the charge to them will be.

Supplies, appliances, and equipment furnished to an inpatient for use **only** outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item, which is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply, is covered as an inpatient hospital service.

Oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

50 - Other Diagnostic or Therapeutic Items or Services

(Rev. 1, 10-01-03)

A3-3101.5, HO-210.5

Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. (See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services.”)

Such services to hospital inpatients may be covered under Part A even when furnished off the hospital premises. For example, diagnostic or therapeutic services of an audiologist off the hospital premises are covered if billed for by the hospital under arrangements (see Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §10.3, for further information concerning “under arrangements”), if the services are furnished at a speech and hearing center, and if the audiologist meets the qualifications for an audiologist:

- Is licensed if applicable by the State in which practicing; and

- Is eligible for a certification of clinical competence in audiology granted by the American Speech and Hearing Association; or

- Meets the education requirements for certification and is in the process of accumulating the supervised experience required for certification.

50.1 - Therapeutic Items

(Rev. 1, 10-01-03)

A3-3101.5.A, HO-210.5

Therapeutic items, which are covered when ordinarily furnished by the hospital to its inpatients, or when ordinarily furnished to hospital inpatients by others under arrangements with them made by the hospital, include but are not limited to the following:

- Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations;

- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ; and

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

With respect to items that leave the hospital with the patient upon discharge, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

50.2 - Diagnostic Services of Psychologists and Physical Therapists

(Rev. 1, 10-01-03)

A3-3101.5.B, HO-210.5

When a psychologist or physical therapist is a salaried member of the staff of a hospital, their diagnostic or therapeutic services to inpatients of that hospital are covered. See the Medicare Claims Processing Manual for information on distinguishing between professional and technical services, and for information about billing and payment for nonphysician practitioners.

50.3 - Diagnostic Services Furnished to an Inpatient by an Independent Clinical Laboratory Under Arrangements With the Hospital

(Rev. 1, 10-01-03)

A3-3101.5.C, HO-210.5

Diagnostic services furnished to an inpatient by an independent clinical laboratory under arrangements with the hospital are reimbursable under hospital insurance provided the lab is certified by CLIA to perform the services.

An independent laboratory is one which is independent both of an **attending** or **consulting** physician's office and also independent of any hospital which meets at least the requirements to qualify as an emergency hospital (e.g., maintains clinical records, has a utilization review plan, meets the health and safety requirements found necessary by the Secretary of Health and Human Services).

A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.

A laboratory operated by or under the supervision of a hospital (or the organized medical staff of the hospital) that does not meet at least the definition of an emergency hospital is considered to be an independent laboratory. However, a laboratory serving hospital patients and operated on the premises of a hospital that meets the definition of an emergency hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not an independent laboratory. A laboratory that a physician or group of physicians maintains for performing diagnostic tests in connection with their own or the group practice is also not considered to be an independent laboratory.

An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a hospital that meets at least the definition of an emergency hospital or of the organized medical staff of such a hospital. Refer to “The Conditions of Participation for Hospitals” found at 42 CFR 482 and below for a description of independent lab approval requirements when the hospital is participating.

Where a laboratory operated on hospital premises is claimed to be independent or where an out-of-hospital facility is designated as a hospital laboratory, the CMS regional office makes the determination concerning the laboratory's status.

A clinical laboratory is a laboratory where microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

The "Conditions of Participation for Hospitals (HIRM-1)" call for independent clinical laboratory services furnished under arrangements made by a hospital to be furnished only by a laboratory meeting the specified conditions for coverage under the program. These require that:

- Where State or applicable local law provides for licensing of independent clinical laboratories, the laboratory is either licensed under law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories; and

- Such laboratories also meet the health and safety requirements prescribed by the Secretary of Health and Human Services. (See "The Conditions of Participation for Hospitals" at 42 CFR 482).

Where independent laboratory services are provided to patients of a participating hospital under arrangements with the hospital, the law does not require as a condition of payment in an individual case that the independent laboratory be approved under the program. In processing individual claims, the intermediary, therefore, need not verify that the services were obtained from an approved laboratory. The intermediary should make payment for laboratory services although it may know that the laboratory from which the hospital has obtained the service is not approved under the program. However, it should promptly refer this information to the appropriate regional office for review of the determination of the hospital's compliance with the conditions of participation and for whatever action the regional office deems appropriate. The above policy applies to PPS exempt hospitals. Note that under PPS, there is no separate payment for lab services furnished to inpatients.

50.4 - Diagnostic Services Furnished a Hospital Inpatient Under Arrangement With the Laboratory of Another Participating Hospital

(Rev. 1, 10-01-03)

A3-3101.5.D, HO-210.5

Diagnostic services furnished a hospital inpatient under arrangements with the laboratory of another participating hospital are reimbursable on a cost basis under Part A to the hospital obtaining the services if the hospital is PPS exempt. If the hospital is not exempt, there is not separate payment for lab services furnished to inpatients.

NOTE: Where a PPS exempt hospital obtains diagnostic laboratory services for inpatients under arrangements described in §§50.3 and 50.4 the cost to the hospital obtaining the services would be the reasonable charge for the laboratory's service.

60 - Services of Interns or Residents-In-Training

(Rev. 1, 10-01-03)

A3-3101.6, HO-210.6

Hospital insurance covers the reasonable cost of the services of medical or osteopathic interns or residents-in-training under a teaching program approved by the appropriate approving body.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The services of interns and residents-in-training in the field of podiatry who are in a residency program approved by the Council on Podiatric Medical Education of the

American Podiatric Medical Association are covered on the same basis as the services of other interns and residents in other approved residency programs.

70 - Inpatient Services in Connection With Dental Services

(Rev. 1, 10-01-03)

A3-3101.7, HO-210.7

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital. In addition, hospital inpatient services, which are necessary because of the patient's underlying medical condition and clinical status or the severity of a noncovered dental procedure, are covered.

When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services are not covered. The services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

80 - Health Care Associated With Pregnancy

(Rev. 1, 10-01-03)

A3-3101.12, HO-210.13

Reasonable and necessary services associated with pregnancy are covered and reimbursable under the Medicare program. Because pregnancy is a condition sufficiently at variance with the usual state of health, it is appropriate for a pregnant woman to seek medical care. The increased possibility of illness or injury accompanying this condition is well recognized, and medical supervision is required throughout pregnancy and for a brief period beyond. Skilled medical management is appropriate throughout the events of pregnancy, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care. Similarly, if the pregnancy terminates, whether spontaneously or for therapeutic reasons (i.e., where the life of the mother would be endangered if the fetus were brought to term), the need for skilled medical management and/or medical services is equally as important as in those cases carried to full term. After the infant is delivered, items and services furnished to the infant cannot be covered and reimbursed under the program on the basis of the mother's eligibility.

90 - Termination of Pregnancy

(Rev. 1, 10-01-03)

B3-4276.1,.2

Effective for services furnished on or after October 1, 1998, Medicare will cover abortions procedures in the following situations:

1. If the pregnancy is the result of an act or rape or incest; or

2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

NOTE: The "G7" modifier must be used with the following CPT codes in order for these services to be covered when the pregnancy resulted from rape or incest, or the pregnancy is certified by a physician as life threatening to the mother:

59840	59841	59850
59851	59852	59855
59856	59857	59866

100 - Treatment for Infertility

(Rev. 1, 10-01-03)

A3-3101.13

Effective for services rendered on or after January 15, 1980, reasonable and necessary services associated with treatment for infertility are covered under Medicare. Like pregnancy (see §80 above), infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally would be expected to be fertile to seek medical consultation and treatment. Contractors should coordinate with QIOs to see that utilization guidelines are established for this treatment if inappropriate utilization or abuse is suspected.

110 - Inpatient Hospital Stays for Rehabilitation Care

(Rev. 1, 10-01-03)

A3-3101.11, HO-211

110.1 - General

(Rev. 1, 10-01-03)

A3-3101.11.A, HO-211.A

Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization. In addition, in some cases an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services.

Patients needing rehabilitative services require a hospital level of care, if they need a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and

2. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis.

Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.

110.2 - Preadmission Screening

(Rev. 1, 10-01-03)

A3-3101.11.B, HO-211.B

Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of preadmission screening in a particular case is not adequate reason for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission

screening information is important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

110.2.1 - Admission Orders

(Rev. 1, 10-01-03)

42 CFR 412.606

At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

110.3 - Inpatient Assessment of Individual's Status and Potential for Rehabilitation

(Rev. 1, 10-01-03)

A3-3101.11.C, HO-211.C, CFR 412.606

Medicare Part A fee-for service beneficiaries in IRFs are assessed by a clinician using the CMS' patient assessment instrument upon admission and at discharge. The CMS' patient assessment instrument consists of nine sections, each to collect different categories of patient information. These categories include identification and demographic information about the patient, medical information, and information related to quality of care and basic patient safety. IRFs must computerize and electronically report the patient assessment data.

In general, the admission assessment must have an assessment reference date of day three of the IRF stay, be based upon observations done in the first three days of the IRF stay and be completed by day 4 of the IRF stay.

The discharge assessment must have an assessment reference date that is the actual day that one of two events occurs first: (1) the day on which the patient is discharged from the IRF; or (2) the day on which the patient dies. The discharge assessment is based upon observations done in the three calendar days prior to and including the assessment reference date on the discharge assessment. The discharge assessment must be completed by the 5th calendar day that follows the discharge assessment reference date with the discharge assessment reference date itself being counted as the first day of the five calendar day time period.

In certain cases, a beneficiary may have an interrupted stay that may affect the assessment reference dates, completion dates, and encoding date. An interrupted stay is

defined as one in which an IRF patient is discharged from the IRF and returns to the same IRF within three consecutive calendar days that begins with the day of discharge and ends on midnight of the third day.

When a beneficiary has an interrupted stay, the interrupted stay must be documented on the assessment instrument. If the interruption is less than three calendar days, the IRF does not need to complete a new admission assessment. However, in those cases where the patient is discharged and returns after three consecutive calendar days, the IRF is required to complete a new admission assessment.

110.3.1 - General

(Rev. 1, 10-01-03)

A3-3101.11.C.1, HO-211.C.1

Coverage is available for inpatient assessment of a patient's potential to benefit from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination is made on the basis of information available in the patient's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's condition by the necessary disciplines. Inpatient assessments conducted by a rehabilitation team through examination of the patient usually require between 3 to 10 calendar days, but on occasion may require more. This 3 to 10 day period is often one where the patient is receiving therapies rather than simple screening assessments. Where more than 10 days are required, the case is carefully reviewed to ensure that such additional time was necessary. An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient.

The fact that an individual received therapy prior to admission to a hospital for a rehabilitation program does not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if:

- Some intervening circumstance rendered such an assessment reasonable and necessary; or

- The subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.

110.3.2 - Specific Examples

(Rev. 1, 10-01-03)

A3-3101.11.C.2, HO-211.C.2

After an inpatient hospital stay for rehabilitation care, which resulted in little improvement in the patient's condition, an individual who undergoes surgery for severe contractures as a result of arthritis may require a reassessment of rehabilitation potential in light of the surgery.

The fact that an individual has some degree of mental impairment is not, per se, a basis for concluding that a multi-disciplinary team evaluation is not warranted. Many individuals who have had CVAs suffer both mental and physical impairments. The mental impairment often results in a limited attention span and reduced comprehension with a resultant problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems.

Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the non-weight-bearing period or a patient with a healed ankle fracture does not require an inpatient hospital stay for rehabilitation care. Accordingly, an inpatient assessment is not warranted in such cases. On the other hand, an individual who has had a CVA that left them significantly dependent in the activities of daily living (even after physical therapy in a different setting) might be a good candidate for a more extensive inpatient assessment if the patient has potential for rehabilitation and their needs are not primarily of a custodial nature.

110.4 - Rehabilitation Hospital Screening Criteria

(Rev. 1, 10-01-03)

A3-3101.11.D, HO-211.D

Rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient probably requires a hospital level of care if they have either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment.

The QIOs will review rehabilitation services if they are rendered at the inpatient facility as part of that particular admission.

The CMS has developed a set of screening criteria to assist the QIOs in applying this level-of-care requirement. The criteria (which are listed below) are designed to enable the QIOs to identify those cases that clearly involve a hospital level of rehabilitative care.

The QIOs are expected to use these criteria in performing their screens of rehabilitative hospital claims. Thus, if a case satisfies each of the criteria, the QIO may approve the claim at the initial screening level. However, the fact that a case fails to satisfy the criteria does **not** mean that the QIO denies the claim. Rather, it only means that the QIO refers the case to a physician reviewer for a determination as to the medical necessity of the patient's hospitalization.

These criteria set forth below are intended to be applied only at the initial screening level (which is typically conducted by the QIO's nurse reviewer). The criteria do not apply to cases referred to a QIO's physician reviewer. For determinations about reasonableness, medical necessity, and appropriateness of setting, the QIO's physician reviewer is expected to make a determination on the basis of their knowledge, expertise and experience, and upon an assessment of each beneficiary's individual care needs rather than on fixed criteria.

At the initial screening, a QIO determines that the patient requires a rehabilitative hospital level of care if all of the following screening criteria are met.

110.4.1 - Close Medical Supervision by a Physician With Specialized Training or Experience in Rehabilitation

(Rev. 1, 10-01-03)

A3-3101.11.D.1, HO-211.D.1

A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every two to three days during the patient's stay. This degree of physician involvement which is greater than is normally rendered to a patient in a SNF is an indicator of a patient's need for services generally available only in a hospital setting.

110.4.2 - Twenty-Four Hour Rehabilitation Nursing

(Rev. 1, 10-01-03)

A3-3101.11.D.2, HO-211.D.2

The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation.

110.4.3 - Relatively Intense Level of Rehabilitation Services

(Rev. 1, 10-01-03)

A3-3101.11.D.3, HO-211.D.3

The general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least three hours a day of physical and/or occupational therapy. (The furnishing of services no less than five days a week satisfies the requirement for "daily" services.) While most patients requiring an inpatient stay for rehabilitation need and receive at least three hours a day of physical and/or occupational therapy, there can be exceptions because individual patient's needs vary. In some instances, patients who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitative modalities such as speech-language pathology services, or prosthetic-orthotic services and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy.

An inpatient stay for rehabilitation care can also be covered even though the patient has a secondary diagnosis or medical complication that prevents participation in a program consisting of three hours of therapy a day. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program may be carried out. The intermediary secures documentation of the existence and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.

110.4.4 - Multi-Disciplinary Team Approach to Delivery of Program

(Rev. 1, 10-01-03)

A3-3101.11.D.4, HO-211.D.4

A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse, and one therapist.

110.4.5 - Coordinated Program of Care

(Rev. 1, 10-01-03)

A3-3101.11.D.5, HO-211.D.5

The patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every **two weeks** to:

- Assess the individual's progress or the problems impeding progress;
- Consider possible resolutions to such problems; and
- Reassess the validity of the rehabilitation goals initially established.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record.

110.4.6 - Significant Practical Improvement

(Rev. 1, 10-01-03)

A3-3101.11.D.6, HO-211.D.6

Hospitalization after the pre-admission screening is covered only in those cases where the pre-admission screening results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that is of practical value to the patient, measured against the patient's condition at the start of the rehabilitation program. For example, a multiple sclerosis patients' condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program does not restore the level of function before multiple sclerosis developed, a return to pre-secondary illness level is considered to be a "significant practical improvement" in the condition. In addition, a beneficiary must classify into one of the CMG's payable by Medicare under the IRF PPS.

110.4.7 - Realistic Goals

(Rev. 1, 10-01-03)

A3-3101.11.D.7, HO-211.D.7

While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment is achieving the maximum level of function possible.

110.5 - Length of Rehabilitation Program

(Rev. 1, 10-01-03)

A3-3101.11.E, HO-211.E

Coverage stops when further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement that has occurred and the type of program required to achieve further improvement must be considered. In some cases, an individual may be expected to continue to improve under an outpatient program. There are other situations where further improvement in the individual's ability to function relatively independently in the activities of daily living can be expected only if a multidisciplinary team effort is continued.

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions alone are not a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and assist in discharge planning for the individual.

It is also important to consider how close the patient may be to the planned end of the rehabilitation hospital stay when further progress becomes unlikely. If a patient is within a few days of discharge, transfer to a less intensive setting in another facility would be inappropriate even though further progress in the hospital setting is unlikely. However, it could be appropriate to utilize a "swing bed" arrangement, if it exists in the same facility, for rendering necessary services to the patient pending discharge.

When discharge or transfer to another facility is appropriate, the cut-off point for coverage should not be the last day on which improvement actually occurred. Rather, coverage should continue through the time it would have been reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur and to initiate the patient's discharge.

Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting would be appropriate.

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

(Rev. 1, 10-01-03)

A3-3101.14, HO-210.12, B3-2300.1, A3-3101.14, HO-210.12

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" noncovered services (e.g., cosmetic surgery, noncovered organ transplants,

noncovered artificial organ implants, etc.), including services related to follow-up care and complications of noncovered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare. Services "not related to" noncovered services are covered under Medicare.

Following are examples of services "related to" and "not related to" noncovered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a noncovered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a noncovered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a noncovered transplant or implant, the services related to the admitting condition would be covered.

- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the noncovered transplant, the services would be "related to" noncovered services and would also be noncovered.

Following is an example of services received subsequent to a noncovered inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior noncovered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous noncovered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, repair of complications from transsexual surgery or from cosmetic surgery, removal of a noncovered bladder stimulator, or treatment of any infection at the surgical site of a noncovered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

130 – *Religious Nonmedical Health Care Institution (RNHCI) Services*

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Section 1821 of the Social Security Act provides for coverage of services furnished in a Medicare qualified religious nonmedical health care institution (RNHCI), when the beneficiary meets specific coverage conditions. The beneficiary must have a valid election for RNHCI services and would otherwise qualify for care in a conventional hospital or post hospital extended care facility that was not a religious nonmedical health care institution.

The RNHCI benefit provides only for Part A inpatient services. The Medicare program will only pay for nonmedical health care services furnished in RNHCIs, as defined in Section 1861(ss)(1) of the Act and 42 CFR 403 Subpart G. The program does not pay for supporting religious services or payment for the religious practitioner. The cost of religious items/services and the cost of using a religious practitioner is a personal financial responsibility and not covered by Medicare.

130.1 – *Beneficiary Eligibility for RNHCI Services*

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

A beneficiary may elect to receive care in an RNHCI based on his or her own religious convictions or to revoke that election at any time if for any reason he or she decides to pursue medical care. Section 1821(a) of the Act requires that as a condition for Part A Medicare coverage, the beneficiary must have a condition that would qualify under Medicare Part A for inpatient hospital services or extended care services furnished in a hospital or skilled nursing facility that is not an RNHCI if it were not for their religious convictions.

When a beneficiary has an effective election on file with CMS but does not have a condition that would qualify for Medicare Part A inpatient hospital or posthospital extended care services if the beneficiary were an inpatient of a hospital or a resident of a SNF that is not an RNHCI, then services furnished in an RNHCI are not covered by Medicare. A Medicare claim for services that were furnished to that beneficiary would be treated as a claim for noncovered services. If the beneficiary only needs assistance with activities of daily living, then the beneficiary's condition could not be considered as meeting the Medicare Part A requirements. Prior to submitting a claim to Medicare it is the responsibility of the RNHCI's utilization review committee to determine that the beneficiary meets the Medicare Part A requirements.

If no valid election is filed or the election has been revoked and no new election is in effect, the beneficiary does not have Medicare coverage for services furnished in an RNHCI. Consequently, a Medicare claim for services furnished to such a beneficiary would also be treated as a claim for noncovered services.

In those cases where a beneficiary is admitted to an RNHCI with a valid election, the submission of prior claim for medical services to the Common Working File will revoke the election during the course of the RNHCI stay. If this is the first revocation, the beneficiary may make a new election without any disruption to the benefit. If this, however, is the second or subsequent revocation, the applicable waiting period applies and the remainder of the stay is not covered by Medicare (see 130.2.2).

130.2 – *Election of RNHCI Benefits*

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

Religious non-medical care or religious method of healing means health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets to fulfill a beneficiary's total health care needs.

Medical care or treatment means health care furnished by or under the direction of a licensed physician that can involve diagnosing, treating, or preventing disease and other damage to the mind and body. It may involve the use of pharmaceuticals, diet, exercise, surgical intervention, and technical procedures.

The signed and notarized election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. The election is effective on the date it is signed, and it remains in effect until revoked in writing or by the receipt and filing of a claim for nonexcepted medical treatment.

The completed election form must be filed with the specialty contractor, a copy retained by the RNHCI provider and a copy provided to the beneficiary. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 170 for instructions on submission of elections to the specialty contractor.

Section 1821 defines "excepted" medical treatment as medical care or treatment that is received involuntarily or is required under Federal, State or local law. The term is intended to identify the kinds of medical services that can be provided to a beneficiary with an election for RNHCI services without revoking the election.

Examples of excepted medical care include, but are not limited to the following:

- *A beneficiary that receives vaccinations required by a State or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services; or*

- *A beneficiary who is involved in an accident and receives medical attention at the accident scene, or in transport to the hospital, or at the hospital before being able to make their beliefs and wishes known; or*

- *A beneficiary who is unconscious and receives emergency care and is hospitalized before regaining consciousness or being able to locate his or her legal representative.*

"Nonexcepted" medical treatment is defined as medical care or treatment other than excepted medical treatment. The term is intended to define the kinds of medical services that, if received by a beneficiary who has previously elected RNHCI services, would revoke the individual's election of services.

Examples of nonexcepted medical care could include but are not limited to the following:

- *A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains.*

- *A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture.*

- *A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services.*

- *A beneficiary who has requested a physician to prescribe a wheelchair or other durable medical equipment item.*

Note that the terms 'excepted' and 'nonexcepted' care represent mutually exclusive conditions under §1821 of the Social Security Act. Medicare contractors may use the examples above in making determinations of excepted and nonexcepted care.

130.2.1 - Revocation of RNHCI Election

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Revocation is the cancellation of the RNHCI election and can be achieved in two ways: either by submitting a written statement to the intermediary indicating the desire to cancel the election or by seeking nonexcepted medical care for which Medicare payment is sought.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 170 for instructions on submission of revocations to the specialty contractor. See section 180 of that manual for a description of how Medicare non-specialty contractors revoke elections upon billing for nonexcepted services.

130.2.2 - RNHCI Election After Prior Revocation

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

After an initial revocation, the individual may again file a written election to receive the religious nonmedical health care benefit. This second election takes effect immediately upon its execution. If an individual revokes a second election, the next (third) election cannot become effective until 1 year after the date of the most recent revocation. Subsequent elections are not effective until 5 years after the most recent revocation. Once an election is revoked, Medicare payment cannot be made to an RNHCI unless a valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage.

130.3 - Medicare Payment for RNHCI Services and Beneficiary Liability

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Medicare pays for RNHCI services under TEFRA payment rules (see Pub. 15-2, Provider Reimbursement Manual, chapter 30). RNHCI services are subject to the inpatient hospital cash deductible, when applicable. If services are for the 61st through 90th day of a benefit period or are for lifetime reserve days, RNHCI services are subject to coinsurance (see Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Sections 10.1 and 10.2).

Under normal Medicare rules, a provider of services may only bill a beneficiary deductible and coinsurance amounts. However, total Medicare payments to RNHCIs are subject to limits established in sections 1821(c)(2) (A) or (B) of the Act. In the event that the Medicare program reduces payments to RNHCIs based on these limits, RNHCIs may also bill beneficiaries an amount equal to any such reduction.

130.4 - Coverage of RNHCI Items Furnished in the Home

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Prior to the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare program's RNHCI benefit was limited to inpatient services provided in an RNHCI facility. The MMA revised sections 1821(a) and 1861 of the Social Security Act to extend coverage to RNHCI items and services that are provided in a beneficiary's home and that are comparable to items and services provided by a home health agency that is not an RNHCI.

Beneficiaries elect the RNHCI benefit if they are conscientiously opposed to accepting most medical treatment, since accepting such services would be inconsistent with their sincere religious beliefs. The Medicare home health benefit provides skilled nursing, physical therapy, occupational therapy, speech language pathology and home health aide services to eligible beneficiaries under a physician's plan of care. The home health benefit also provides medical supplies, a covered osteoporosis drug and durable medical equipment (DME) while under a plan of care (see chapter 7).

Medicare covers specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. These services comprise the RNHCI

home benefit. The remainder of the services covered under the Medicare home health benefit are medical in nature and must be provided under the order of a physician. As such, these services conflict with RNHCI beneficiaries' conscientious opposition to medical care.

The RNHCI home benefit must exclude the same services that are excluded from the home health benefit, which include: drugs and biologicals; transportation; services that would not be covered as inpatient services; housekeeping services; services covered under the End Stage Renal Disease program; prosthetic devices; and medical social services provided to family members. These exclusions are defined at 42 CFR 409.49. Additionally, the RNHCI home benefit excludes the items or services provided by any HHA that is not an RNHCI; or any supplier, independent RNHCI nurse or aide that is working directly for a beneficiary rather than under arrangements with the RNHCI.

Medicare requires a brief letter of intent from the provider in order to determine the number of RNHCIs that will be implementing the home service benefit.

In the case where an RNHCI chooses to provide home services then only care on an intermittent basis, which is provided to an eligible beneficiary who is confined to their home for health reasons, will be covered under the home benefit. The home benefit is not to be confused with hospice care, which may involve more frequent visits and can involve institutional services. If for some reason the home serviced patient requires more than intermittent service, then institutional services may be required. However, the patient would need to meet the criteria for admission to a RNHCI, or the patient would require another institutional setting not necessarily covered by Medicare.

Similar to the inpatient RNHCI benefit, the physician role in certifying and ordering the home benefit is replaced with the use of the RNHCI utilization review committee to review the need for care and plan for initial and continued care in the home setting. The home benefit will also require a prompt review of admission to the home service, since the patient must be fully eligible (have a health condition that keeps them confined to the home (42CFR409.42(a), have health needs that can be met with intermittent care, and have a valid election) before billable services can be rendered and Medicare payment requested. Additionally the utilization review committee is responsible for review and approval of care plans and orders for DME items, and review of the need for the continuation of services

As in the original RNHCI benefit, Medicare will only pay for nonmedical services in the home, but not for those religious items or services provided by the RNHCI.

Medicare covers these items and services for dates of service from January 1, 2005 through December 30, 2006. Total Medicare payments under this benefit for each calendar year during this period are limited to $700,000.

130.4.1 - Coverage and Payment of Durable Medical Equipment Under the RNHCI Home Benefit

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Medicare covers a defined list of nonmedical DME items for RNHCI home services that are comparable to items used in the inpatient RNHCI setting and could be provided by an HHA. The DME items include canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals. Those RNHCIs offering home services may order these items without a physician order and without compromising the beneficiary election for RNHCI care. The need for each item of DME ordered must be supported by the RNHCI patient's plan of care for the home setting and the RNHCI nurses' notes for home services. It must be noted that the benefit is applicable only to what we shall refer to as "nonmedical DME items" and does not include any of the related services provided by RNHCI staff members.

The RNHCI shall establish a payment arrangement with one or more DME suppliers to obtain any of the items on the DME list (below) they may require for a beneficiary. The supplier will provide the items and related instructions on use to the beneficiary/family/care giver. The RNHCI will submit claims for these DME items to the RNHCI specialty FI.

The RNHCI must stress to suppliers that DME claims are not to be submitted to the DMERC because this will cause the beneficiary's election for RNHCI care to be revoked.

DME Items and HCPCS Codes for use by RNHCI Home Service Units Canes

E0100 Cane, includes canes of all materials, adjustable or fixed, with tip

E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed with tip

Crutches

E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips

E0113 Crutch underarm, wood, adjustable or fixed, pair, with pad, tip and handgrip

E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips

E0116 Crutch underarm, other than wood, adjustable or fixed, with pad, tip and handgrip

Walkers

E0130 Walker, rigid (pickup), adjustable or fixed height

E0135 Walker, folding (pickup), adjustable or fixed height

E0141 Walker, rigid, wheeled, adjustable or fixed height

E0143 Walker, folding, wheeled, adjustable or fixed height

Commodes

E0163 Commode chair, stationary, with fixed arms

E0167 Pail or pan for use with commode chair

Wheelchairs

K0001 Standard wheelchair

Hospital Beds & Accessories

E0250 Hospital bed, fixed height, with any type side rails, with mattress

E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress

E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress

E0275 Bed pan, standard, metal or plastic

E0276 Bed pan, fracture, metal or plastic

E0290 Hospital bed, fixed height, without side rails, with mattress

E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress

E0325 Urinal; male, jug-type, any material

E0326 Urinal; female, jug-type, any material

Payment to RNHCIs for these specified DME items will be made based on the DME fee schedule. Coinsurance applies to these items. Deductible does not apply to these items.

130.4.2 - Coverage and Payment of Home Visits Under the RNHCI Home Benefit

(Rev. 45, Issued: 02-10-06; Effective: 05-11-06;Implementation: 05-11-06)

Medicare covers intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. The RNHCI nursing personnel may be skilled in ministering to a beneficiary's religious needs (not covered by Medicare), but do not have the training or nursing skill sets required of credentialed/licensed health care professionals (e.g., registered nurse). While RNHCI nurses may provide tender loving care, they are focused primarily on religious healing and meeting basic beneficiary needs for assistance with

activities of daily living (e.g., bathing, toileting, dressing, ambulation), as part of creating a milieu for religious healing. The care provided by an RNHCI nurse is not at the level of either a registered nurse or a licensed practical nurse. The physical care provided by an RNHCI nurse is at a level that could be considered as supportive, but decidedly not "skilled" as defined by the Medicare program.

For purposes of payment for RNHCI nursing services in the home, the following services are comparable to the services of HHAs that are not RNHCIs (e.g., the RNHCI nurse and the home health aide share the following basic tasks):

- Assist with activities of daily living which include: ambulation, bed to chair transfer, and assist with range of motion exercises; bathing, shampoo, nail care and dressing; feeding and nutrition; and toileting;
- Light housekeeping, incident to visit
- Documenting visit

By comparison the home health aide will routinely perform additional medically oriented services (e.g., observation and reporting of existing medical conditions, taking and reporting vital signs, and using basic infection control procedures).

Due to the uniqueness of RNHCI nursing in the Medicare program, Medicare pays for RNHCI nursing visits at a percentage of the HHAs "low utilization payment adjustment" (LUPA) rate for home health aides. Only a visit by an RNHCI nurse to a home will be considered as billable to Medicare. A visit is defined as an episode in which an RNHCI nurse will render physical care to an RHNCI beneficiary in the home setting. The visit is a single billable unit that is not influenced by the number of involved caregivers or the duration of the episode. The difference in skill levels and the incorporation of RNHCI religious activity (noncovered by Medicare) into a visit, resulted in a payment rate that is 80% of the home health aide rate adjusted by metropolitan service area (MSA) wage index rate for the involved RNHCI.

RNHCI nursing visits are paid using the LUPA system even in situations where the involved patient would not be classified as low utilization. The HHAs have moved to PPS, which is constructed on the medical model and therefore inappropriate for RNHCI use. The same "labor"/"non-labor" portions applied in the HHA PPS will be used for calculating the RNHCI nursing visit payments.

Example of LUPA Payment: An RNHCI in Baltimore, MD, provides twelve RNHCI nursing visits over the course of a 30 day period.

1. Home Health Aide Visit (National standardized rate for 2005) $44.76
2. RNHCI Nurse Visit ……(.80 * $ 44.76) 35.81
3. Calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for

1 RNHCI nurse visit……...…….(.76775 * $.35.81) 27.49

4. Apply wage index factor for Baltimore, MD..…(.9907 * $ 27.49) 27.23

5. Calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment

Amount for 1 RNHCI nurse visit…….(.23225 * $ 35.81) 8.32

6. Subtotal—Low Utilization Payment Adjustment

(LUPA) wage for 1 RNHCI nurse visit……..($ 27.49 + $ 8.32) $35.55

7. Total - Calculate total Low Utilization Payment

Adjustment (LUPA) for 12 RNHCI nurse visits provided during the 30-day episode … ……(12 * $ 35.55) $426.60

Step 1. Take the HHA aide visit base rate ($ 44. 76) for the involved year (2005), from the HHA update published annually each November in the **Federal Register**.

Step 2. To calculate the RNHCI nurse visit base rate, multiply the HHA base rate ($ 44.76) by the allowed percentage for an RNHCI nurse visit (.80%) to allow for religious activity and reduced physical care skill level = ($ 35.81)

Step 3. To calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the fixed allowance .76775 by the RNHCI nurse visit rate ($ 35.81) = ($ 27.49)

Step 4. Apply the wage index for the involved MSA from the HHA update published annually each November in the **Federal Register** (Baltimore, MD = .9907) multiplied by the labor portion of the RNHCI nurse visit ($ 27.49) = ($27.23).

Step 5. To calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the fixed allowance .23225 by the RNHCI nurse visit rate ($ 35.81) = ($ 8.32)

Step 6. To calculate the LUPA rate for 1 RNHCI nurse visit add the products from Step 4 ($27.49) and Step 5 ($ 8.32) = ($ 35.55)

Step 7. To calculate the LUPA payment for RNHCI nurse visits to one beneficiary in a 30 day period, multiply the product of Step 6 ($ 35.55) by the number of visits (12) = ($ 426.60)