CMS Manual System

Pub 100-02 Medicare Benefit Policy

Transmittal 37

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: August 12, 2005

Change Request 3912

SUBJECT: Conforming Changes for Change Request 3648 to Pub. 100-02

I. SUMMARY OF CHANGES: Some instructions that were duplicated in Pub 100-02 Section 220 and 230 have been replaced with reference to the appropriate sections. Obsolete terms have been edited, e.g. "speech therapy" to "speech-language pathology" and "direct personal" to "direct.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : September 12, 2005

IMPLEMENTATION DATE : September 12, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	6/10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
R	6/20 - Outpatient Hospital Services
R	6/20.2 - Distinguishing Outpatient Hospital Services Provided Outside the Hospital
R	6/20.4.1 - Coverage of Outpatient Therapeutic Services
R	7/90 - Medical and Other Health Services Furnished by Home Health Agencies
R	8/ Table of Contents
R	8/30.2.1 - Skilled Services Defined
R	8/30.4.2 - Speech-*Language* Pathology
R	8/40 - Physician Certification and Recertification
R	8/50.3 - Physical *Therapy*, Speech-*Language Pathology*, and

	Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision
R	8/70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-*Language* Pathology Services
R	8/70.4 - Services Furnished Under Arrangements With Providers
R	15/10 - Supplementary Medical Insurance (SMI) Provisions

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Manual Instruction
Business Requirements

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-02	Transmittal: 37	Date: August 12, 2005	Change Request 3912

SUBJECT: Conforming Changes for CR3648 to Pub. 100-02

I. GENERAL INFORMATION

A. Background: This change was made to delete therapy service certification language from Pub. 100-01 that is also in Pub. 100-02 and to consolidate the information in one place. It also changes the term speech therapy to speech-language pathology, as has been appropriate for many years

B. Policy: There is no new policy.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3912.1	Contractors shall update the terms "speech therapy", and "speech-language therapy" to "speech-language pathology" or "speech-language pathology services" in related LCDs and educational materials whenever they modify these documents or issue new documents. It is not necessary to change the documents merely to update this language.	x		x						
3912.2	Contractors shall update the term "direct personal" supervision to "direct" supervision, when applied to Part B services incident to a physician's or nonphysician practitioner's service.	x		x						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 12, 2005 **Implementation Date:** September 12, 2005 **Pre-Implementation Contact(s):** Dorothy Shannon 63396 **Post-Implementation Contact(s):** Dorothy Shannon 63396	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Payment may be made under **Part B** for physician services and for the nonphysician medical and other health services listed below when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A.

In PPS hospitals, this means that Part B payment could be made for these services if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission;
- The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made);
- The day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability);
- The patient was not otherwise eligible for or entitled to coverage under Part A (See the Medicare Benefit Policy Manual, Chapter 1, §150, for services received as a result of noncovered services); or
- No Part A day outlier payment is made (for discharges before October 1997) for one or more outlier days due to patient exhaustion of benefit days after admission but before the case's arrival at outlier status, or because outlier days are otherwise not covered and waiver of liability payment is not made.

However, if only day outlier payment is denied under Part A (discharges before October 1997), Part B payment may be made for only the services covered under Part B and furnished on the denied outlier days.

In non-PPS hospitals, Part B payment may be made for services on **any** day for which Part A payment is denied (i.e., benefit days are exhausted; services are not at the hospital level of care; or patient is not otherwise eligible or entitled to payment under Part A). Services payable are:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently

inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;

- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech*-language* pathology services, and outpatient occupational therapy (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§220 *and 230*);
- Screening mammography services;
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).

Coverage rules for these services are described in the Medicare Benefit Policy Manual, Chapters: 11, "End Stage Renal Disease (ESRD);" 14, "Medical Devices;" or 15, "Medical and Other Health Services."

For services to be covered under Part A or Part B, a hospital **must** furnish nonphysician services to its inpatients directly or under arrangements. A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision. This provision is applicable to all hospitals participating in Medicare, including those paid under alternative arrangements such as State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals.

In all hospitals, **every** service provided to a hospital inpatient other than those listed in the next paragraph must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

These services, when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and not covered under Part A. They are:

- Physicians' services (including the services of residents and interns in unapproved teaching programs);
- Influenza vaccine;
- Pneumoccocal vaccine and its administration;
- Hepatitis B vaccine and its administration;
- Screening mammography services;
- Screening pap smears and pelvic exams;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self management training services; and
- Prostate screening.

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

20 - Outpatient Hospital Services

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The following rules pertaining to the coverage of outpatient hospital services are not applicable to physical therapy, speech-*language* pathology, occupational therapy, or end stage renal disease (ESRD) services furnished by hospitals to outpatients. See the Medicare Benefit Policy Manual, Chapter 1*5*, "Covered Medical and Other Health Services," §§220 *and 230*, for rules on the coverage of outpatient physical therapy, occupational therapy and speech-*language* pathology furnished by a hospital.

20.2 - Distinguishing Outpatient Hospital Services Provided Outside the Hospital

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Diagnostic services are covered when provided by the hospital whether furnished in the hospital or at other locations. Outpatient therapeutic services, furnished incident to physician's services, are covered when furnished outside the hospital only if there is direct personal supervision by a physician. Thus, it may be necessary to distinguish between diagnostic and therapeutic services when services are provided outside the hospital. Outpatient physical therapy, occupational therapy, and speech*-language* pathology services are not subject to the direct physician supervision requirement. See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§220 *and 230*, for coverage of outpatient physical therapy, occupational therapy, and speech*-language* pathology services.

Where the rules of coverage require a distinction between diagnostic and therapeutic services the hospital may accept the physician's designations. Normally, however, the physician does not separate the services and need not be asked to do so.

20.4.1 - Coverage of Outpatient Therapeutic Services

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Therapeutic services which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency room services.

To be covered as incident to physicians' services, the services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. The services and supplies must be furnished on a physician's order by hospital personnel and under a physician's supervision. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient. For example, if a hospital therapist, other than a physical, occupational or speech *-language pathologist*, goes to a patient's home to give treatment unaccompanied by a physician, the therapist's services would not be covered. See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§220 *and 230* for outpatient physical therapy and speech*-language* pathology coverage conditions.

90 - Medical and Other Health Services Furnished by Home Health Agencies

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Payment may be made by intermediaries to a home health agency which furnishes either directly or under arrangements with others the following "medical and other health services" to beneficiaries with Part B coverage in accordance with Part B billing and payment rules other than when a home health plan of care is in effect.

1. Surgical dressings (for a patient who is not under a home health plan of care), and splints, casts, and other devices used for reduction of fractures and dislocations;

2. Prosthetic (Except for items excluded from the term "orthotics and prosthetics" in accordance with §1834(h)(4)(C) of the Act for patients who are under a home health plan of care);

3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes and adjustments to these items when ordered by a physician. (See the Medicare Benefit Policy Manual, Chapter 15);

4. Outpatient physical therapy, outpatient occupational therapy, and outpatient speech-*language* pathology services (for a patient not under a home health plan of care). (See the Medicare Benefit Policy Manual, Chapter 15); and

5. Rental and purchase of durable medical equipment. (See the Medicare Benefit Policy Manual, Chapter 15.) If a beneficiary meets all of the criteria for coverage of home health services and the HHA is providing home health care under the Hospital Insurance Program (Part A), any DME provided and billed to the intermediary by the HHA to that patient must also be provided under Part A. Where the patient meets the criteria for coverage of home health services and the HHA is providing the home health care under the Supplementary Medical Insurance Program (Part B) because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be furnished under the Part B home health benefit or as a medical and other health service. Irrespective of how the DME is furnished, the beneficiary is responsible for a 20 percent coinsurance.

6. Ambulance service. (See the Medicare Benefit Policy Manual, Chapter 10, Ambulance Services)

7. Hepatitis B Vaccine. Hepatitis B vaccine and its administration are covered under Part B for patients who are at high or intermediate risk of contracting hepatitis B. High risk groups currently identified include: end-stage renal disease (ESRD) patients, hemophiliacs who receive factor VIII or IX concentrates, clients of

institutions for the mentally retarded, persons who live in the same household as an hepatitis B virus carrier, homosexual men, illicit injectable drug users. Intermediate risk groups currently identified include staff in institutions for the mentally retarded, workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. Persons in the above listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy. The vaccine may be administered, upon the order of a doctor of medicine or osteopathy, by home health agencies.

8. Hemophilia clotting factors. Blood clotting factors for hemophilia patients competent to use such factors to control bleeding without medical or other supervision and items related to the administration of such factors are covered under Part B.

9. Pneumococcal and influenza vaccines. See Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.2 "Immunizations."

10. Splints, casts. See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

11. Antigens. See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

Medicare Benefit Policy Manual

Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

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30.4.2 - Speech-*Language* Pathology

50.3 - Physical *Therapy*, Speech-*Language Pathology*, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision

70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-*Language* Pathology Services

30.2.1 - Skilled Services Defined

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech*-language* pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

30.4.2 - Speech-*Language* Pathology

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

40 - Physician Certification and Recertification

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The SNF must obtain and retain the physician's NPS, or CNS') certification and recertification statements. The intermediary may request them to assist in determining medical necessity when necessary. The SNF will determine how to obtain the physician's certification and recertification statements. There is no requirement for a specific procedure or form as long as the approach permits verification that the certification and recertification requirement is met. The certification or recertification may be entered or included in forms, notes, or other records a physician, nurse practitioner or clinical nurse specialist normally signs in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be signed by a physician, NP or CNS.

If the SNF's failure to obtain a certification or recertification is not due to a question of the necessity for the services, but to the physician's, NP's or CNS' refusal to certify on other grounds (e.g., the physician objects in principle to the concept of certification and recertification), the SNF cannot charge the beneficiary for covered items or services. Its provider agreement precludes it from doing so.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.

In addition, only physicians may certify outpatient physical therapy and outpatient speech-*language* pathology services.

Further information regarding certification and recertification of extended stay services, including who may certify, details on the content of the certification or recertification, timing of recertifications and the impact of delays on certifications and recertifications may be found in the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, "Physician Certification and Recertification of Services," §§40 - 40.4.6

50.3 - Physical *Therapy*, Speech*-Language Pathology*, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

For Physical Therapy, see the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §80.

For Speech*-Language* Pathology, see Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §100.

For Occupational Therapy, see Medicare Benefit Policy Manual, Chapter 1,"Inpatient Hospital Services," §90.

Note these services must be provided by the SNF or by others under arrangements with the SNF for beneficiaries in either a covered Part A stay or a non-covered stay in the SNF. Bundling to the SNF is not required for beneficiaries residing in a non-certified portion of a facility containing a distinct part SNF if the facility as whole is not primarily engaged in the provision of skilled care. See Chapter 7, SNF Part B Billing, §10 in the Medicare Claims Processing Manual, for a clarification of bill types used to make this distinction clear in billing.

70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech*-Language* Pathology Services

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Under Part A, physical therapy, occupational therapy, and speech pathology services are included in the SNF PPS rate for cost reporting periods beginning on or after July 1, 1998. For inpatient Part B residents and outpatient services, payment for such services is under a fee schedule. The SNF must bill for physical therapy, occupational therapy, or speech*-language* pathology services for Part A residents beginning with its first cost reporting period that starts on or after July 1, 1998, and for Part B for services furnished on or after July 1, 1998. The SNF (rather than an outside provider/supplier such as an approved clinic or rehabilitation agency, or a participating hospital) bills Medicare. Payment is made directly to the SNF. The patient is responsible only for applicable Part A coinsurance or the Part B deductible and coinsurance amounts.
See also the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

70.4 - Services Furnished Under Arrangements With Providers

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The SNFs may arrange with others to furnish covered Part B physical therapy, occupational therapy, or speech-*language* pathology services. The SNF (rather than an outside provider/supplier, another SNF or a HHA) bills Medicare, and payment is made directly to the SNF. When such arrangements are made, SNF receipt of payment for the arranged services (as with services provided directly) relieves the beneficiary or any other person of further liability to pay for them.

The ensuing payment arrangement between the SNF and the outside supplier is a private matter, outside the purview of CMS.

10 - Supplementary Medical Insurance (SMI) Provisions

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The supplementary medical insurance plan covers expenses incurred for the following medical and other health services under Part B of Medicare:

- Physician's services, including surgery, consultation, office and institutional calls, and services and supplies furnished incident to a physician's professional service;
- Outpatient hospital services furnished incident to physicians services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy, outpatient occupational therapy, outpatient speech-language pathology services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the patient's home;
- Ambulance service;
- Prosthetic devices, other than dental, which replace all or part of an internal body organ;
- Leg, arm, back and neck braces and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or change in the patient's physical condition;
- Certain medical supplies used in connection with home dialysis delivery systems;
- Rural health clinic (RHC) services;
- Federally Qualified Health Center (FQHC) services;
- Ambulatory surgical center (ASC) services;
- Screening mammography services;
- Screening pap smears and pelvic exams;
- Screening glaucoma services;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management services;
- Prostate screening; and

- Home health visits after all covered Part A visits have been used.

See §250 for provisions regarding supplementary medical insurance coverage of certain of these services when furnished to hospital and SNF inpatients.

Payment may not be made under Part B for services furnished an individual if the individual is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of a request for payment or lack of a physician certification.

Some medical services may be considered for coverage under more than one of the above-enumerated categories. For example, electrocardiograms (EKGs) can be covered as physician's services or as other diagnostic tests. It is sufficient to determine that the requirements for coverage under one category are met to permit payment.

Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments analogous to premiums which entitle enrollees to services or to repairs or replacement of devices or equipment or parts thereof without charge or at a reduced charge, are not considered expenses incurred for covered items or services furnished under such contracts or undertakings. Examples of such arrangements are memberships in ambulance companies, insurance for replacement of prosthetic lenses, and service contracts for durable medical equipment.