Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1841

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.17 – 3611.2 (Cont.)	6-111 – 6-120.3 (13 pp.)	6-111 – 6-120.2 (12 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: Various dates as described in the instruction*
IMPLEMENTATION DATE: April 1, 2002

Section 3610.18, Payment for Blood Clotting Factor Administered to Hemophilia Inpatients, reflects the following changes:

- Changes the Average Wholesale Price from 85% to 95% beginning FY 2001.
- Discontinues the use of HCPCS code J7196 effective December 31, 1999.
- Adds HCPCS codes J7198 and J7199 effective January 1, 2000 and Q2022 effective July 1, 2000.
- Instructs intermediaries to obtain payment allowances from their local carrier for discharges after September 30, 2000.
- Instructs intermediaries to multiply the number of units by 100 and multiply that number by the price per IU to obtain the payment amount.
- Corrects the payment calculation for HCPCS Code Q0187.
- Changes the reporting of HCPCS code Q0187, for discharges after September 30, 2000 to 1 billing unit per 1.2 mg.
- Adds diagnosis codes 286.5 and 286.7 effective for discharges on or after August 1, 2001.

Do not reopen and reprocess any claims that have not been brought to your attention.

These instructions should be implemented within your current operating budget.

3610.17 Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals.--

A. Criteria for Sole Community Hospitals (SCHs).--For cost reporting periods beginning on or after October 1, 1989, an SCH is a rural hospital that meets one of the following:

- o Located more than 35 miles from other like hospitals;
- o Located between 25 and 35 miles from other like hospitals, and:
  - -- No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;
  - -- Has fewer than 50 beds and would admit at least 75 percent of the inpatients from its service area except that some patients seek specialized care unavailable at the hospital; or
  - -- Other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years because of local topography or prolonged severe weather conditions;
- o Located between 15 and 35 miles from other like hospitals, but because of local topography or prolonged severe weather conditions the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
- o Effective October 1, 1990, because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Any SCH which qualified under the prior criteria which would lose eligibility as a result of the new criteria may retain its status as an SCH.

An urban hospital more than 35 miles from other like hospitals is also considered a SCH.

B. Criteria for Medicare Dependent Hospitals (MDHs).--For cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993, an MDH is a rural hospital that meets all of the following:

- o Has 100 or fewer beds;
- o Is not classified as an SCH; and
- o For its cost reporting period that began during FY 87, is dependent on Medicare for at least 60 percent of its inpatient days or discharges.

C. Payment to SCHs and MDHs.--Pay these hospitals the highest of three rates as the basis for payment:

- o An updated target amount based upon the hospital's 1982 costs;
- o An updated target amount based upon the hospital's 1987 costs; or
- o The Federal PPS rate, including any applicable outlier amount.

The actual payment amount for each bill is determined by PRICER based upon information you maintain in your provider specific file. Review and possible lump sum adjustment applies when the cost report is reviewed.

D. Claims Processing.--Use the following to enable PRICER to calculate the appropriate rates for these facilities--

- o 14 for a MDH that is not an RRC;
- o 15 for a MDH that is also an RRC;
- o 16 for a rebased SCH that is not an RRC; and
- o 17 for a rebased SCH that is also an RRC.

Calculate the higher of the 1982 or 1987 adjusted base period costs per discharge (hospital specific rate) and adjust to the 1990 level. Enter this amount in field 21, position 81-87 effective for the first day of the cost report period beginning April 1, 1990 or later. Enter even if you expect the hospital to be paid at the Federal PPS rate. Preloading before the effective date is acceptable as long as the correct effective date is used for the record. Leave the field blank if the hospital did not operate in either 1982 or 1987.

PRICER calculates the payment based upon the higher of the Federal rate or the hospital-specific rate in field 21, and where the hospital-specific rate is higher, PRICER reports the amount of the difference in the hospital-specific field. (See §3656.3C.) Carry this amount forward in the hospital-specific payment field to your PS&R record for use at cost settlement.

3610.18 Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.--Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Act to provide that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment is to be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factor furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011(d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

The add-on payment for FY 1999 will be calculated using the same methodology used in the past. The price per unit of clotting factor will be established based on 85 percent of the current price listing available from the 1998 Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP). Beginning FY 2001 the payment for blood clotting factor administered to hemophilia inpatients is equal to 95 percent of the AWP. The payment amounts will be determined using the most recent AWP data available to the carrier at the time you perform these annual update calculations. Obtain the updated payment amounts from the carrier in the jurisdiction of the provider. These amounts are updated annually and are effective for discharges beginning on or after October 1 of the current year through September 30 of the following year.

A. Billing.--Three separate add-on amounts have been set, one for each of the three basic types of clotting factor: Factor VIII, Factor IX and other factors which are given to the patients with inhibitors to Factors VIII and IX.

The HCPCS codes which identify the three types of clotting factors along with the price per unit for discharges occurring on or after June 19, 1990, and before October 1, 1991 are:

J7190	Factor VIII	- $ .64 per IU
J7194	Factor IX, complex,	- .26 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-clotting inhibitors.)	- 1.00 per IU

For discharges occurring on or after October 1, 1991, and through September 30, 1992, the codes and charges are:

J7190	Factor VIII	- $ .72 per IU
J7194	Factor IX, complex,	- .26 per IU
J7196	Other Hemophilia blood factors (e.g., anti-clotting inhibitors.)	- 1.11 per IU

The prices per unit for discharges October 1, 1992, through September 30, 1993, are:

J7190	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .30 per IU
J7196	Other Hemophilia blooding clotting factors	- l.02 per IU

The prices per unit for discharges October 1, 1993, through September 30, 1994, are:

J7190	Factor VII	- $ .76 per IU
J7194	Factor IX	- .33 per IU
J7196	Other Hemophilia blooding clotting factors	- 1.02 per IU

Effective January 1, 1994, there is an additional covered clotting factor:

J7192 Factor VIII, Anti-Hemophilic, recombinant - $ .76 per IU

For discharges occurring on or after October 1, 1997 through September 30, 1998.

J7190	Factor VIII	- $ .76 per IU
J7192	Factor VIII	- 1.00 per IU
J7194	Factor IX	- .32 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-inhibitors)	- 1.10 per IU

Effective for services on or after April 1, 1998, two new HCPCS billing codes are established for purified and recombinant Factor IX.

Q0160	Factor IX (Anti-Hemophilic factor, purified, non-recombinant)	- $ .93 per IU
Q0161	Factor IX, (Anti-Hemophilic Factor, purified, Recombinant)	- $1.00 per IU

For discharges occurring on or after October 1, 1998 through September 30, 1999, the prices are as follows:

J7190	Factor VIII (Anti-Hemophilic Factor, Human)	$ .78 per IU
J7192	Factor VIII (Anti-Hemophilic Factor, Recombinant)	1.00 per IU
J7194	Factor IX, (Complex)	.38 per IU
J7196	Other Hemophilia clotting Factor, (anti-inhibitors)	1.10 per IU
Q0160	Factor IX (Anti-Hemophilic Factor, purified, nonrecombinant)	.93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	1.00 per IU

For discharges October 1, 1999 through September 30, 2000, the following prices apply to add-on payments for blood clotting factor administered to inpatients with hemophilia:

J7190	Factor VIII (Antihemophilic Factor, Human)	$0.79 per IU
J7191	Factor VIII (Antihemophilic Factor, Porcine)	$1.87 per IU
J7192	Factor VIII (Antihemophilic Factor, Recombinant)	$1.03 per IU
J7194	Factor IX (Complex)	$0.45 per IU
J7196	Other Hemophilia clotting Factors (e.g., anti-inhibitors) **(Discontinued 12/31/1999)**	$1.43 per IU
J7198	Anti-Inhibitor **(effective 1/1/2000)**	$1.43 per IU
J7199	Hemophilia Clotting Factor, Not Otherwise Classified **(effective 1/1/2000)**	
Q0160	Factor IX (antihemophilic Factor, purified, nonrecombinant)	$0.97 per IU
Q0161	Factor IX (Antihemophilic Factor, recombinant)	$1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	$1.19 per MCG
Q2022	Von Willebrand Factor Complex (**effective 7/1/2000**)	$1.05 per IU

Beginning FY 2001 the payment for blood clotting factor administered to hemophilia inpatients is equal to 95 percent of the AWP. The payment amounts will be determined using the most recent AWP data available to the carrier at the time you perform these annual update calculations. For discharges on and after October 1, 2000, obtain the payment allowances from the carrier in the jurisdiction of the provider.

PRICER does not calculate the payment amount. Calculate the payment amount and subtract the charge from those submitted to PRICER so it is not included in cost outlier computations.

One hundred IUs of any of the clotting factors except HCPCS Code Q0187, Factor VIIa, are reported as one unit. (100 IUs = one billing unit.) Therefore, payment for one billed unit of hemophilia clotting Factor VIII furnished December 1, 1993, is $76.00. One billed unit of Factor IX is $33.00.
One billed unit of other hemophilia clotting factors is $102.00. For discharges occurring on or after October 1, 2000, providers report HCPCS Code Q0187 based on 1 billing unit per 1.2 mg.

If the number of units provided is between even hundreds, hospitals round to the nearest hundred. Thus, units of 1 to 49 are rounded down to the prior 100 and units of 50 to 99 are rounded up to the next 100 (i.e., 1,249 units are entered on the bill as 12; 1,250 units are entered as 13).

In reporting the number of IUs administered, hospitals divide the number of IUs administered by 100 and round the answer to the nearest whole number to determine the billing unit. (An answer which includes fractions of .50 to .99 = 1 additional billing unit. An answer which includes fractions of .01 to .49 = no additional billing units). The formula for calculating the payment amount is: # of units x 100 x price per IU= payment amount. The following examples illustrate the correct billing for the different types of clotting factors:

EXAMPLE 1: A patient receives 1,200 IUs of Factor VIII (J7190) on December 1, 1993. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (1,200 divided by 100 = 12 billing units.) The hospital enters 12 in FL 46 of the HCFA-1450. 1 unit x 100 x price = payment amount. The payment amount is $912 (12 billing units x $76 (100 IUs x $.76)).

EXAMPLE 2: A patient receives 3,449 IUs of Factor IX (J7194) on January 4, 1994. The hospital divides this number by 100 to obtain the number of billing units. (3,449 divided by 100 = 34.49 billing units.) The hospital rounds down to the nearest whole number to obtain the billing units and enters 34 in FL 46. 1 unit x 100 x price = payment amount. The payment amount is $1,122 (34 billing units x $33 (100 IUs x $.33)).

EXAMPLE 3: A patient receives 5,250 IUs of anti-inhibitors (J7196) (which are a type of other hemophilia clotting factor) on July 6, 1994. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (5,250 divided by 100 = 52.50 billing units.) The hospital rounds up to the nearest whole number to obtain the billing units and enters 53 in FL 46. 1 unit x 100 x price = payment amount. The payment amount is $5,406 (53 billing units x $102 (100 IUs x $1.02).

EXAMPLE 4: A patient receives 4,850 MCGs of Factor VIIa (Q0187) on November 1, 1999. The hospital divides the number of MCGs administered by 1000 to convert the MCGs to MGs (4,850 divided by 1000 = 4.85). The hospital calculates the number of billing units represented by 4.85 and divides by 1.2 (4.85 divided by 1.2 = 4.04 or 4 billing units) and enters 4 in FL 46. The payment amount is $4,760 (4 billing units x $1190 (1000 x $1.19)).

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 999,999,949 (reported as 9,999,999), the hospital reports the excess as a second line for revenue code 636 and repeats the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and another line shows 500,001.

NOTE: For discharges occurring on or after October 1, 2000, providers report HCPCS Q0187 based on 1 billing unit per 1.2 mg.

Revenue Code 636 is used. It requires HCPCS. Other inpatient drugs continue to be billed without HCPCS codes under pharmacy. Electronic billers must enter the HCPCS code in field 5 of Record Type 60. (See Addendum A.)

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is not applicable to inpatient Part B claims. Separate payment is not made to SNFs.

B. Intermediary Action.--Make the following changes to your systems:

- o Accept HCPCS codes for inpatient services;

o Edit to require HCPCS codes with Revenue Code 636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. Units provided generally range from about 600 IUs (reported as 6) to over 10,000 (reported as 100 on the bill). Do not edit units except to ensure a numeric value;

o Develop inpatient fee tables based on HCPCS codes and revenue code 636. Pay the fee amount regardless of the charges;

o Reduce charges forwarded to PRICER by the charges for revenue code 636. Retain the charges and revenue and HCPCS codes for CWF, and for PS&R;

o Determine what changes you need in your remittance record to hospitals;

o Modify your data entry screens to accept HCPCS codes for hospital inpatient claims (bill types 110, 111, 112, 113, 114, 115, 117, & 118);

o Include the HCPCS code and payment amount in the following records for each HCPCS code billed under revenue code 636:

RECORD	HCPCS CODE	PAYMENT AMOUNT
PS&R UNIBILL	Financial Data Corresponding to CWF	Field 79
CWF (HUIP)	Field 90	Field 99

o Treat the bill as a single bill for MSP, and for charging deductible and coinsurance. Use total charges for deductible and coinsurance calculations.

Changes are not planned for MSP pay. Where MSP recovery is made, the PS&R system allocates MSP primary payer payments between revenue code 636 and the remainder of the charges. It will delete the primary payment applicable to the final revenue code 636 payment from the primary payment amount carried forward to the PS&R detail record. PS&R will do this allocation based on charges for revenue code 636 and total covered Medicare charges.

The PS&R provides a separate revenue code report for charges under revenue code 636 for your use at cost report review.

The September 1, 1993 PPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-9-CM diagnosis code for hemophilia is included on the bill. Since blood clotting factors are only covered for beneficiaries with hemophilia, ensure that one of the following hemophilia diagnosis codes is listed on the bill before payment is made:

286.0 Congenital factor VIII disorder
286.1 Congenital factor IX disorder
286.2 Congenital factor IX disorder
286.3 Congenital deficiency of other clotting factor
286.4 von Willebrands' disease

Effective for discharges on or after August 1, 2001, payment may be made if one of the following diagnosis codes is reported:

286.5 Hemorrhagic disorder due to circulating anticoagulants
286.7 Acquired coagulation factor deficiency

C. Part A Remittance Advice.--

1. **X12.835 Ver. 003030M**.--

a. For remittances reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment exhibiting an >OA' Group Code and adjustment reason code "97' (payment is included in the allowance for the basic service/ procedure)

followed by the associated dollar amount (POSITIVE) and units of service. For this version of the 835, >OA' group coded line level CAS segments are informational and are not included in the balancing routine. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

b. For remittances reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment PLB segment with the provider level adjustment reason code >CA' (Manual claims adjustment) followed by the associated dollar amount (NEGATIVE).

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new PLB adjustment reason code specifically for PIP payment Hemophilia Add On situations for future use. However, continue to use adjustment reason code >CA' until further notice.

c. Enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the reason code 97 and PLB code >CA' adjustments are related to the Hemophilia Add On.

2. **X12.835 Ver. 003051**.--

a. For remittances reporting PIP and/or non-PIP payments, Hemophilia Add On information will be reported in the claim level 2-062-AMT and 2-064-QTY segments. The 2-062-AMTO1 element will carry a >ZK' (Federal Medicare claim MANDATE - Category 1) qualifier code followed by the total claim level Hemophilia Add On amount (POSITIVE). The 2-064QTY01 element will carry a >FL' (Units) qualifier code followed by the number of units approved for the Hemophilia Add On for the claim. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new AMT qualifier code specifically for the Hemophilia Add On for future use. However, continue to use adjustment reason code >ZK' until further notice.

b. For remittances reporting PIP payments, the Hemophilia Add On will be reported in the provider level adjustment PLB segment with the provider level adjustment reason "ZZ" followed by the associated dollar amount (NEGATIVE).

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new PLB, adjustment reason code specifically for the Hemophilia Add On for future use. However, continue to use PLB adjustment reason code "ZZ" until further notice.

c. Enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and ZZ entries are related to the Hemophilia Add On. (Effective with version 4010 of the 835, report ZK in lieu of FL in the QTY segment.)

3. **Standard Hard Copy Remittance Advice**.--

a. For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

b. Add the Remark Code 'MA103' (Hemophilia Add On) to the remittance advice under the REM column for those claims that qualify for Hemophilia Add On payments.

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ANSI ASC X12 835, where additional information is available.

3610.19 Medicare Rural Hospital Flexibility Program.-

The Medicare Law allows establishment of a Medicare Rural Hospital Flexibility Program by any State that has submitted the necessary assurances and complies with the statutory requirements for designation of hospitals as Critical Access Hospitals (CAHs).

To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, and must be located more than a 35-mile drive from any other hospital or critical access hospital, or be certified by the State to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24 hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and maintain a length of stay, as determined on an annual average basis, of no longer than 96 hours.

An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS.

3610.20 Grandfathering Existing facilities.--As of October 1, 1997, no new EACH designations can be made. The EACHs designated by CMS before October 1, 1997, will continue to be paid as sole community hospitals for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

3610.21 Requirements for CAH Services and CAH Long-term Care Services.--

A. Effective November 29, 1999, CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or submit a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent entity. Thus, intermediaries are not required to obtain documentation showing that a PRO or equivalent entity has, on request, approved stays beyond 96 hours in specific cases. A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. A patient is considered discharged when the admission's office records the discharge and (1) the patient has been discharged by the appropriate practitioner on the medical chart and (2) the patient is no longer receiving services. The patient would have to be out of the room and the room available for occupancy.

Calculate the CAH's length of stay based on patient census data. If a CAH exceeds the length of stay limit, send the report to the CMS Regional Office and a copy to the State agency. The CAH will be required to develop and implement a corrective action plan acceptable to the CMS Regional Office, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

B. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements.

1. The facility has been certified as a CAH by CMS;

2. The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and,

3. The facility has been granted swing-bed approval by CMS.

C. A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

3610.22 Payment for Services Furnished by a CAH.--

A. Payment for Inpatient Services Furnished by a CAH.--Effective for cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. Payment for inpatient CAH services is billed as a 11x type of bill and is subject to Part A deductible and coinsurance requirements.

B. Payment for Outpatient Services Furnished by a CAH.--For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in item 1 below. For cost reporting periods beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in item 2. If a CAH elects payment under item 2 (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for all of the cost reporting period to which it applies. If the CAH wishes to be paid under the all inclusive method, that election should be made in writing by the CAH, which notifies you 60 days in advance of the beginning of the affected cost reporting period. If the CAH makes no election, it will be paid for outpatient services under the standard method in item 1.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles: lesser of cost or charges, reasonable compensation equivalent (RCE) limits, any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or blended payment rates for ASC, radiology, and other diagnostic services.

1. Standard method: Cost-based Facility Services, with Billing of Carrier for Professional Services.--Payment for outpatient CAH services under this method will be made for 80 percent of the reasonable cost of the CAH in furnishing those services, after application of the Part B deductible. Payment for professional medical services furnished in a CAH to CAH outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant or nurse practitioner, that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X should be used for all outpatient services including ASC services. Referenced diagnostic services (nonpatients) will continue to be billed on a 14x type of bill.

2. All Inclusive Method: Cost-Based Facility Services Plus Fee Schedule for Professional Services.--Section 403(d) of the BBRA amended §834(g) to permit the CAH to elect this method of reimbursement for services and items furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

Payment to the CAH for each outpatient visit will be the sum of the following amounts:

(a) For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the Form HCFA-1450, (or electronic equivalent) the facility service(s) rendered to outpatients will be listed along with the appropriate revenue code. Pay the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible; plus

(b) On a separate line, the professional services will be listed, along with appropriate HCPC code (physician or other practitioner). Pay 115 percent of whatever Medicare would pay of the physician fee schedule. (Multiply the fee schedule amount, after applicable deductions, by 1.15 percent.)

Outpatient services, including ASC services, rendered in an all inclusive method rate provider will be billed using the 85X type of bill. Revenue code 510 should be on the bill with visits indicated in the units field and the dollar amount in the charges field. If there is no amount for the revenue code 510, place an "0" in the charge field. Referenced diagnostic services (nonpatients) will continue to be billed on a 14X type of bill.

C. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, as described in §3626.3, except as described in paragraphs D. and E.

D. Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost of hepatitis B vaccine and its administration. Deductible and coinsurance apply. Payment for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Follow the instructions as described in §3660.10.

E. Regardless of the payment method that applies under paragraph B, make payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, co-payment, or any other cost-sharing.

3610.23 Payment for Post-Hospital SNF Care Furnished by a CAH.—Under §203 of the Benefits Improvement and Protection Act (BIPA) of 2000, swing beds in CAHs are exempt from §1888(e)(7) of the Act (as enacted by §4432(a) of the Balanced Budget Act of 1997), which applies the SNF Prospective Payment System (PPS) to SNF services furnished by swing-bed hospitals generally. In addition, this provision establishes a new reimbursement system for CAHs that provides full reasonable cost payment for CAH swing-bed services. This provision is effective with cost reporting periods beginning on or after the date of the enactment of the BIPA 2000, December 21, 2000.

Currently, to calculate the swing bed cost carve out from routine services, Medicare substitutes the pre-determined regional rate as a proxy for total swing bed routine costs and then applies that same pre-determined rate to total swing bed days. Under the BIPA 200 provision, adjust the CAH swing bed rate effective with the first day of the provider's fiscal year beginning on/after December 21, 2000. Instead of using the pre-determined rate for SNF-like swing bed days, calculate an interim payment reflecting an estimate of each facility's routine cost in the current year. This interim payment rate will be calculated from the latest available cost reporting data. To reimburse a CAH for its swing bed services based services based on cost, it will be necessary to refer to the CAH's most recent cost report to track the number of SNF-like swing bed days, total patient days, and total routine costs. Presently, the cost report calculates total routine costs through worksheet D-1 of the Form HCFA-2552-96.

SNF-like swing bed routine costs should be calculated using existing procedures; i.e., multiplying the average statewide rate per patient day paid under the state Medicaid plan by the number of SNF-like swing bed days. The SNF-like swing bed costs should then be deducted from the hospital's total routine costs. Then, to calculate the SNF-like swing bed cost per day, the adjusted routine costs are divided by the sum of the total number of inpatient routine care days and total SNF-like swing bed days. This cost per day is then applied against the SNF-like swing bed days to arrive at the carve out for SNF swing bed costs. That same per diem is then applied against the Medicare swing bed days resulting in Medicare share of routine swing bed costs.

The cost report instructions will be modified on Worksheet D-1 to accommodate this change in payment procedures for CAHs.

The ancillary costs are apportioned to Medicare based on billed charges. The cost report currently calculates Medicare's share of ancillary costs through worksheet D-4 of the same cost reporting Form HCFA-2552-96. No change would be required to the cost report for calculating swing bed ancillary costs.

Settlement for CAHs for swing bed services will continue to be calculated on Worksheet E-2.

All CAH SNF bills should have a "z" in the third position of the provider number.

3610.24 Review of Form HCFA-1450 for the Inpatient.-- All items on Form HCFA-1450 are completed in accordance with §3604.

3611. HOSPITAL CAPITAL PAYMENTS UNDER PPS

The Omnibus Budget Reconciliation Act of 1987 established an effective date of October 1, 1991, for capital PPS. Capital PPS will pay hospitals a fixed amount for each Medicare admission upon completion of a 10-year transition period.

Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs. They continue to be paid for capital-related costs on a reasonable cost basis.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to PPS for operating costs. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines in §§3610.1 - 3610.14, also apply to capital PPS payments. Outlier thresholds and computation methods have been combined effective with FY 1993 for operating and capital costs.

Capital transfer cases are paid on a per diem basis analogous to the manner in which operating PPS payments are made for transfer cases.

Beneficiary deductible and coinsurance obligations do not apply to capital costs. Ancillary costs paid under Part B do not impact capital PPS payments. The 10-year transition period was established to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. These high capital cost hospitals are known as “hold harmless” hospitals. The transition period also provides for phase-in of the national rate for those hospitals with capital obligations that are less than the national rate.

A combined payment is made for both operating costs and capital costs under PPS, but the value of the payment for each must be separately identified in the remittance advice for accounting purposes.

3611.1 Federal Rate.--The standard Federal capital payment for FY 1992 and later years is based on the projected national average Medicare capital costs per discharge for each of the fiscal years. The Federal rate is adjusted for each hospital's case mix, day and cost outliers and wage index location. A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a disproportionate share (DSH) percentage greater than 0.

The Federal rate is adjusted annually to reflect changes in these factors.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. Calculate the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the HCFA Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the cost reporting period.) Review the hospital's records and make any needed changes in the count at the end of the cost reporting period. Enter the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by PRICER.

3611.2 Hold Harmless Payments.--In FY 1992, hospitals with a hospital-specific rate for capital that is above the Federal PPS rate for the cost reporting period that ended in FY 1990 can receive the higher of:

- The hold harmless-old capital rate, which is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital (see §3611.5 for the definitions of old and new capital); or

- The hold harmless - 100 percent Federal rate.

Adjust the hospital-specific rate in the cost report for the period ending in FY 1990 for case mix. Update the rate to FY 1992 levels using the projected increase in national average capital costs per discharge to initially determine whether a hospital should be paid under the hold harmless or the fully prospective methodology. The type of methodology is entered in the provider-specific file. (See §3656.3.)

Hospitals paid under the fully prospective methodology may change to the hold harmless methodology if justified by the addition of obligated capital and other changes in remaining old capital costs subsequent to the base period. This option is available through the later of a hospital's cost reporting period beginning in FY 94 or after obligated capital has been put in use. Hospitals must request an extension from you by the later of January 1, 1993, or within 180 days of the event causing the delay, if they will be unable to put an asset in use for inpatient care by October 1, 1996. The new hospital-specific rate reflects the disposal of old assets and the addition of obligated capital costs, but not new capital acquisitions. If the recalculated hospital-specific rate exceeds the Federal rate, the hospital will be paid under the hold harmless methodology. The payment methodology in effect for FY 94 (or after the obligated capital has been put in use, if later) determines the payment methodology applicable for the remainder of the transition period under either transition payment methodology.

Do not hold harmless a hospital for increased costs resulting from a lease arrangement entered into after December 31, 1990.

If a hospital has such low Medicare utilization in its original capital base period that it is not required to file a cost report, its hospital-specific rate will be based on its old capital costs per discharge in the first 12-month cost reporting period for which a cost report is filed.

Convert a reasonable cost/hold harmless hospital to the 100 percent Federal payment rate when:

- Advantageous due to reductions in depreciation and/or the allowable percentage of old capital;

- A hospital elects to be paid at 100 percent of the Federal rate; or