Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-97 **Date: JULY 17, 2001**

CHANGE REQUEST 1525

SUBJECT: Claims Processing Instructions for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration

This Program Memorandum (PM) contains claims processing instructions and the standard systems and CWF changes required for contractors to process demonstration claims with dates of service on or after January 1, 2002 for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration. Systems should be operational to process claims under these demonstrations as of January 1, 2002, although the implementation at any specific facility might vary. Demonstration contracts will last three years although CMS will have the option to extend them and/or add additional demonstration sites.

IMPLEMENTATION LIMITED TO DEMONSTRATION AREAS

The Medicare Participating Centers of Excellence Demonstration will be targeted to programs in Illinois, Michigan and Ohio. The Provider Partnerships Demonstration which is currently under development and subject to final approval will target hospitals in New York and Pennsylvania. In addition, selected demonstration sites ***must*** use intermediaries and carriers that operate on the selected standard systems (Fiscal Intermediary Standard System (FISS) for Part A claims and Multi-Carrier System (MCS) for Part B claims). Hospitals and physicians submitting claims to contractors processing on other claims systems will not be eligible for the demonstration and, therefore, changes to those systems will ***not*** be required.

BACKGROUND

Participating Centers of Excellence

The goal of the demonstration is to align hospitals' and physicians' incentives to work together to provide coordinated, cost effective care, thus achieving savings to the Medicare program and giving hospitals and physicians the flexibility to allocate resources as they determine is most appropriate. Medicare will designate special status as a "Medicare Participating Center of Excellence" on high volume, high quality cardiovascular and orthopedic programs offering lower prices to the Medicare program. Applicants must complete an in-depth application and clinical/organizational quality review process prior to having their financial proposals considered. Under this demonstration CMS will be making a bundled payment for physician and hospital services related to specific cardiovascular and orthopedic procedures (Attachment I, Tables 1A and 1B, provides a complete list of the Diagnosis Related Groups (DRGs) and DRG/procedure codes covered). For some DRGs, not all of the procedures covered under the DRG will be included in the demonstration and some procedures will continue to be paid according to traditional Part A & Part B processing rules. For example, DRG 116 includes implantation of pacemakers as well as Percutaneous Transluminal Coronary Angioplasties (PTCAs) with stents. Only PTCAs with stents are covered under the demonstration. Discharges under DRG 116 for pacemaker implants will be paid according to traditional fee for service Medicare processing. There is also the possibility global payment rates within a DRG will be procedure code specific (e.g. a different global payment for primary hip replacements vs. revisions of hip replacements), and the ability to subset payment procedures and rates within a DRG must be available.

All physicians practicing at these hospitals must agree to seek payment directly and solely from the hospital for services they have provided to patients covered under this demonstration. The demonstration will select approximately 12 cardiovascular programs and 12 orthopedic programs at hospitals in three states in Region V (Chicago): Michigan, Illinois , and Ohio.

Medicare Provider Partnership Demonstration

The Medicare Provider Partnership Demonstration (PPD), which is currently under development and pending final approval, shares many similarities with the Medicare Participating Centers of Excellence demonstration. In particular, the system requirements for these two demonstrations are almost exactly the same although they have unique demonstration numbers and other unique aspects which are highlighted in this change request. Therefore, this change request is being submitted in support of both demonstrations even though implementation of PPD is not confirmed.

The Provider Partnership Demonstration is also designed to align the financial incentives of physicians and hospitals to work together to provide coordinated, cost effective care. Since there will be a single global payment for each Medicare fee for service case covered under the DRG system, both the hospital and the physician staff will have a parallel incentive to work together to increase the efficiency of services. The hospital will be allowed to reward increases in efficiency through incentives to physicians and other clinical staff who successfully improve the cost effectiveness of care for the patients under their supervision. The major difference between this demonstration and the Medicare Participating Centers of Excellence Demonstration for payment systems is that it will not be limited to specific procedures. The application and process for selecting demonstration hospitals will also differ.

Participating hospitals will be chosen for administrative quality, financial stability, clinical quality, and the ability of the hospital administration and physicians to work together constructively, but will not be required to meet all of the volume and rigorous quality criteria of a Medicare Participating Center of Excellence. The two demonstrations will use similar operating systems, eligibility rules and payment processes. The primary differences will be that in the Provider Partnership Demonstration (PPD):

1. All DRGs are included in the demonstration at each hospital site.

2. Cases that would normally be paid under the per diem rules in the ten post acute care (PAC)-DRGs will be excluded from the PPD and paid under normal rules. Cases in those ten DRGs that, in the regular program would normally be paid a full DRG-based amount, will be included in the demonstration and paid a full global payment.

3. DRGs will not be subdivided by procedure codes for the purposes of determining whether or not the discharge should be covered under the demonstration or the specific payment amount.

The Provider Partnership Demonstration will take place in approximately six hospitals in New York and Pennsylvania.

DEMONSTRATION DESIGN

Beneficiary Eligibility for Demonstration

These demonstrations represent an alternative to the traditional Part A and Part B fee for service processing systems. Therefore, patients must be eligible for Part A, enrolled in Part B, and have available at least one lifetime reserve day at the time of admission to the demonstration hospital in order to have their services covered under this demonstration. Other beneficiaries, either because their health care is paid for through other arrangements or because their inclusion would unduly complicate the payment arrangements between Medicare and the demonstration sites, will be excluded from the demonstration payment arrangement. Specifically, the demonstration will exclude the following groups of patients:

- Medicare beneficiaries who are enrolled in Part A *or* Part B *only;* Medicare beneficiaries without any lifetime reserve days at the time of admission;

- Medicare beneficiaries who are enrolled in any type of HMO (including a health care prepayment plan (HCPP) or Medicare+Choice (M+C) health plan), receive medical benefits under the Railroad Retirement Board (RRB) Program, or are insured by the United Mine Workers of America (UMWA);
- Medicare beneficiaries for whom Medicare is a secondary payer (including indicator for MSP due to auto liability); and
- Medicare beneficiaries who are transferred to another acute care hospital paid under the Prospective Payment System *AND* for whom the length of stay is short enough such that the transferring hospital (i.e., the demonstration hospital) would be paid less than the full DRG under traditional fee for service Medicare processing rules.

Services for all of the above groups of beneficiaries will be paid under traditional Part A and Part B processing rules.

Services Covered Under The Demonstration

Medicare Participating Cardiovascular Centers of Excellence will be paid a global payment only for the DRGs and procedures listed on Table 1A. Medicare Participating Orthopedic Centers of Excellence will be paid a global payment only for the DRGs and procedures listed on Table 1B. Provider Partnership Demonstration sites will be paid a global payment for all DRGs. It will be the project officer's responsibility to work with the appropriate contractors to update the list of DRGs covered under the demonstration and insure that the "look up" table for pricing for the hospital(s) affected is updated as well. Unlike the Centers of Excellence demonstration, the Provider Partnership Demonstration will cover complete DRGs and will not split any DRGs for payment purposes.

Pricing

The global payment will include all inpatient hospital and associated inpatient physician services for the admission. Additional payment for outliers will not be made for either demonstration, and an adjustment for outliers will be included in the rates. For the Centers of Excellence Demonstration, no additional payment will be made for short stay "PAC transfer" discharges (see below under Transfers). The normal rates will include an adjustment for these cases. For the Provider Partnership Demonstration, PAC transfers that would normally be paid under the per diem short stay rules will be excluded from the demonstration and paid under those per diem rules.

Claims for pre admission testing, readmissions, and physician services included within the standard global surgical fee will continue to be handled as they are for all other admissions under regular Medicare fee for service reimbursement rules. For example, under a global payment, if a surgeon submits an outpatient or office based claim for follow up, it would not be paid separately and would be considered to have been included in the global payment just as, under fee for service rules, it would be considered to be part of the part B global surgical fee.

Pass-throughs (e.g., direct medical education) will continue to be processed as they are now under the traditional fee for service Medicare program. Prospective capital payments will be included in the global payment and should not be paid separately.

However, interim payments for disproportionate share (DSH) and indirect medical education (IME) should continue to be processed as they normally would be at the time the demonstration claim is paid. At the time of settlement, all discharges, including those covered under the demonstration, should be used to calculate the appropriate DSH and IME payments due to the hospital.

The global payment will be subject to the inpatient Part A deductible as well as any Part A copayments that might be applicable. For the Part B component of the global payment, a fixed copayment will be pre-determined for each hospital and DRG reflecting an actuarial estimate equivalent to 20 percent of the portion of the global payment attributable to Part B services. No Part B deductible will be applied.

Full Access to Any Medicare Provider

There will be no attempt to restrict beneficiary access to any providers under these demonstrations. However, all physicians practicing at demonstration hospitals will be subject to the payment provisions of the demonstration if they provide services to beneficiaries covered under the demonstration. Claims from non-demonstration hospitals and professional providers will continue to be processed in the standard manner. Non-demonstration covered services and/or services for non-eligible beneficiaries at participating demonstration hospitals will continue to be paid according to traditional fee for service Medicare rules.

PAYMENT PROCESSING REQUIREMENTS

Overview

A major focus during the initial phase of both of these demonstrations will be to develop and implement the administrative infrastructure to allow for efficient operations and the building of an automated global claims processing capability. There are several systems modifications proposed which are critical to automating the claims payment process under these demonstrations. A proposed flow chart is provided in Attachment II for reference.

The changes outlined in this PM are intended to achieve two goals:

1. The efficient payment of a single, global payment to the hospital or other contracting entity; and

2. Assuring that Medicare does not "double pay" by paying on a fee for service basis Part B physician claims which should be included in the global payment.

Due to the complexity of the changes required to support these demonstrations and the desire to coordinate overlapping requirements with other programs, this change request does not address the issue of retroactively, automatically adjusting claims. This is an important component of the second goal mentioned above. "Auto adjusting" is the term used to refer to the process of automatically, (without any manual intervention on the part of a Medicare carrier) identifying and recouping funds for Part B physician claims which have been processed on a fee-for-service basis but should be included in the global payment. A separate change request will be submitted to address how this will ultimately be handled. On an interim basis appropriate alternative, manual processes will be designed to achieve this purpose.

The following discussion is organized into sections corresponding to the flow chart and processes described. Within each section, we have enumerated where in the process (e.g., Fiscal Intermediary (FI), carrier, Common Working File (CWF)) each action is being taken.

I. Notice of Admission (NOA)*

A. Hospital - Demonstration hospitals will be required to electronically notify the intermediary whenever a beneficiary to be covered under the demonstration(s) is admitted (or as soon thereafter as possible) or if the patient's demonstration status (i.e., covered or not covered under the demonstration) changes. The proposed standardized "Notice of Admission" (NOA) will take advantage of the same process used to elect hospice benefits, receive services by a religious non-medical health care facility, and "enroll" in the new coordinated care demonstration. Demonstration hospitals *must* report the demonstration number on all NOAs as well as all bills submitted. (There will be a separate demonstration number for Centers of Excellence and the Provider Partnership Demonstration.)

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* Use of the Notice of Election format to serve as a "Notice of Admission" for these two demonstrations was approved by the National Uniform Billing Committee (NUBC) on February 12, 2001.

B. Intermediary-

1. Upon receipt of the NOA from the hospital, the FI will check to determine whether the NOA is for a demonstration hospital, AND that the NOA includes the appropriate demonstration number. If the NOA is from a provider that is not a demonstration hospital, then the FI will return the NOA and send a transmittal with the appropriate reason to the hospital.

2. If the provider is a demonstration hospital and did not report the appropriate demonstration number, then the FI will return the NOA to the hospital requesting that the hospital resubmit an NOA with the complete, correct information.

3. If the NOA is for a demonstration hospital and the correct demonstration number is reported, the FI will transmit the NOA to the CWF.

   The FI will also be responsible for transmitting all notices to the hospital as directed by the CWF *(see below)*.

C. Common Working File-

1. Upon receipt of the NOA from the FI, CWF will check whether an NOA already exists in the auxiliary record file set up to store NOAs. If this is a new NOA, CWF will edit the NOA to determine whether the beneficiary is eligible for the demo. The following requirements will be checked for:

   - Eligible for Part A and enrolled in Part B;
   - At least one lifetime reserve day on the date of admission;
   - Not enrolled in any managed care plan (M+C, HCPP, cost-based HMO, or any other similar plan);
   - Must not be covered under Railroad Retirement Board or United Mine Workers; and
   - Medicare must be the primary payer. *

2. If any of the above conditions are not met, the NOA will be rejected by CWF which will, in turn, notify the FI to return the NOA to the hospital.

3. If the above conditions are all met, the CWF will set up a record in an auxiliary file with the relevant information. It will then notify the FI that the NOA has been accepted. The FI will then send the appropriate acknowledgement to the hospital confirming the action.

4. If this is not a new NOA, CWF will check to see if it is a cancellation of an existing NOA (e.g., in the case where a patient was originally expected to be covered under a demonstration DRG but due to a change in clinical situation is now expected to be discharged under a different, non-demonstration DRG). If so, CWF will cancel the NOA.

   In all cases CWF will notify the FI of the action taken, and, in turn, the FI will notify the hospital that the change has been made.

II. Final Discharge Billing Process

A. Hospital - All hospitals will be required to bill electronically. Hospitals must report the appropriate demonstration number on all claims associated with the demonstration. Final bills for demonstration patients will not be paid unless there is an NOA on file.

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* Beneficiaries with an MSP indicator on their records due to potential auto insurance liability will be excluded from these demonstrations even if ultimately, due to the diagnosis and services provided being unrelated to the auto accident, Medicare would end up as the primary payer. This is being done to simplify the demonstration processing requirements. <u>Any</u> current MSP indicator, therefore, would exclude a beneficiary from the demonstrations.

B. Intermediary - Upon receipt of the final discharge bill from the hospital, the FI will make several "edit checks" in order to determine whether this is a demonstration claim. When necessary to reject claims as discussed below, an FI must follow existing Return to Provider (RTP) procedures and use RTP messages as indicated. Do not use a remittance advice to reject a demonstration claim.

1. First, the FI will check whether the hospital's provider number matches the list of hospitals participating in the demonstration. (This list will be provided to the FI by the project officer.) If it is not a demonstration provider, traditional fee for service (FFS) processing rules will be followed.

2. If it is a demonstration provider, a second check will be made: The FI will look to see if there is a demonstration number on the claim.

3. If the answer to #2, above, is "no", the FI will check to determine whether a special condition code has been put on the bill by the hospital to indicate that the claim should not be processed as a demonstration claim even though it may be for a covered procedure. *(Condition Code B1- "Beneficiary Ineligible for Demonstration Program", to be effective October 1, 2001, has been approved for use for this purpose by the NUBC.)* The intent of this condition code is to allow for timely and efficient fee-for-service processing when the hospital knows in advance that the beneficiary is not eligible for coverage under the demonstration, and the claim should be processed in the traditional fee-for-service manner (e.g., if Medicare is a secondary payer or the beneficiary does not have Part B).

4. If there is a condition code on the claim, the FI will transmit the claim to CWF to check whether there is an NOA on file for this admission.

    a. If there is an open NOA on file, CWF will reject the claim back to the FI which will, in turn, return the claim to the hospital, instructing them to cancel the NOA before submitting the final discharge bill.

    b. If there is no NOA on file (or only a cancelled NOA), CWF will proceed with traditional fee for service processing of the claim.

5. ***(In order to process beyond this point, all claims will need to go through the grouper in order to get the DRG assigned.***) If the demonstration number is on the claim (edit check #2) the FI will check to see if the DRG for the claim is a DRG that is covered under the demonstration. A provider specific list of covered DRGs will need to be set up. If the DRG is not covered under the demonstration, the claim will be returned to the hospital for re-billing without the demonstration number.

6. If there is *neither* a *demonstration number nor a special condition code* on the claim (edit check #3), the FI will check to see if the DRG for the claim is a DRG that is covered under the demonstration. A provider specific list of covered DRGs will need to be set up. If the DRG is not covered under the demonstration, the claim will be processed as a traditional fee-for-service Part A claim.

    However, because an NOA may have been set up under the expectation that the discharge DRG would be one covered under the demonstration, CWF will still need to check for a matching (i.e., with the same date of admission) open NOA. If one is found, the CWF will reject the claim back to the FI, which will, in turn, return the claim to the hospital, instructing them to cancel the NOA before re-submitting the bill. If there is no corresponding open NOA, then traditional FFS Medicare processing rules will be followed.

7. If the DRG is covered under the demonstration, the FI will confirm that the procedure is also covered under the demonstration (e.g., Under Centers of Excellence, certain procedures under DRGs 116, 209, & 471 are excluded from the demonstration).

    a. If the procedure is not covered under the demonstration AND there is a demonstration number on the claim, the claim will be returned to the hospital for re-billing without the demonstration number.

   b. If the procedure is not covered under the demonstration AND there is *no demonstration number on the claim*, it will be processed as a traditional fee-for-service Part A claim. However, the same procedure as outlined in paragraph 2 of Item 6 above must be followed to check for potentially matching open NOAs which must first be cancelled prior to processing payment.

8. If the DRG and procedure are covered under the demonstration and there is a demonstration number on the claim, the FI will check to see if, based on the claim, the patient is being discharged to another inpatient acute care facility *(see also below, Special Situations-Transfers)*. If the answer to this is yes, the FI must also check to see whether the length of stay would warrant a full DRG payment for the given DRG.

9. If the DRG and procedure are covered under the demonstration, but neither the demonstration number nor the special condition code are on the claim, the FI will return the claim to the hospital for re-billing. The hospital must put either the demonstration number or the condition code on the bill to indicate how it should be paid.

10. If the patient is not being transferred or, if transferred, the length of stay is long enough to warrant a full DRG payment, the claim will be transmitted to CWF. *(For the Centers of Excellence demonstration, only acute care transfers should be considered. For the Provider Partnership Demonstration, both acute care and post acute care (ten specific DRGs) should be considered when reviewing "transfers". See below, "Special Circumstances" under "Transfers".)*

11. If the patient is being transferred and the length of stay is short enough for the DRG such that a per diem payment less than the full DRG would be paid the hospital, the FI will return the claim to the hospital for re-billing with the appropriate condition code and without the demonstration number.

After processing by the CWF (see below II(C), the claim will come back to the FI for final processing. If the claim is to be paid under one of the demonstrations, the FI will be responsible for processing the global payment and sending demonstration specific remittance advice statements and Medicare Summary Notices (MSNs) to hospitals and beneficiaries, respectively.

The FI will also be responsible for returning the claim if so directed by CWF, and sending appropriate notice to the hospital. The FI may be directed to return the claim by CWF under the following conditions:

•If there is a matching open NOA but the claim should not be processed under the rules of the demonstration (e.g., a condition code is present or the discharge DRG and/or procedure are not covered under the demonstration); and

•If there is no NOA when one is required under the rules of the demonstration.

Under either of the above conditions, CWF will direct the FI to return the claim; the hospital will be told to either set up the NOA or cancel the NOA; if appropriate, the hospital may also be told to re-bill without the demonstration number and with the indicated condition code. If a beneficiary is not eligible for the demonstration but an NOA has been set up, the hospital must cancel the NOA before the traditional fee for service payment can be processed. However, if a hospital submits a final discharge bill with a demonstration number on the claim for a patient covered under the demonstration, it will not be required to separately submit a revocation to the NOA. CWF will effectively "revoke" the NOA by putting the discharge date from the final bill on the NOA.

C. Common Working File (CWF) -

1. Upon receipt of the demonstration claim from the FI, the CWF will check to see if there is an auxiliary record (i.e., NOA) on file corresponding to the claim.

   a. If there is no NOA on file, CWF will reject the claim back to the FI. The FI will return the bill to the hospital. The hospital will be told to re-bill with the appropriate condition

code and without the demonstration number or, if this should be a demonstration claim, set up the NOA prior to billing.

b. If there is an NOA for this admission on file, CWF will "revoke" the NOA by putting the discharge date on the NOA in the auxiliary record.

2. If the claim has not been rejected, after the CWF has put the discharge date on the NOA, it will transmit the claim back to the FI with authorization to pay the global payment.

3. After the discharge date has been put on the NOA by the CWF, the claim will be sent to the national claims history file.

4. If a demonstration hospital submits a claim with a condition code indicating it should not be paid under the demonstration, *OR* for any other claim (regardless of DRG), CWF must first check for an open, matching NOA before "authorizing" the FI to pay a traditional Medicare inpatient DRG. A matching NOA is defined as one with the same date of admission for the same beneficiary at that hospital. If a matching NOA is found, the hospital must be directed by the FI to first cancel the NOA and then resubmit the bill for payment. This situation may happen if, at the time of admission, the patient is expected to receive specific services covered under the demonstration and an NOA is submitted, but, as a result of subsequent events, the patient is discharged under a non-demonstration DRG. Open NOAs must be cancelled in a timely manner to prevent Part B physician claims from being incorrectly processed on a no pay basis. When the open NOA is cancelled, any such Part B physician claims which have already been processed as no pay, will be "reversed", thereby allowing them to be resubmitted for payment.

III. Part B Claims Processing

A. Physician or other Professional Provider *-

Only claims from physicians or other professional providers for services at the hospital [place of service = inpatient (code=21), outpatient (code =22), or emergency room (code = 23)] will be included in the global payment. Claims from DME suppliers, ambulance providers, etc. will not be part of the demonstration and will be processed according to traditional fee for service Medicare rules.

Physicians will be requested *but not required* to submit claims electronically. All physicians will be required to accept assignment for demonstration related claims. They will be notified of this through educational efforts prior to and during the demonstration.

Physicians who provide services at non-demonstration hospitals to patients who are transferred to or transferred from demonstration hospitals on the same date of service will be required to submit the claim with the appropriate site of service provider ID in order to have the claim be processed correctly and receive payment. For example, if a doctor treats and stabilizes a beneficiary in the emergency room of a non-demonstration hospital and then transfers that patient to a demonstration hospital, she/he is eligible to be paid under the traditional fee for service Medicare program for those services. They are not included in the global payment to the demonstration hospital. The doctor providing services must put the Medicare provider number (not just the name) of the non-demonstration hospital where the services were provided in item 32, with the prefix HSP. Claims without the correct site of service provider ID will be processed as no pay claims under the assumption that the services took place at the demonstration hospital and should be included in the global payment. *(See also "System Specifications", section "IV Carrier Requirements", item C-19.)* **Nothing in this PM is intended to contradict previously or subsequently issued PMs which require physicians to submit other claims for hospital-based services with the appropriate site of service provider ID.**

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* For simplicity, all future reference in this document will be to "physician" claims. However, this would include all other Medicare covered Part B professional claims from, for example, dentists, therapists, etc.

B. Carrier-

1. Only physician or other professional claims where the place of service is a hospital (inpatient, emergency room, or outpatient) will be covered under the demonstration. The carrier will receive the claim from the physician and transmit it to the CWF. No special front end processing is required for the demonstration at this point.

2. After processing by CWF (see section III(C) below), the carrier will be responsible for processing the bill as directed by CWF and sending appropriate notices to the professional provider. In the case where the claim is to be processed as a "no pay claim" because payment is covered under the global payment to the hospital, the carrier should put the demonstration number on the claim. This process should be automated to reduce or eliminate manual handling of demonstration claims.

   Demonstration claims shall be processed as assigned claims. Carriers may use existing logic to change the assignment on claims.

   The remittance advice sent to the Part B provider should note the substituted payment provisions of the demonstration, and also state that if the provider subsequently learns that a patient was not covered under the demonstration she/he may resubmit the claim for processing. (This may result from a transfer or as a result of the patient ultimately being discharged under a non-demonstration DRG.). Carriers should use new remark code N67 for this purpose:

N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: The facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

   As with any new remark code, carriers must notify providers of the new code and message prior to initial use in an electronic remittance advice transaction.

3. The standard notice from the carrier to the beneficiary will be suppressed.

4. On a weekly basis, the carrier will prepare a report for each demonstration hospital showing all Part B demonstration claims (i.e., those processed as "no pay") processed in the previous week for services rendered at that hospital. The report shall also show demonstration claims that have been retroactively adjusted and re-processed as traditional Medicare fee-for-service claims (see section IV (C)4). The intent of this report is to allow the hospital to determine how the global payment should be distributed. The report should be sorted by beneficiary, date of admission, Part B provider , and date of service. The report shall include a record for each claim line processed and the amount that would have normally been paid under traditional Medicare fee for service rules for each covered service. Attachment III shows a sample format for the report along with a definition of the fields to be included.

   Because information about the hospital, date of admission, and date of discharge are not available on the Part B claims, this information must be provided by CWF *(See section III (C), Items 6 & 9.)* CWF will provide the carrier with the site of service provider ID, admission date and discharge date associated with each demonstration claim. A separate look up file with the name and address of each hospital corresponding to the provider ID number will be provided to the carrier by the project officer. The carrier shall capture and

maintain this information in a format that can be accessed by the carrier for routine, automated reporting to the demonstration hospitals.

C. Common Working File (CWF) -

1. Upon receipt of the claim from the carrier, the CWF will first check to see if there is an auxiliary record from an NOA on file for the beneficiary. If there is no NOA on file for the beneficiary, the CWF will process the claim as it would a traditional FFS Part B claim and transmit the claim back to the carrier as appropriate.

2. If there is an auxiliary record reflecting an active NOA on file for the beneficiary (i.e., the NOA was submitted and not cancelled), CWF will check whether the date of service on the claim falls on or between the admission and discharge date (inclusive of both dates) on the NOA. If there is no discharge date on the NOA yet (i.e., because CWF has not received the final bill with a discharge date with which to "revoke" the NOA), then CWF will check to see if the dates of service fall on or after the date of admission on the NOA. If the answer to either of these checks is "no", the CWF will follow traditional FFS processing rules and transmit the claim back to the carrier as appropriate.

3. If the date criterion in #2 above, is met (i.e., the answer to either of the above edits is "yes"), then CWF will check to determine whether the site of service provider ID has been filled in.

4. If the answer to #3 above, is "no," then CWF will check to see if there is a discharge date on the NOA. If there is no discharge date on the NOA *OR* if there is a discharge date on the NOA but the date of service on the claim matches either the admission or discharge date on the NOA, then CWF will reject the claim back to the carrier. The carrier will return the claim to the provider with instructions to re-bill with the appropriate site of service provider ID. The claim will neither be rejected nor processed as a no pay bill under the rules of the demonstration, and the re-submission by the provider with the appropriate site of service provider ID will not be seen as a duplicate claim.

5. If, however, there is no site of service provider ID on the claim, but there is a discharge date on the NOA and the date of service is NOT the same as either the admission or the discharge date reflected on the NOA, then CWF will reject the claim back to the carrier with a unique error code which will indicate that this is a demonstration claim (unique error codes need to be established for each demonstration) to be processed as a "no pay claim" *(see B(2) above).*

6. When CWF returns a claim to the carrier which it has determined should be processed as a "no pay" claim under the rules of one of these demonstrations, CWF shall also provide a "trailer record" to the carrier indicating the hospital where the services were provided, the date of admission, and, if available, the date of discharge. This information shall come from the NOA auxiliary record which is stored by CWF, and shall be used by the carrier, in conjunction with data from the Part B claims, to prepare reports for the participating demonstration hospitals. *(See also section III (B), item 4.)*

7. If the site of service provider ID is filled in, CWF will check to determine whether the site of service on the claim matches the hospital on the NOA. If there is a match, CWF will "reject the claim back to the carrier" with a unique error code which will indicate that this is a demonstration claim (unique error codes need to be established for each demonstration) to be processed as a "no pay claim" *(see C(5) and B(6) above).*

8. If the site of service provider number does not match, CWF will then check to see if the discharge date is on the NOA. If there is no discharge date on the NOA, then the CWF will follow traditional FFS processing rules and transmit the claim back to the carrier as appropriate. The assumption is that the claim is not going to be covered under the global payment. After the final discharge bill is received and the discharge date is put on the NOA, the claim will be adjusted and processed on a no pay basis in accordance with the provisions of the demonstration , if determined to be appropriate.

9. If the date criteria are met (check #2 above) and the site of services do not match (check #8 above) but there is a discharge date on the NOA (check #8 above), then the CWF will check to determine if the date of service is on either the admission or discharge date--(i.e., not on one of the in-between inpatient dates). If the answer is "no," CWF will "reject the claim back to the carrier" with a unique error code which will indicate that this is a demonstration claim and to be processed as a "no pay claim" *(see B(5) & B(6) above).*

   When CWF returns a claim to the carrier which it has determined should be processed as a "no pay" claim under the rules of one of these demonstrations, CWF shall also provide a "trailer record" to the carrier indicating the hospital where the services were provided, the date of admission, and, if available, the date of discharge. This information shall come from the NOA auxiliary record which is stored by CWF, and shall be used by the carrier, in conjunction with data from the Part B claims, to prepare reports for the participating demonstration hospitals. *(See also section III (B), item 4.)*

10. If the answer to the edit in #9 above is "yes" (i.e., the date of service on the claim is on the admission or discharge date of the admission), then the CWF will follow traditional FFS processing rules and transmit the claim back to the carrier, as appropriate. This will allow for traditional fee-for-service payment in situations where patients are transferred to or from demonstration hospitals. When a patient is transferred, services provided at the non-demonstration hospital should be paid according to traditional fee-for-service rules. However, if the service occurs during an admission covered under the demonstration, but not on either the admission or discharge date, the assumption is that the service has been provided at another facility through a special arrangement with the demonstration facility which will be responsible for covering the costs of that service (both the facility and physician components).

11. After the carrier processes the no pay claim, the carrier will send the claim back to CWF, which will "accept" it and also send the claim to the national claims history file.

IV. Paying Re-Submitted Demonstration "No Pay" Claims After Cancellation of NOA

The presence of an open NOA causes related Part B claims to be processed as "no pay" claims. Under certain circumstances, however, a hospital may submit an NOA but subsequently determine that a beneficiary is not eligible for coverage under the demonstration. The hospital will then submit to the FI a cancellation of the NOA. However, during the time that the NOA was open, some Part B claims may have been submitted and processed under the rules of the demonstration as "no pay" claims. If the NOA is canceled, then these services must be able to be re-processed under the traditional fee-for-service Part B Medicare program.

A. Hospital

1. It is the hospital's responsibility to submit a cancellation of the NOA to the FI as soon as it becomes aware that a beneficiary will not be eligible for coverage under the demonstration.

2. It is the hospital's responsibility to notify physicians who may have submitted bills to the carrier and had them processed as "no pay" under the demonstration that the services may now be eligible for payment under traditional Medicare Part B rules.

B. Physician or other Part B Professional Provider

1. The physician will be instructed to re-submit claims previously processed on a "no pay" basis, but which should now be processed for traditional Medicare payment with a specific HCPCS modifier:

   GB *Claim being resubmitted for payment because it is no longer covered under a global payment demonstration*

   (This modifier was approved by CMS's HCPCS coding workgroup on April 24, 2001 for use for these demonstrations after January 1, 2002.)

This modifier should be at the claim line level and be repeated for each service for which the physician is requesting payment. In order to insure accurate processing, this modifier should be in the first or second modifier position on the claim record.

C. Carrier

1. Upon receipt of a claim with the assigned modifier, the carrier will suspend the claim as a "Suspected Duplicate" for manual review.
2. The carrier will be responsible for validating that the services billed on the re-submitted match those on the claim that was previously processed on a "no pay" basis and for which the associated NOA was subsequently cancelled. Therefore, this re-submitted claim is now eligible for traditional fee for service payment. All edits and/or reviews that would be followed with regular fee for service claims should be followed.
3. The carrier shall void the original no pay claim so that it does not appear as a final demonstration claim in the national claims history file.
4. The carrier shall notify hospitals in the standard report (see section III(B)4) of all demonstration claims which are reprocessed as fee for service claims.

SPECIAL CIRCUMSTANCES

I. Transfers

A. Acute Inpatient Hospital (PPS) Transfers

In order to avoid the problems of calculating appropriate global per diems, when an inpatient acute care transfer occurs from a demonstration hospital to another non-demonstration PPS hospital *AND* the length of stay at the originating, demonstration hospital is short enough such that under traditional payment processing a per diem less than the full DRG payment would be made, payment shall revert to traditional separate Part A and Part B processing rules. As described above (starting in section II(B)), if the claim has not been billed with the appropriate condition code indicating that the demonstration provisions should not apply, the claim will be returned by the FI and hospitals will be directed to: (1) Electronically submit a cancellation of the NOA; (2) Re-bill with the appropriate condition code; and (3) Omit the demonstration number from the claim. The FI must use RTP procedures rather than a remittance advice to return these claims.

If an NOA is cancelled for any reason, Part B claims subsequently submitted would be processed as any other non-demonstration Part B claim.

If, as a result of the original NOA, Part B physician or professional provider claims (i.e., not DME or ambulance) have already been processed on a "no pay" basis, the Part B provider will be allowed to resubmit the claim to the carrier. The hospital will be required to notify the Part B provider that s/he has should resubmit the claim to the carrier for FFS payment. The carrier must not consider these bills duplicate submissions.

Patients transferred to a demonstration hospital from a non-demonstration PPS hospital are eligible to have their services covered under the demonstration regardless of length of stay at either hospital. The originating hospital and its associated providers are to be paid according to regular Medicare FFS payment rules. Claims for services by providers at the originating hospital, including those provided on the date of discharge or transfer, are not covered under the global reimbursement rate. Only services provided by physicians at the demonstration hospital on the date of admission or discharge are to be reimbursed under the global payment, but services provided by physicians at other hospitals on those days may be due to a transfer and will be paid under the traditional fee-for-service Medicare program rules. Providers will have to bill with the non-demonstration hospital site of service provider ID on the claim in order to receive payment.

B. Post Acute Care (PAC) Transfers

In FY 1999, pricing edits were implemented for 10 DRGs when the patient was "transferred" to a post acute provider (skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency care, etc.) and the patient's length of stay was one or more days less than the geometric mean for that DRG. PAC Transfers will be handled differently under the two demonstrations:

- Centers of Excellence Demonstration: Because the negotiated global payments already adjust for these shorter stays, these edits should NOT be applied to claims under this demonstration.

- Provider Partnerships Demonstration: PAC transfer cases that would normally be paid under the per diem amounts will be excluded from the demonstration, and paid under normal, separate Part A & Part B processing rules. Hospitals must put the correct condition code on the claim in order for it to process and be paid correctly. Demonstration numbers should NOT be put on these claims. PAC transfer cases which have a length of stay long enough to warrant a full DRG payment should be processed under the global payment rules of the demonstration.

II. Health Professional Shortage Area (HPSA) Bonus Payments

Providers who would otherwise be eligible for HPSA bonus payments for services provided to beneficiaries in the absence of these demonstrations should continue to receive them under either demonstration. Physicians will be directed to submit no pay claims with all of the necessary modifiers and other information required for this purpose. However, HPSA payments are calculated based on actual payments and demonstration claims will be processed as “no pay” claims. Therefore, at the time HPSA payments are calculated, the system must also estimate what would have been paid for demonstration claims (e.g., Medicare allowable x 80 percent; because demonstration claims will not be subject to the Part B deductible, this does not need to be figured into the calculation).

III. Cost Reporting and Reconciliation for Hospital Payments

In processing claims, the FI must indicate on the processed claim record what portion of the global payment is attributable to Part A demonstration payment and the Part B demonstration payment. These amounts will be on the look up table provided to the FI by the project officer. Splitting out the payment will insure that the money comes out of the appropriate trust fund; in addition, it should insure that only Part A dollars are reported in the Provider Statistics and Reimbursement (PSR) report and any other Part A-specific cost reports. Payments should be recorded in such a way to avoid the need for reprogramming cost reports. Separation of demonstration claims will not be required for these reports although, if needed, the demonstration number will be on every claim for subsequent “back end” reporting purposes.

IV. Direct Medical Education, Indirect Medical Education (IME) & Disproportionate Share (DSH)

Direct Medical Education is paid as a pass through to the hospital and is not paid on an interim basis with each discharge. It should continue to be processed in this manner and should be unaffected by either demonstration.

It is also the intent that IME and DSH, which are paid on an interim basis with each claim, should continue to be paid as they would be in the absence of the demonstration. Interim IME & DSH payments which are calculated in the pricer module should continue to be added to the global DRG payment at the time the claim is processed. During the settlement and reconciliation process, all hospital days, including those for demonstration patients, should be included.

V. Capital Payments

A. Capital Pass-Throughs

It is expected that by the time either of these demonstrations are implemented, a very small number of hospitals (primarily those that are new providers) will be receiving pass through capital payments. It is not expected that demonstration hospitals will be among them.

B. Prospective Capital

Prospective Capital Payments will be included in the global payment and should not be added to the claim at the time it is processed.

SYSTEM SPECIFICATIONS

The sections below build on the general descriptions above and itemize some of the requirements and issues to be addressed. Specifications here are not intended to contradict anything previously stated in the body of this document. Moreover, <u>this enumeration is not intended to be all inclusive and any omissions should not necessarily imply changes that are unnecessary.</u> The overall business needs previously stated in this memorandum should take precedence.

I. General Requirements

G 1 A list of participating hospitals, the Medicare provider number, a technical contact person at the hospital, and the payment amounts will be forwarded as soon as finalized.

G 2 Both the intermediaries and the carriers involved in the demonstrations should continue to prepare their remittance advice transactions, using the modifications listed under intermediary and carrier requirements as appropriate.

G 3 CMS will calculate the global payment amount and fixed Part B copayment (in lieu of a variable Part B coinsurance) applicable to each covered DRG or DRG and procedure code grouping as appropriate. This Part B copayment will be unique for each hospital and DRG (or DRG/procedure code group) regardless of actual services rendered to an individual beneficiary. The calculated amounts will be provided to the applicable FIs by CMS. No Part B deductible will be applied to demonstration claims.

G 4 A bundled payment for all Part A and Part B services associated with the covered inpatient stay will be made to the participating center by the FI serving the applicable hospital.

G 5 To be eligible to participate in the demonstrations, the Medicare beneficiary must have both Part A and Part B coverage, and Medicare must be the primary payer. Also, any beneficiary entitled under the Railroad Retirement Board, enrolled in a managed care organization, or Health Care Prepayment Plan (including United Mineworkers of America) cannot participate in the demonstrations. Additionally, no bundled payment should be made for a Medicare managed care organization member that is an inpatient at a teaching hospital that is participating in the demonstration. These latter claims should be processed as they are now, when appropriate, to reimburse hospitals for indirect medical education expenses.

G 6 In an attempt to limit the additional burden on contractors and build an automated infrastructure that can support a larger program in the future, demonstration crossover claims (i.e., claims where there is a Medigap provider which will pick up some of the patient payments) should continue to be processed in the same manner as they are under traditional processing. It is recognized that these claims may cause some confusion for Medigap insurers and efforts will be made by CMS to educate them about the demonstration.

II. Hospital Requirements

H 1 To avoid inappropriate payments, a Notice of Admission (NOA) transaction will be used to admit and delete admissions of beneficiaries in the demonstration. The NOA must be submitted for new admissions and to cancel an admission. However, it will not be necessary

to submit a separate NOA upon discharge. The discharge date from the final discharge bill will be put on the NOA by CWF thereby "revoking" it when the patient is discharged. If an error is made on an NOA, the hospital will be required to cancel the original NOA and submit a new NOA. Hospitals must submit the NOA electronically and receive notification that the election was received prior to billing for demonstration related services.

Hospitals utilizing the UB-92 flat file format should use record type 40 to report the type of bill: 11A or 11D, as appropriate. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3) and type of bill (Field No. 4) are required.

Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the type of bill: 11A or 11D as appropriate in 2-130-CLM01, CLM05-01, AND CLM05-03.

H 2 Completion of the Notice of Admission by the Hospital – Listed below are the specific instructions for completing each required field on the NOA.

Record Type (RT) 10, Fields 11- 16. Provider Name, Address, and Telephone Number (Required).--The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. FAX numbers are desirable. Enter the corresponding 837 data in 2-040-PER, 2-015-NM1, 2-025-N3, and 2-030-N4.

RT 40, Field 04. Type of Bill (Required).--Enter the three-digit numeric type of bill code: 11A, or 11D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular enrollment. It is referred to as a "frequency" code. Enter the corresponding 837 data in 2-130-CLM.

3rd Digit - Frequency.

A - Election Notice
D - Cancellation

Use of the type of bill code and frequency digits specified above was approved by the NUBC for use in these demonstrations on February 12, 2001.

RT 20, Fields 4-6. Patient's Name (Required).--Show the patient's name with the surname first, first name, and middle initial, if any. Enter the corresponding 837 data in 2-095-NM1.

RT 20, Fields 12-16. Patient's Address (Required).--Show the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code. Enter the corresponding 837 data in 2-105-N3 and 2-110-N4.

RT 20, Field 8. Patient's Birth Date (Required).--(If available.) Show date of birth numerically as CCYYMMDD. If the date of birth cannot be obtained after a reasonable effort, zero fill the field. Enter the corresponding 837 data in 2-115-DMG02.

RT 20, Field 7. Patient's Sex (Required).--Show an "M" for male or an "F" for female. Enter the corresponding 837 data in 2-115-DMG03.

RT 20, Field 17. Admission Date (Required).--Enter the admission date. Show the date numerically as CCYYMMDD. Enter the corresponding 837 data in 2-135.B-DTP03.

RT 10, Field 6. National Provider Identifier (Required).--This is the six-digit number assigned by Medicare. Enter the corresponding 837 data in 2-005-PRV03.

RT 30, Fields 12-14. Insured's Name (Required).--Enter the beneficiary's name on line A if Medicare is the primary payer. *(If Medicare is not the primary payer, the beneficiary is ineligible for these demonstrations.)* Show the name as on the beneficiary's HI card. Enter the corresponding 837 data in 2-325.B-NM1.

RT 30, Field 7. Certificate/Social Security Number and Health Insurance Claim/Identification Number (Required).--Show the number as it appears on the patient's HI card, Social Security Award Certificate, utilization notice, MSN or EOMB, temporary eligibility notice, etc., or as reported by the SSO. Enter the corresponding 837 data in 2-095-NM109.

Treatment Authorization Code field (FL63).--Use this field to insert the appropriate demonstration number ("07" for Participating Centers of Excellence ; "08" for Provider Partnerships).

A hospital representative will send original, signed notice of admission election statement has been sent to the intermediary and they have retained a copy in their records.

H 3 All claims from hospitals must be submitted electronically using Medicare standard formats. Follow the general review instructions in §3604 of the Medicare Intermediary Manual, Part 3.

Applicable Bill Types -

The Applicable bill type is 11X

Hospitals utilizing the UB-92 flat file format should use record type 40 to report the appropriate bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3) and type of bill (Field No. 4) are required.

Hospitals utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the appropriate bill type in 2-130-CLM01, CLM05-01, AND CLM05-03.

Demonstration Number Reporting -

The demonstration special processing number is "07" for Centers of Excellence and "08" for Provider Partnerships.

Hospitals utilizing the UB-92 flat file use record type 31, Contract Number (Field No. 15) to report the demonstration number.

Hospitals utilizing the Medicare A 837 Health Care Claim Version 3051 implementation 3A.01 and 1A.C1, report the demonstration number in 2-325.E-NM1 NM109

Hospitals utilizing the Health Care Claim: Institutionalization 837 version 4010, report the demonstration number in 2010BC REF02 (REF01 = 2U)

Condition Code Reporting

Condition Code B1, "Beneficiary Ineligible for Demonstration Program", has been approved by the National Uniform Billing Committee to be used for these demonstrations effective 10/1/2001.

Hospitals utilizing the UB-92 flat file use record type 41, Condition Code (Field No. 4-13) to report condition code.

Hospitals utilizing the Medicare A 837 Health Care Claim Version 3051 implementation 3A.01 and 1A.C1, report the condition code in 2-225.E-HI.

Hospitals utilizing the Health Care Claim: Institutional 837 version 4010, report the condition code in HI - CONDITION INFORMATION

H 4 The Notice of Admission process outlined is based on similar enrollment procedures utilized for Religious Non-Medical Health Care Institutions (RNHCI) and the Coordinated Care Demonstration. Hospitals must submit the NOA electronically and receive notification that the election was received prior to billing for demonstration related services.

III. Intermediary Requirements

I 1 A remittance advice will be sent to the provider for each adjudicated (i.e., not rejected) claim. The remittance advice will show the total global payment allowed under the demonstration including any portion of the global payment attributable to the interim payment for indirect medical education or disproportionate share. In addition, patient liabilities for the Part A deductible and coinsurance and/or the appropriate fixed Part B copayment that will be applied under the demonstration must also be shown on the remittance advice.

I 2 Intermediaries must continue to report any regular Part A coinsurance for a demonstration claim (with claim adjustment group PR and reason code 2) in the remittance advice. Coinsurance attributable to the Part B services that previously would have been paid by the carrier must be reported using group PR and claim adjustment reason code 3 (copayment amount) with remark code M137 (Part B coinsurance under a global payment demonstration) at the claim level. PR signifies that the patient (or his/her other supplemental payer) is responsible for payment of this amount. Under the demonstrations, the facility must collect both types of coinsurance from the beneficiary or the beneficiary's supplemental payer. We must differentiate between the types of patient liabilities for Medicare accounting purposes.

I 3 Demonstration inpatient claims will be identified for CWF in field 77, positions 831 and 832. The demonstration special processing number is 07 for Centers of Excellence and 08 for Medicare Provider Partnership.

I 4 For bills submitted to CWF, the FIs will report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the claims record. The FIs will compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program, and other payment amounts in the value code area of the claims record as shown below.

Code	Title	Definition
Y1	Part A Demonstration Payment	This is the portion of the payment designated as reimbursement for Part A services per the OFM contract. No deductible or coinsurance has been applied.
Y2	Part B Demonstration Payment	This is the portion of the payment designated as reimbursement for Part B services per the OFM contract. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration.

I 5 Information regarding what would have been paid in the absence of a demonstration is not required to be put on the remittance advice sent to hospitals. However, periodic reports (no less than quarterly) showing what was paid and what would have been paid under Part A will be required to be produced by the intermediary. (Separate reports will be produced by the carrier showing no pay demonstration claims processed under Part B and what would have been paid in the absence of the demonstration. See Attachment III.)

I 6 The FIs will be responsible for computing and applying the applicable Part A deductible and coinsurance amounts and applying the DRG-specific fixed Part B copayment (which CMS will calculate in lieu of the traditional coinsurance) amount. The Part B deductible will not be applied to payments made under these demonstrations.

The Part A blood deductible should be applied as usual. The Part B blood deductible should be waived as there is no Part B deductible applied for this demonstration.

I 7 The Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) is to contain the beneficiary's total liability including Part A deductible, Part A coinsurance, Part B coinsurance (the fixed copayment), and Part A blood deductible, if applicable.

I 8 An Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) will be issued to the Medicare beneficiary containing the following statements.

Para graph #	**MSN Message #**	**MSN Text- English**	**MSN Text - Spanish**
1	60.1	(Name of Hospital), in partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service	(Name of Hospital) en cooperación con médicos en su área, están participando en una demostración de Medicare el cual utiliza un método de pago simplificado que combina todos los hospitales y médicos relacionados a sus servicios de hospital. Este pago sencillo va a hacer el proceso de facturación más fácil mientras que mantiene el costo más bajo o al mismo nivel de como era bajo el sistema tradicional de pago.
2	30.2	You should not be billed separately by your physician(s) for services provided during this inpatient stay	Usted no debe ser facturado separadamente por sus doctores para servicios proporcionados durante esta hospitalizacion interna.
3	60.2	The total Medicare approved amount for your hospital service is $ ______________. $___________ is the Part A Medicare amount for hospital services and $___________ is the Part B Medicare amount for physician services (of which Medicare pays 80 %). You are responsible for any deductible and coinsurance amounts represented.	La cantidad total que Medicare aprobó por sus servicios de hospital es de $__________. $___________ es la cantidad de Medicare Parte A por sus servicios de hospital y $_________ es la cantidad de Medicare Parte B por sus servicios médicos (de los cuales Medicare paga el 80%). Usted es responsable por cualquier deducible y coaseguro presentado más abajo.
4	60.3	Medicare has paid $___________for hospital and physician services. Your Part A deductible is $_________. Your Part A blood deductible is $_____. Your Part A coinsurance is $_________. Your Part B coinsurance is $_________.	Medicare pagó $_________ por servicios de hospital y por servicios médicos. Su deducible de la Parte A es $__________. Su deducible de la Parte A para sangre es $___________. Su coaseguro de la Parte A es $__________. Su coaseguro de la Parte B es $__________.

I 9 FIs will use all current edits on the Centers of Excellence and Medicare Provider Partnership claims. The only EXCEPTION to this will be the bypassing of edits for post acute care (PAC) transfers for the ten specified DRGs for the Centers of Excellence demonstration. For the Provider Partnership Demonstration, short stay PAC discharges/transfers will be

excluded from the demonstration and processed according to traditional fee for service rules (see above, Special Circumstances I (B)).

I 10 Normal activities for audit, medical review, MSP and fraud and abuse will be required for Centers of Excellence and Medicare Provider Partnership claims.

I 11 For Medicare cost reporting purposes; demonstration patients will be treated as Medicare patients. During the cost report and reconciliation process, adjustments to indirect medical education, disproportionate share, and other "per admission" payments will be made to reflect demonstration payments.

I 12 Claims will be counted as part of the normal monthly workload.

I 13 Because IME and DSH payments should be processed in the same manner as for non-demonstration claims, they should be included in calculations of payment accuracy by the FI.

I 14 Interest will be paid on the Part A portion of the claim to the extent it would otherwise have been paid to the hospital in the absence of the demonstration.

I 15 If a patient is readmitted to the same demonstration hospital within 72 hours of discharge, the same payment rules that would be followed in the absence of the demonstrations should be followed. Thus, if the admission would be considered as part of the original admission for purposes of payment (i.e., a second DRG payment would not be made), then it would also be considered to be covered under the first global DRG payment. (Hospitals would be required to submit a new NOA to cover the admission.) If the second admission would be considered a new admission for purposes of payment, then a second global payment could also be made. Similarly, if pre-admission services at a hospital would be covered under the traditional Part A inpatient DRG payment, then they should also be considered part of the global payment.

IV. Carrier Requirements

C 1 Carriers will use all current edits (including current duplicate logic) on demonstration claims. Auto-adjudication logic may still be applied. Claims denied for reasons not related to the demonstration should be processed with the appropriate routine denial reason code.

C 2 All physician and professional practitioner claims related to the demonstration will be processed by the carriers as “no pay” claims. All claims must be processed to determine the amount that would have been paid had it not been for the demonstration. No payment will be made on these claims.

C 3 In cases where a claim previously processed as a “no-pay” claim becomes eligible for payment under traditional Part B fee-for-service processing (e.g., as a result of a PPS transfer and subsequent cancellation of the NOA), it will be the provider's responsibility to resubmit the bill. These claims shall not be considered duplicate submissions. The carrier must process these bills as any other FFS claim, applying all edits and/or reviews that would otherwise be performed. In order to insure the accuracy of “demonstration claim” history in the national claims history file, previously filed “no pay” claims will need to be “backed out” prior to paying the re-submitted fee for service claim.

C 4 Claims will be processed by the carrier who has responsibility for the state where the service is rendered.

C 5 In computing what Medicare would have paid under the demonstrations, carriers are not to apply the Part B deductible, blood deductible or coinsurance or post any of them to the beneficiary history.

C 6 All Explanations of Medicare Benefits (EOMB)/Medicare Summary Notices (MSNs) from the carrier for "no pay" claims applicable to demonstration patients will be suppressed. Information related to Part B payments will be included on the EOMB/ MSN sent by the FI.

C 7 Normal activities for fraud and abuse and audit will not be required on demonstration claims. Irregularities that may indicate potential fraudulent behavior should be reported to the applicable RO. As part of the independent evaluation of each of these demonstrations, an analysis of demonstration claims will be performed.

C 8 Practitioners located in HPSAs will be directed to use the appropriate HPSA modifier on their claims.

C 9 Claims will be counted as part of the normal monthly workload as CWF no payment bills.

C 10 Report the number of no-payment demonstration claims processed on line 11 (Claims Denied) on the monthly Medicare Program Carrier Performance Report - Page 1 (Form HCFA-1565). Line 11 is a subset of line 15 (Total Claims Processed), which is the basis for estimating the claims processed workload in the administrative budget process. Also, report these claims on line 18 (Other) on the Medicare Program Quarterly Supplement to the Carrier Performance Report (Form HCFA-1565A).

C 11 Automated response units (ARUs) -- The demonstration claims should be deleted from the ARU system and requests for information should be forwarded to a live representative at the carrier site. The ARU message should not be changed in order to try and accommodate the demonstrations.

C 12 Appeals -- The carrier claims will not be subject to appeals. Instead, a new message , N83 will be used:

N 83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

C 13 The Demonstration ID number is 07 for the Centers of Excellence Demonstration and 08 for the Provider Partnership Demonstration. To facilitate CWF acceptance of these demonstration claims and their movement to the National Claims History, enter the demonstration ID number on the HUBC, field 49, Positions 264-265. Locations of the demonstration number on claims are as follows:

Form HCFA-1500 Paper Claims
The demonstration ID number appears in field 19.

Electronic Claims
National Standard Format - The demonstration number appears at record/field EAO-43.0 Special Program Indicator

ANSI X 12N 837 (version 3051) - The demonstration ID number is submitted in 2-180.C-REF, as follows: REF 01= P4 Project Code; REF 02 = Demonstration Project Number (__) *(Note: Use 07 or 08, as appropriate)*

ANSI X12N 837 (version 4010) - The demonstration ID number is submitted in loop 2300,2-180-REF, as follows: REF01=P4 Project Code; REF 02= Demonstration Project Identifier

C 14 Exclude demonstration claims from medical review savings reports.

C 15 Correct Coding Initiative activities should continue as usual.

C 16 Doctors will be strongly encouraged to bill Part B claims electronically, although they will not be required to do so in order to participate in the demonstration. In addition, while efforts will be made to automate payment processes involved in the demonstration, exceptional circumstances may require the ability to do manual overrides.

C 17 Physicians will be required to accept assignment for all claims. Patient and provider educational materials will be used to notify and inform beneficiaries and providers. Carriers shall use existing logic to change the assignment on claims submitted as unassigned.

C 18 This PM requires that physicians submit claims with the correct site of service provider ID if the services were rendered at non-demonstration hospitals to beneficiaries who were, on that same date, transferred to or from a demonstration hospital. In the absence of a site of service provider ID which is different from a demonstration hospital, the claim may, depending upon the circumstances, be processed as a "no pay" claim under the assumption that services were provided at a demonstration hospital and are to be covered under the global payment.

If a physician performs a service(s) in a hospital (Place of Service Codes = 21, 22, or 23), the physician should put the Medicare provider number of the hospital, in addition to name and address. The Medicare provider number should be preceded with "HSP" and put in item 32 on the claim form. Providers are permitted to bill only one site of service provider number per claim.

Electronic Claims

National Standard Format - Report the Medicare provider number of the hospital in NSF record EA1, field 04; report the hospital/facility name in NSF record EA0, field 39; report the hospital/facility address in NSF record EA1, fields 6 through 10.

ANSI X 12N 837 (version 3051) - Report the Medicare provider number and the name of the hospital/facility in 2-250.A-NM109 as follows: NM101= "61" (performed at); NM102= "2"; NM103=Facility Name; NM108= "FA" and NM109= Medicare hospital/facility provider number. Report the hospital/facility address in 2-265.A-N3 and 2-270-A.N3.

ANSI X 12N 837 (version 4010) - Report the name of the hospital/facility in loop 2310D 2-250-NM1 as follows: NM101= "77" (service location): NM102="2"; NM103=Facility Name. Report the Medicare provider number of the facility in 2-271-REF as follows: REF01="ID" and REF02=Facility provider number. Report the hospital/facility address 2-265-N3 and 2-270-N4.

C 19 In order to provide hospitals with information on "no pay" claims that have been processed for services at their demonstration site, carriers must develop the capability to accept, store, and access the trailer records with NOA specific information which CWF is being directed to provide. Since routine weekly reporting will be required, this function should be automated to the extent practical to eliminate the need for routine manual processes.

V. Common Working File (CWF) Requirements

CWF 1

This change request requires that the site of service provider ID be transferred to the Common Working File in order to accomplish the edits described in Section III "Part B Claims Processing".

CWF 2

Whenever CWF determines that a claim should be rejected back to the carrier and processed as a "no pay" claim under the rules of these demonstrations, a trailer record with information from the NOA should also be returned to the carrier. Information to be included on the trailer record shall include the provider identification number of the hospital where services were provided, the date the patient was admitted to the hospital, and, if available at the time the claim is processed, the date the patient was discharged.

CWF 3

Before processing any claims under the traditional Medicare fee-for-service Part A rules, CWF must check to determine that there are no open NOAs for that beneficiary and date of admission. If a matching NOA is found, the claim should be rejected by CWF back to the

carrier. The carrier must instruct the hospital to submit a cancellation to the open NOA before re-submitting the claim for payment.

CWF 4

Physician or other professional provider demonstration claims which are processed by the carrier on a "no pay" basis should not be sent to any of the "screens" (e.g., surgery, cancer, etc.) in CWF. However, claims re-submitted for payment with the indicated modifier should be handled as any other traditional fee-for-service Medicare claim, including being sent through whatever screens or edits might apply.

CWF 5

If a beneficiary has multiple, overlapping open NOAs specific to one of these demonstrations, CWF should match claims based on the demonstration number and then the site of service ID on the claim. If the site of service is not on the claim, CWF should direct the carrier to return the bill to the provider with instructions to the provider to re-submit the bill with the site of service provider identification number *(see Section III(c)4)*.

The *effective* date for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

These instructions should be implemented within your current operating budget. There are no extra funds allowed for processing claims under this demonstration.

This PM may be discarded December 31, 2005 unless otherwise extended.

All contractors should address questions or issues surrounding implementation of these instructions to their regional office contact. The demonstration contact person for this PM is Jody Blatt at (410) 786-6921.

Attachments

ATTACHMENT I

Table I A: DRGs Included in Medicare Participating Cardiovascular Centers of Excellence Demonstration

CARDIAC DRGs		
DRG #	Description	ICD 9 Code
104	Cardiac Valve & Other Major Cardiothoracic proc w/ cardiac catheterization	All codes
105	Cardiac valve & Other major cardiothoracic procedures w/o cardiac catheterization	All codes
106	Coronary Bypass w/PTCA	All codes
107	Coronary Bypass w/cardiac catheterization	All codes
109	Coronary Bypass w/cardiac catheterization	All codes
112	Percutaneous CV procedures	All codes
116	Pacemaker Implants or PTCA w/Coronary Artery Stent Implant	Only codes for PTCA w/Stent • Principle diagnosis from MDC 5, AND • Operating .room procedures 3596,3601,3602,3605, 3609,3734, AND • Non-operating room procedures 3606
124	Circulatory Disorders except AMI w/catheterization & complex diagnosis	All codes
125	Circulatory Disorders except AMI, w/catheterization but w/o complex diagnosis	All codes

Table I B: DRGs Included in Medicare Participating Orthopedic Centers of Excellence Demonstration

ORTHOPEDIC DRGs		
DRG #	Description	ICD 9 Code
209	Major Joint & Limb reattachment Procedures of Lower Extremity	Only codes for hips & knees • Hips: 8151,8152,8153 • Knees: 8154, 8155
471	Bilateral or multiple major joint procedures of lower extremity	Only codes for hips & knees • Hips: 8151,8152,8153 • Knees: 8154, 8155

ATTACHMENT II

Systems Flow Charts

A. Notice of Admission Process
B. Discharge Billing Process
C. Part B Claims Processing
D. Paying Re-Submitted Demonstration “No Pay” Claims After Cancellation of NOA

ATTACHMENT III

Weekly Report to Demonstration Hospitals From Carriers Showing Part B Claims Processed as "No Pay Bills"

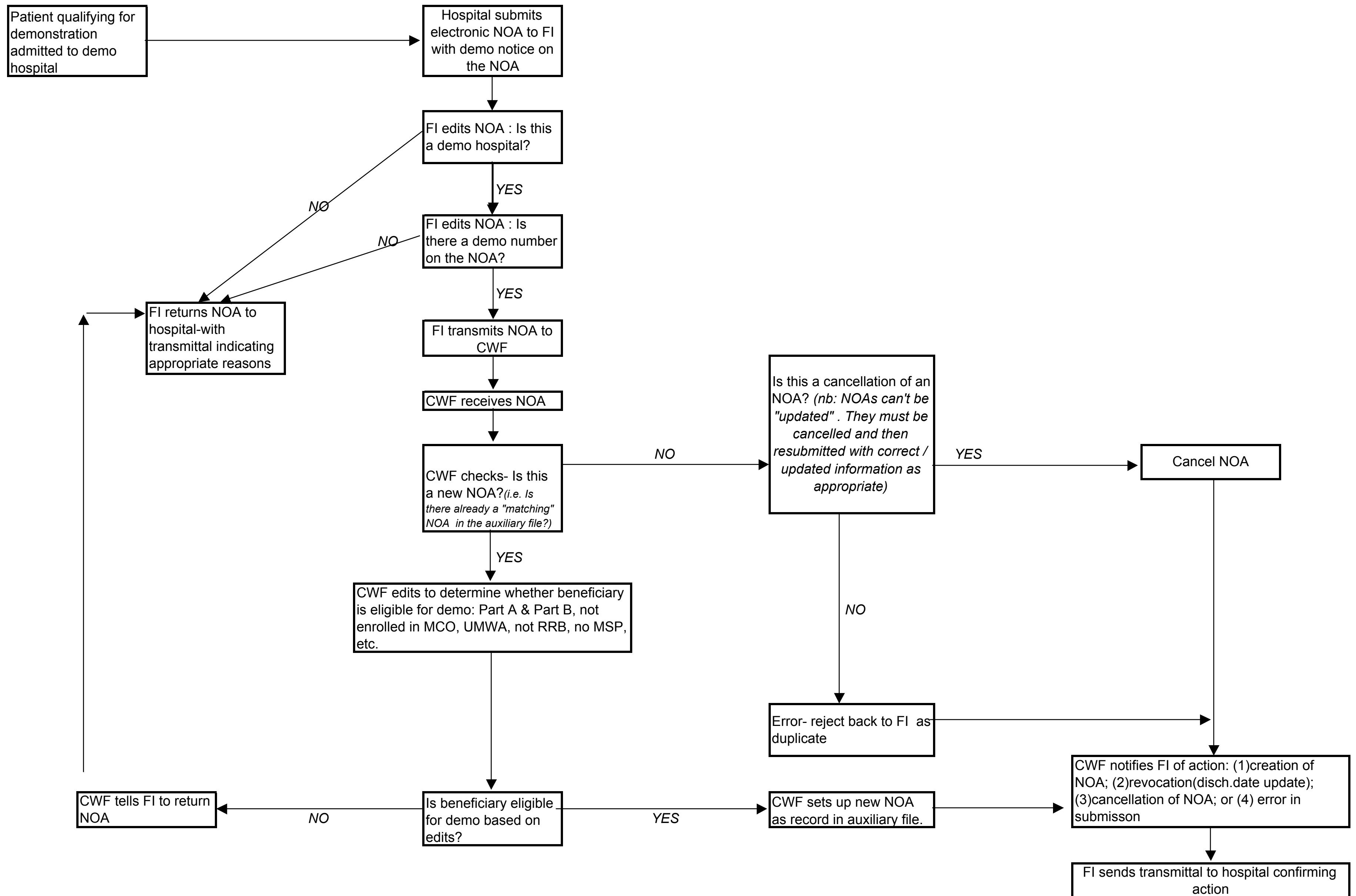
FACILITY NUMBER	FACILITY NAME AND ADDRESS							
HICN	**BENEFICIARY: LAST NAME, FIRST NAME, MI**	**DATE OF ADMIT**	**DATE OF DISCHARGE**	**Part B PIN**	**PART B PROVIDER: LAST NAME, FIRST INITIAL**	**DATE OF SERVICE**	**PROCEDURE CODE with MODIFIERS**	**MEDICARE PART B ALLOWANCE**
123456789a		mmddccyy	mmddccyy	1234567890		mmddccyy		

Data Dictionary

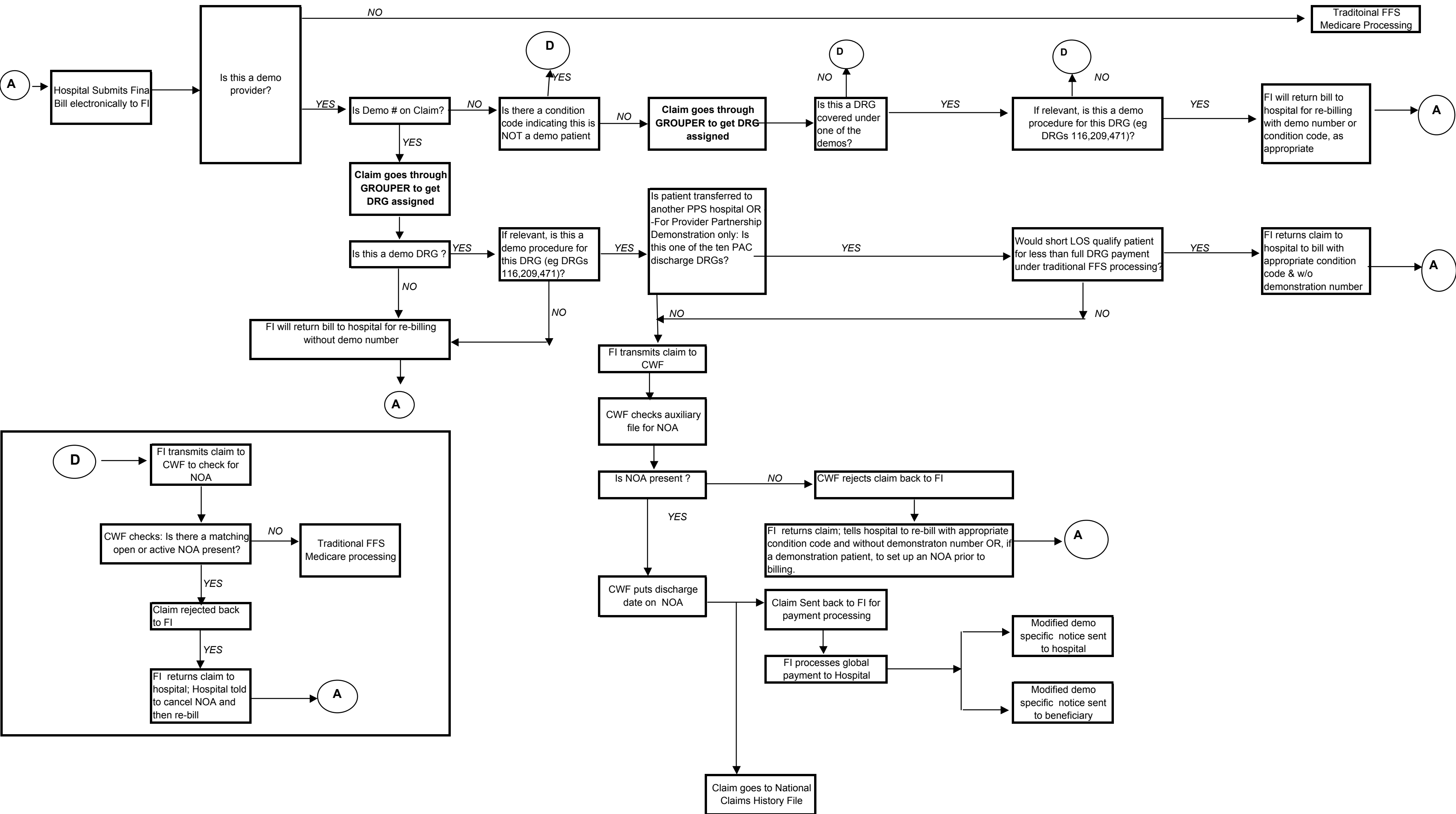
Data Element(s)	Definition / Format	Source
Facility Number	ID number of hospital where services took place`	NOA
Facility Name	Name of hospital where services took place	NOA
Facility Address	Street Address, City, State and Zip Code of hospital where services took place	NOA
HICN	Beneficiary Health Insurance Claim Number	Claim
Beneficiary Name	Name of the Beneficiary Last Name, First Name, Middle Initial	Claim
Date of Admission	The Date the patient was admitted to the hospital (MMDDYY)	NOA
Date of Discharge	The date the patient was discharged from the hospital. (MMDDYY)	NOA
Part B PIN	Number assigned by the carrier to identify the provider who actually performed the service.	Claim
Part B Provider Name	The name of the individual that rendered the service to the patient (Last name, First Initial)	Claim
Date of Service	The date the service was actually performed (MMDDYY for a single date of service; MMDDYYMMDDYY for a range of dates, with the first entry showing the first date of service and the second date showing the last date of service for the service)	Claim
Procedure code	The HCPCS/CPT-4 code that describes the service	Claim
Modifier(s) (1-4)	Codes identifying special circumstances related to the service.	Claim
Medicare Part B Allowance	The amount that would have been allowed on this claim if it was not a demonstration no-pay claim (Numeric S9(9)v99)	Claim

NOTICE OF ADMISSION (NOA) PROCESSING

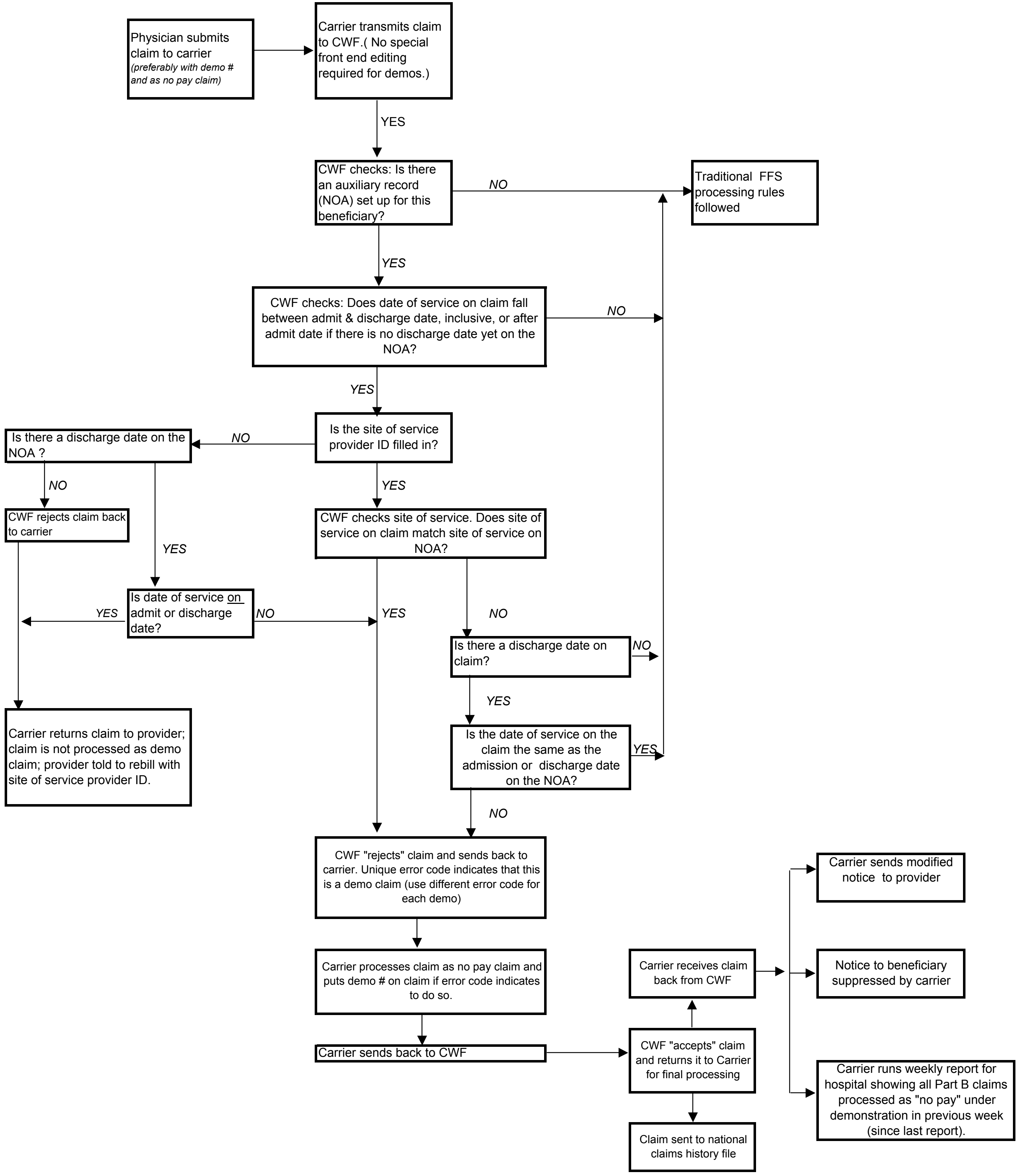
DISCLAIMER: *Proposed general overview of "logical flow" of notice of admission and global payment process. This is not intended to reflect every step taken by automated systems or represent an actual proposed systems flow.*



DISCHARGE PROCESS



PART B CLAIMS PROCESSING



PAYING RESUBMITTED NO PAY CLAIMS AFTER CANCELLATION OF NOA