CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 276 **Date: AUGUST 13, 2004**

CHANGE REQUEST 3399

SUBJECT: Further Information Related to CR 3175, Distinct Part Units of Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: CAHs were informed in CR 3175 that they could establish psychiatric and rehabilitation distinct part units. This CR addresses the new provider numbers and how these units should be paid.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: January 3, 2005

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/30.1/Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units
R	3/140/Inpatient Rehabilitation Facility Prospective Payment System
R	3/140.3/Billing Requirements Under IRF PPS

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

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SUBJECT: Further Information Related to CR 3175, Distinct Part Units of Critical Access Hospitals (CAHs)

I. GENERAL INFORMATION

A. Background: The Medicare Modernization Act (MMA) of 2003, PL 108-173, section 405(g) stated that CAHs may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004.

B. Policy: Inpatient Rehabilitation Facilities (IRFs) located in a CAH will be paid under the Inpatient Rehabilitation Facility PPS (See Pub. 100-04, chapter 3, section 140 for billing requirements) and will be identified by provider number xx-Rxxx. Inpatient psychiatric units located in a CAH will be paid on a reasonable cost basis until the inpatient psychiatric facility prospective payment system is created (expected in 2005). These units are identified by provider number xx-Mxxx.

NOTE: Although this policy is effective for cost reporting periods beginning on or after October 1, 2004, CMS is unable to process claims for these units until January 3, 2005. Providers should submit their Distinct Part Unit claims and Medicare will release these claims for payment on January 3, 2005, applying applicable interest.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an “X” in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3399.1	Medicare claims processing systems shall recognize provider numbers xx-Rxxx and xx-Mxxx and apply all applicable claims processing systems edits.	X				X			X	
3399.2	The standard systems shall pay for services in an IRF, identified by provider number xx-Rxxx under the IRF PPS.					X			X	
3399.3	The standard systems shall pay for services in a psychiatric unit, identified by provider number xx-Mxxx under the current payment methodology for psychiatric hospitals and distinct part units.					X			X	
3399.4	FIs shall create a provider specific file for the IRFs identified by provider number xx-Rxxx.	X								
3399.5	FIs shall hold claims with provider numbers xx-Mxxx and xx-Rxxx until January 3, 2004 and apply condition code 15.	X								
3399.5.1	FIs shall release claims for payment and add interest upon implementation.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3399.1	These provider numbers will be billed under the 11X and 12X types of bill.
3399.2	CMS shall modify the IRF PC Pricer to accept provider number xx-Rxxx.
3399.4	CMS shall accept an IRF provider specific file with xx-Rxxx.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Cost reporting periods beginning on or after October 1, 2004 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Pat Barrett at pbarrett@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

(Rev. 276, Issued 08-13-04, Effective: 10-01-04, Implementation: 01-03-05)

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. The CAH's length of stay will be calculated by their FI based on patient census data and reported to the CMS regional office (RO). If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS RO, 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 *an acute care* hospital to its inpatients. 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 operates up to 25 beds for either acute (CAH) care or SNF swing bed care (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.

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.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

1. The facility *distinct part unit* has been certified as a CAH by CMS;

2. The distinct part unit *meets* the conditions of participation requirements for hospitals;

3. The distinct part unit must also meet the requirements, other than conditions of participation *requirements*, that would apply if the unit were established in an acute care hospital;

4. Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit *was* established in an acute care (non-CAH)

hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities *in CAHs are identified by provider number xx-Rxxx and* are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, section 140 for billing requirements) and the Inpatient Psychiatric Units *in CAHs are identified by provider number xx-Mxxx* and are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);

5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;

6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

(Rev. 276, Issued 08-13-04, Effective: 10-01-04, Implementation: 01-03-05)

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by §125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F) and §305 of the Benefits Improvement and Protection Act of 2000 (BIPA), authorizes the implementation of a per discharge prospective payment system (PPS), through new §1886(j) of the Act, for inpatient rehabilitation hospitals and rehabilitation units *now jointly* referred to as inpatient rehabilitation facilities (IRFs).

The IRF PPS is effective for cost reporting periods beginning on or after January 1, 2002. IRF PPS payment rates include all costs of furnishing covered IRF services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR 413.85 and 413.86, bad debts, and other costs not covered under the PPS.

Effective for cost reporting periods beginning on or after October 1, 2004, the Medicare Modernization Act of 2003, Public Law 108-173, section 405(g) established that CAHs may open rehabilitation distinct part units. These IRFs will also be paid under the IRF PPS.

140.3 - Billing Requirements Under IRF PPS

(Rev. 276, Issued 08-13-04, Effective: 10-01-04, Implementation: 01-03-05)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The *August 7, 2001, Final Rule, and subsequent final rules* contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, *there is* an item-by-item guide, which *specifies* detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on Form 1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill 11X) to their FIs. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG *payment* classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and *pay* a claim under *the IRF* PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation *distinct part* units the third digit will be a T *if the unit is located in an acute care hospital or an R if the unit is located in a CAH*.

- The Revenue code, Form Locator (FL) 42, Record Type (RT) 60, field 5), (SV201), must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates, FL44, (RT60, field 6), (SV202-2), must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG

is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

Covered Charges, FL47, (RT60, field 10), (SV203), should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. *Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.*

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- IRFs are required to report the number of units in FL 46 based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges, FL 47.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3 (RT 40, field 8-21), 2300 loop HI code BH). If benefits are exhausted prior to the stay,

submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.