CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 207 | **Date: JUNE 18, 2004**

CHANGE REQUEST 3309

I. SUMMARY OF CHANGES: This CR notifies fiscal intermediaries and providers of changes in policy (MMA section 211(e)) when a patient is a member of a Medicare Advantage organization for only a portion of the billing period, to include inpatient rehabilitation facilities and long term care hospitals. It also reflects new terminology per MMA, the use of Medicare Advantage organization instead of Medicare + Choice Organization.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: July 19, 2004**

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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
R	1/90/ Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 207	Date: June 18, 2004	Change Request 3309

SUBJECT: Expansion of Policy Where Patient is a Member of a Medicare Advantage (MA) Organization For Only a Portion of the Billing Period to Include Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCH)

I. GENERAL INFORMATION

A. Background: 42 CFR 422.264 outlined a policy for coverage in a MA organization that begins or ends during an inpatient stay, for hospitals paid under the prospective payment system (PPS). The rule states that the patient's status at admission determines liability. For example, a patient is admitted to a hospital on January 28 and is discharged on February 5. On February 1 the patient enrolls in an MA organization. Medicare fee-for-service (FFS) is liable for this inpatient stay because the patient had Medicare FFS at admission. A similar scenario would be true if the patient disenrolled in the MA organization on February 1. In this case the MA organization is responsible for this inpatient stay.

B. Policy: The Medicare Modernization Act of 2003, section 211(e) expanded this policy to include other inpatient hospitals under a PPS, IRFs and LTCHs.

C. Provider Education: A provider education article related to this instruction will be available at http://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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3309.1	FIs shall apply Condition Code 65 to claims for non-PPS providers.	FIs
3309.2	CWF shall apply edits already in place based on the presence or non-presence of Condition Code 65 as the deciding factor in determining the payer.	CWF

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

<table>
<tr>
<td>Effective Date: January 1, 2004

Implementation Date: July 19, 2004

Pre-Implementation Contact(s): Sarah Shirey, (410) 786-0187

Post-Implementation Contact(s): Appropriate Regional Office</td>
<td>These instructions shall be implemented within your current operating budget.</td>
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Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 207, 06-18-04)

90 - Patient Is a Member of a *Medicare Advantage (MA) Organization* for Only a Portion of the Billing Period

90 - Patient Is a Member of a *Medicare Advantage (MA) Organization* for Only a Portion of the Billing Period

(Rev. 207, 06-18-04)

HO-408, HH-412

Where a patient either enrolls or disenrolls in an *MA organization* (See *Pub. 100-01*, the General Information, Eligibility, and Entitlement Manual, Chapter 5, *§80* for definition) during a period of services, two factors determine whether the *MA organization* is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS, and
- The date of enrollment.

Hospital Services

If the provider is an inpatient acute care hospital, *inpatient rehabilitation facility or a long term care hospital*, and the patient changes *MA* status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability.

If the hospital *in*patient was not an *MA* enrollee upon admission but enrolls before discharge, the *MA organization* is not responsible for payment.

For *hospitals exempt from PPS (children's hospitals, cancer hospitals, and psychiatric hospitals/units) and Maryland waiver hospitals*, if the *MA organization* has processing jurisdiction for the *MA* involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or *MA organization*. When forwarding a bill to an *MA organization*, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the *MA organization* is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Home Health

If the patient was enrolled in the *MA organization* before start of care, the *MA organization* is liable until disenrollment. Upon disenrollment, an episode must be opened under home heath PPS for billing to the FI.

If the beneficiary was not an *MA* enrollee upon admission but enrolls before discharge, the *MA organization* is not responsible for payment.

If the provider is not a PPS provider, the *MA organization* is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.