Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1119

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.19 - 3611.2	6-117 - 6-120.1 (5 pp.)	6-117 - 6-120 (5 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: November 29, 1999
IMPLEMENTATION DATE: November 29, 1999

Section 3610.19, Medicare Rural Hospital Flexibility Program, lists types of facilities that are eligible to participate as a Critical Access Hospital (CAH). (This was implemented upon enactment of the BBRA on November 29, 1999).

Section 3610.21, Requirements for Critical Access Hospital Services and CAH Long-term Care Services, changes the 96-hour stay per inpatient to 96-hour annual average on inpatient stays in CAHs. (This was implemented upon enactment of the BBRA on November 29, 1999).

NEW/REVISED MATERIAL--EFFECTIVE DATE: November 29, 1999
IMPLEMENTATION DATE: October 1, 2000

Section 3610.22, Payment for Services Furnished by a CAH, all-inclusive rate method of payment for outpatient services will be an option for the cost reporting period beginning on or after October 1, 2000. This section also changes laboratory services payment from reasonable cost to using the fee schedule with no patient liability.*

***Systems changes that will allow lab services to be paid on a fee schedule will not be available until October 1, 2000. The statute is clear that these services are paid based on the lab fee schedule with no deductible or coinsurance. CAHs are to no longer collect coinsurance from the beneficiary for lab services. Coinsurance that have been collected for lab services provided on or after November 29, 1999, should be returned to the beneficiaries in a manner that is appropriate and timely. The differences will be reconciled, if there are any, for hospitals paid based on reasonable costs at the end of their cost reporting period.**

The CAHs are to inform beneficiaries not to make coinsurance payments for lab services even if they appear on their Explanation of Your Medicare Benefits or your Medicare Summary Notice.

DISCLAIMER: **The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

These instructions should be implemented within your current operating budget.

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

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

c. Enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and CA entries are related to the Hemophilia Add On.

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

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

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

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

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

c. Enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and CA entries are related to the Hemophilia Add On.

3610.19 Medicare Rural Hospital Flexibility Program.--

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

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

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

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

* A. Effective November 29, 1999, CAHs are no longer required to maintain documentation showing
* that individual stays longer than 96 hours were needed because of inclement weather or other emergency
* conditions, or to obtain a case-specific waiver of the 96-hour limit from a peer review organization (PRO)
* or equivalent entity. Thus, intermediaries are not required to obtain documentation showing that a PRO
* or equivalent entity has, on request, approved stays beyond 96 hours in specific cases. A CAH may
* provide acute inpatient care for a period that does not exceed, as determined on an annual, average basis,
* 96 hours per patient. The CAH's length of stay will be calculated by its intermediary based on patient
* census data and reported to the HCFA regional office. If a CAH exceeds the length of stay limit, it will
* be required to develop and implement a corrective action plan acceptable to the HCFA regional office, or
* face termination of its Medicare provider agreement.
*
* Items and services that a CAH provides to its inpatients are covered if they are items and services of a
* type that would be covered if furnished by a hospital to hospital inpatients.
*
* B. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements.

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

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

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

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

3610.22 Payment for Services Furnished by a CAH.--

* A. Payment for Inpatient Services Furnished by a CAH.--Effective for cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating
* costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.
* Payment for inpatient CAH services is billed as a 11x type of bill and is subject to Part A deductible and
* coinsurance requirements.
*
* B. Payment for Outpatient Services Furnished by a CAH.--For cost reporting periods beginning
* before October 1, 2000, a CAH will be paid for outpatient services under the method in item 1 below.
* For cost reporting periods beginning on or after October 1, 2000, the CAH will be paid under the method
* in item 1 below unless it elects to be paid under the method in item 2. If a CAH elects payment under item
* 2 (cost-based facility payment plus fee schedule for professional

professional services) for a cost reporting period, that election is effective for all of the cost reporting period to which it applies. If the CAH wishes to be paid under the elective method, that election should be made in writing by the CAH, which notifies you 60 days in advance of the beginning of the affected cost reporting period. If the CAH makes no election, it will be paid for outpatient services under the standard method in item 1.

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

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

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

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

2. Elective Method: Cost-Based Facility Services Plus Fee Schedule for Professional Services.--Section 403(d) of the BBRA amended §1834(g) to permit the CAH to elect this method of reimbursement for cost reporting beginning on or after October 1, 2000. For facility and professional medical services to outpatients furnished during a period for which this method is elected, a CAH will be paid an amount equal to the sum of 80 percent of its reasonable costs of its outpatient services, after application of the Part B deductible, and the amount of payment that would be made under the Part B physician fee schedule for professional services, after applicable Part B deductible and coinsurance.

Outpatient service, including ASC services, rendered in an all-inclusive rate provider method will be billed using the 85X type of bill. Revenue code 510 should be on the bill with visits indicated in the units field and "0" in the charges field. Referenced diagnostic services (nonpatients) will continue to be billed on a 14x type of bill.

The elective method is not available for cost reporting periods beginning before October 1, 2000.

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

D. Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost of hepatitis B

* vaccine and its administration. Deductible and coinsurance apply. Payment for screening mammography
* is not subject to applicable Part B deductible, but coinsurance does apply. Follow the instructions as
* described in §3660.10.
*
* E. Regardless of the payment method that applies under paragraph B, payment for clinical diagnostic
* laboratory tests furnished to CAH outpatients on or after November 29, 1999, will be made under the
* clinical diagnostic laboratory fee schedule, as described in §3628, with no application of deductible or
* coinsurance.

3610.23 Payment for Post-Hospital SNF Care Furnished by a CAH.--The SNF-level services provided by a CAH, are paid under the methodology specified for swing-bed hospitals at 42 CFR 413.114 and §§2230 - 2230.10 of the Provider Reimbursement Manual. Since this is consistent with reasonable cost principles, continue to pay for those services under that methodology.
Follow the rules for payment in §3634 for swing-bed services.

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

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

3611. HOSPITAL CAPITAL PAYMENTS UNDER PPS

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

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

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

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

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

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

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

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

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

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

- o The hold harmless - 100 percent Federal rate.

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

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

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

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

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

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

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

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