Medicare
Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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REFER TO: CHANGE REQUEST 1119

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
415.18 - 415.22 (Cont.)	4-177 - 4-180 (4 pp.)	4-177 - 4-180 (4 pp.)

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

Section 415.19, 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 415.21, Requirements for Critical Access Hospital (CAH) Services and CAH Long-term Care Services, is revised to change 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 415.22, Payment for Services Furnished by a CAH, provides an all-inclusive rate method of payment for outpatient services available for the cost reporting period beginning on or after October 1, 2000. This section also changes the laboratory services payment from reasonable cost to fee schedule payment 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. You 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.**

Please inform your beneficiaries that they are no longer required to make coinsurance payments for lab services even if they appear on their EOMBs or MSNs.

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o For its cost reporting period that began during FY 91, the hospital must have at least 5000 discharges, or equal to the median number of discharges for urban hospitals in that census region, if fewer, or if an osteopathic hospital, must have had at least 3000 discharges.

HCFA publishes these figures each year in the Federal Register, reflecting the annual PPS update.

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

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

o Located more than 35 miles from other like hospitals;

o Located between 25 and 35 miles from other like hospitals; and;

+ No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located with a 35-mile radius of the hospital, or if larger, within its service area;

+ Has fewer than 50 beds and would admit at least 75 percent of the inpatients from its service area except that some patients seek specialized care unavailable at the hospital; or

+ Other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years because of local topography or prolonged or severe weather conditions.

o Located between 15 and 35 miles from other like hospitals, but because of local topography or prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

o Effective October 1, 1990, because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Any SCH which qualified under the prior criteria that would lose eligibility under the new criteria, retains its status as a SCH.

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

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

o Has 100 or fewer beds;

o Is not classified as an SCH; and

o For its cost reporting period that began during FY 87, is dependent on Medicare for at least 60 percent of its inpatient days or discharges.

C. Payment to SCHs and MDHs.--Hospitals are paid based on the highest of three rates:

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

415.19 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.

415.20 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.

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

A. Effective November 29, 1999, CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or submit a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent entity to the intermediary. 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 their fiscal 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.

415.22 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 that 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 subject to Part A deductible and coinsurance requirements. Inpatient services should be billed as a 11X type of bill.

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 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 service, 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. Referenced diagnostic services 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, 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 (non-patients) will continue to be billed on a 14x type of bill.

The all-inclusive rate 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.

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 for 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.

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 with no application of deductible or coinsurance.

415.23 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 the 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.

415.24 Review of Form HCFA-1450 for the Inpatient.--All items on Form HCFA-1450 are completed in accordance with §460.