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 1044

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.17 - 3611.2	6-111 - 6-120.1 (11 pp.)	6-111 - 6-120 (11 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* ***October 1, 1999***
IMPLEMENTATION DATE: ***Refer to Program Memorandum* AB-00-20**

Section 3610.18, Payment for Blood Clotting Factor Administered to Hemophilia Inpatients, is revised to extend coverage of the blood clotting factor administered to hemophilia inpatients on or after October 1, 1999. The payment rates in this instruction are in effect until September 30, 2000. Field locators for HCPCS Code and Payment Amount have been revised to reflect the claim expansion effective 4/1/00.

Claims need not be reopened for the above instruction. However, process claims brought to your attention in accordance with this instruction.

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.

3610.17 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 within 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 of 2 out of 3 years because of local topography or prolonged 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 of 2 out of 3 years; or
- 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 which would lose eligibility as a result of the new criteria may retain its status as an 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.--Pay these hospitals the highest of three rates as the basis for payment:

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

The actual payment amount for each bill is determined by PRICER based upon information you maintain in your provider specific file. Review and possible lump sum adjustment applies when the cost report is reviewed.

D. Claims Processing.--Use the following to enable PRICER to calculate the appropriate rates for these facilities--

- o 14 for a MDH that is not an RRC;
- o 15 for a MDH that is also an RRC;
- o 16 for a rebased SCH that is not an RRC; and
- o 17 for a rebased SCH that is also an RRC.

Calculate the higher of the 1982 or 1987 adjusted base period costs per discharge (hospital specific rate) and adjust to the 1990 level. Enter this amount in field 21, position 81-87 effective for the first day of the cost report period beginning April 1, 1990 or later. Enter even if you expect the hospital to be paid at the Federal PPS rate. Preloading before the effective date is acceptable as long as the correct effective date is used for the record. Leave the field blank if the hospital did not operate in either 1982 or 1987.

PRICER calculates the payment based upon the higher of the Federal rate or the hospital-specific rate in field 21, and where the hospital-specific rate is higher, PRICER reports the amount of the difference in the hospital-specific field. (See §3656.3C.) Carry this amount forward in the hospital-specific payment field to your PS&R record for use at cost settlement.

3610.18 Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.--Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Act to provide that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment is to be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factor furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

The add-on payment for FY 1999 will be calculated using the same methodology used in the past. The price per unit of clotting factor will be established based on 85 percent of the current price listing available from the 1998 Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP).

A. Billing.--Three separate add-on amounts have been set, one for each of the three basic types of clotting factor: Factor VIII, Factor IX and other factors which are given to the patients with inhibitors to Factors VIII and IX.

The HCPCS codes which identify the three types of clotting factors along with the price per unit for discharges occurring on or after June 19, 1990, and before October 1, 1991 are:

J7190	Factor VIII	- $ .64 per IU
J7194	Factor IX, complex,	- .26 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-clotting inhibitors.)	- 1.00 per IU

For discharges occurring on or after October 1, 1991, and through September 30, 1992, the codes and charges are:

J7190	Factor VIII	- $ .72 per IU
J7194	Factor IX, complex,	- .26 per IU
J7196	Other Hemophilia blood factors (e.g., anti-clotting inhibitors.)	- 1.11 per IU

The prices per unit for discharges October 1, 1992, through September 30, 1993, are:

J7190	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .30 per IU
J7196	Other Hemophilia blooding clotting factors	- l.02 per IU

The prices per unit for discharges October 1, 1993, through September 30, 1994, are:

J7190	Factor VII	- $ .76 per IU
J7194	Factor IX	- .33 per IU
J7196	Other Hemophilia blooding clotting factors	- 1.02 per IU

Effective January 1, 1994, there is an additional covered clotting factor:

J7192 Factor VIII, Anti-Hemophilic, recombinant - $ .76 per IU

For discharges occurring on or after October 1, 1997 through September 30, 1998.

J7190	Factor VIII	- $ .76 per IU
J7192	Factor VIII	- 1.00 per IU
J7194	Factor IX	- .32 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-inhibitors)	- 1.10 per IU

Effective for services on or after April 1, 1998, two new HCPCS billing codes are established for purified and recombinant Factor IX.

Q0160	Factor IX (Anti-Hemophilic factor, purified, non-recombinant)	- $ .93 per IU
Q0161	Factor IX, (Anti-Hemophilic Factor, purified, Recombinant)	- $1.00 per IU

For discharges occurring on or after October 1, 1998 through September 30, 1999, the prices are as follows:

J7190	Factor VIII (Anti-Hemophilic Factor, Human)	- $ .78 per IU
J7192	Factor VIII (Anti-Hemophilic Factor, Recombinant)	- 1.00 per IU
J7194	Factor IX, (Complex)	- .38 per IU
J7196	Other Hemophilia clotting Factor, (anti-inhibitors)	- 1.10 per IU
Q0160	Factor IX (Anti-Hemophilic Factor, purified, nonrecombinant)	- .93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	- 1.00 per IU

For discharges October 1, 1999 through September 30, 2000, the following prices apply to add-on payments for blood clotting factor administered to inpatients with hemophilia:

J7190	Factor VIII (Antihemophilic Factor, Human)	$0.79 per IU
J7191	Factor VIII (Antihemophilic Factor, Porcine)	$1.87 per IU
J7192	Factor VIII (Antihemophilic Factor, Recombinant)	$1.03 per IU
J7194	Factor IX (Complex)	$0.45 per IU
J7196	Other Hemophilia clotting Factors (e.g., anti-inhibitors)	$1.43 per IU
Q0160	Factor IX (antihemophilic Factor, purified, nonrecombinant)	$0.97 per IU
Q0161	Factor IX (Antihemophilic Factor, recombinant)	$1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	$1.19 per MCG

PRICER does not calculate the payment amount. Calculate the payment amount and subtract the charge from those submitted to PRICER so it is not included in cost outlier computations.

One hundred IUs of any of the clotting factors are reported as one unit. (100 IUs = one billing unit.) Therefore, payment for one billed unit of hemophilia clotting Factor VIII furnished December 1, 1993, is $76.00. One billed unit of Factor IX is $33.00. One billed unit of other hemophilia clotting factors is $102.00. If the number of units provided is between even hundreds, hospitals round to the nearest hundred. Thus, units of 1 to 49 are rounded down to the prior 100 and units of 50 to 99 are rounded up to the next 100 (i.e., 1,249 units are entered on the bill as 12; 1,250 units are entered as 13).

In reporting the number of IUs administered, hospitals divide the number of IUs administered by 100 and round the answer to the nearest whole number to determine the billing unit. (An answer which includes fractions of .50 to .99 = 1 additional billing unit. An answer which includes fractions of .01 to .49 = no additional billing units). The following examples illustrate the correct billing for the different types of clotting factors:

EXAMPLE 1: A patient receives 1,200 IUs of Factor VIII (J7190) on December 1, 1993. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (1,200 divided by 100 = 12 billing units.) The hospital enters 12 in FL 96 of the HCFA-1450. The payment amount is $912 (12 billing units x $76 (100 IUs x $.76)).

EXAMPLE 2: A patient receives 3,449 IUs of Factor IX (J7194) on January 4, 1994. The hospital divides this number by 100 to obtain the number of billing units. (3,449 divided by 100 = 34.49 billing units.) The hospital rounds down to the nearest whole number to obtain the billing units and enters 34 in FL 96. The payment amount is $1,122 (34 billing units x $33 (100 IUs x $.33)).

EXAMPLE 3: A patient receives 5,250 IUs of anti-inhibitors (J7196) (which are a type of other hemophilia clotting factor) on July 6, 1994. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (5,250 divided by 100 = 52.50 billing units.) The hospital rounds up to the nearest whole number to obtain the billing units and enters 53 in FL 96. The payment amount is $5,406 (53 billing units x $102 (100 IUs x $1.02).

EXAMPLE 4: A patient receives 4,850 MCGs of Factor VIIa (Q0187) on November 1, 1999. The hospital divides the number of MCGs administered by 100 to obtain the number of billing units (4850 divided by 100 = 48.50 billing units). The hospital rounds up to the nearest whole number to obtain the billing units and enters 49 in FL 96. The payment amount is $5,831 (49 billing units x $119 (100 MCGs x $1.19).

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 999,999,949 (reported as 9,999,999), the hospital reports the excess as a second line for revenue code 636 and repeats the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and another line shows 500,001.

Revenue Code 636 is used. It requires HCPCS. Other inpatient drugs continue to be billed without HCPCS codes under pharmacy. Electronic billers must enter the HCPCS code in field 5 of Record Type 60. (See Addendum A.)

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is not applicable to inpatient Part B or SNF claims.

B. Intermediary Action.--Make the following changes to your systems:

o Accept HCPCS codes for inpatient services;

o Edit to require HCPCS codes with Revenue Code 636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. Units provided generally range from about 600 IUs (reported as 6) to over 10,000 (reported as 100 on the bill). Do not edit units except to ensure a numeric value;

o Develop inpatient fee tables based on HCPCS codes and revenue code 636. Pay the fee amount regardless of the charges;

o Reduce charges forwarded to PRICER by the charges for revenue code 636. Retain the charges and revenue and HCPCS codes for CWF, and for PS&R;

o Determine what changes you need in your remittance record to hospitals;

o Modify your data entry screens to accept HCPCS codes for hospital inpatient claims (bill types 110, 111, 112, 113, 114, 115, 117, & 118);

o Include the HCPCS code and payment amount in the following records for each HCPCS code billed under revenue code 636:

RECORD	HCPCS CODE	PAYMENT AMOUNT
PS&R UNIBILL	Financial Data Corresponding to CWF	Field 79
CWF (HUIP)	Field 90	Field 99

o Treat the bill as a single bill for MSP, and for charging deductible and coinsurance. Use total charges for deductible and coinsurance calculations.

Changes are not planned for MSP pay. Where MSP recovery is made, the PS&R system allocates MSP primary payer payments between revenue code 636 and the remainder of the charges. It will delete the primary payment applicable to the final revenue code 636 payment from the primary payment amount carried forward to the PS&R detail record. PS&R will do this allocation based on charges for revenue code 636 and total covered Medicare charges.

The PS&R provides a separate revenue code report for charges under revenue code 636 for your use at cost report review.

The September 1, 1993 PPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-9-CM diagnosis code for hemophilia is included on the bill. Since blood clotting factors are only covered for beneficiaries with hemophilia, ensure that one of the following hemophilia diagnosis codes is listed on the bill before payment is made:

286.0 Congenital factor VIII disorder
286.1 Congenital factor IX disorder
286.2 Congenital factor IX disorder
286.3 Congenital deficiency of other clotting factor
286.4 von Willebrands' disease

C. Part A Remittance Advice.--

1. **X12.835 Ver. 003030M**.--

a. For remittances reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment exhibiting an 'OA' Group Code and adjustment reason code "97' (payment is included in the allowance for the basic service/ procedure) followed by the associated dollar amount (POSITIVE) and units of service. For this version of the 835, 'OA' group coded line level CAS segments are informational and are not included in the balancing routine. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

b. For remittances reporting PIP payments, the Hemophilia Add On will also 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 PIP payment Hemophilia Add On situations for future use. However, continue to use 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 reason code 97 and PLB code 'CA' adjustments are related to the Hemophilia Add On.

2. **X12.835 Ver. 003051**.--

a. For remittances reporting PIP and/or non-PIP payments, Hemophilia Add On information will be reported in the claim level 2-062-AMT and 2-064-QTY segments. The 2-062-AMTO1 element will carry a 'ZK' (Federal Medicare claim MANDATE - Category 1) qualifier code followed by the total claim level Hemophilia Add On amount (POSITIVE). The 2-064QTY01 element will carry a 'FL' (Units) qualifier code followed by the number of units approved for the Hemophilia Add On for the claim. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

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

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.

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 ASZ X12 835, where additional information is available.

3610.19 Medicare Rural Hospital Flexibility Program.--Section 1820 of the Act, before the enactment of the Balanced Budget Act of 1997 (BBA, PL 105-33), established the Essential Access Community Hospital (EACH) program. Under that program, seven States received grants to develop rural health networks consisting of Rural Primary Care Hospitals (RPCHs) and EACHs. RPCHs were limited-service rural hospitals that provided outpatient and short-term inpatient hospital care on an urgent or emergency basis. They then released patients or transferred them to an EACH or other acute care hospital. To be designated as RPCHs, hospitals had to meet certain criteria, including requirements that they not have more than 6 inpatient beds for acute (hospital-level) care and maintain an average inpatient length of stay of no more than 72 hours.

When the BBA was enacted, Montana had a separate, limited-service hospital program called the Medical Assistance Facility (MAF) program, which had been in operation since 1988. This program operated under a demonstration waiver from HCFA that allowed these limited service hospitals to be reimbursed for providing treatment to Medicare beneficiaries even though they are not required to meet all requirements applicable to hospitals.

The new legislation replaced the current seven-State EACH/RPCH program with a new Medicare Rural Hospital Flexibility Program that will be available in any State that submitted the necessary assurances 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 keep each inpatient for no longer than 96 hours, unless a longer stay is warranted because of inclement weather or other emergency conditions, or a Peer Review Organization or other equivalent entity, on request, waives the 96 hour restriction. 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 (42CFR 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. Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. The certification is required no later than one day before the date on which the bill for inpatient CAH services is submitted to the intermediary. Certifications need not routinely be submitted with inpatient bills, but should be retained at the CAH and made available on request to the intermediary or the HCFA regional office.

B. Subject to the 96-hour limit on inpatient stays in CAHs, 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. The part of an inpatient stay that exceeds 96 hours will be covered if it would be considered medically necessary if furnished by a hospital, and the CAH documents either that transfer of the patient to a hospital is precluded because of weather or other emergency conditions, or a PRO or equivalent entity has, on request, waived the 96-hour restriction with respect to the specific case.

C. 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.

D. 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. 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.

B. Effective for cost reporting periods beginning after October 1, 1997, payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that following principle do not apply: the lesser of costs or charges (LCC) rule, the RCE limits for physician services to providers, any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.130(j)(7), blended payment amounts for ASC, radiology, or other diagnostic services, and the clinical laboratory payment methodology (lesser of actual charge or the fee schedule amount).

C. For outpatient services beginning with the first cost reporting period after October 1, 1997, in facilities that previously participated as RPCHs and elected the cost-based RPCH payment plus professional services method, the facility will continue to bill as before. The intermediary will adjust interim payments to reflect elimination of any fee schedule or blended rate payment methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in accordance with existing reasonable cost principles, as described in item B.

D. A RPCH facility that elected the all-inclusive method of payment for outpatient services will need to stop billing the FI on a per-visit basis. They are to bill on a service-by-service basis beginning with the facility's first cost reporting period beginning after October 1, 1997. Once a facility begins the new payment change, all physician and practitioner professional services must be excluded from its billings to the FI.

The all-inclusive rate method is not available for cost reporting periods beginning after October 1, 1997. Professional services should be billed by the physician or practitioner to the Part B carrier, using the appropriate physician/practitioner provider number, not the facility's provider number.

The FI will pay for facility services in accordance with existing Medicare reasonable cost principles, as described in item B. The Part B carrier will pay for professional medical service under the physician fee schedule.

E. To avoid any interruption of payment, MAFs will retain and continue to bill under their existing provider numbers until new CAH numbers in the 1300 series are assigned. Bills submitted under MAF numbers will then be paid under the MAF payment rules until the transition to a CAH is complete. All CAHs will submit bills using the 85x bill type.

F. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, as described in §3626.3. Coinsurance is computed on the basis of the CAH's charges for its services.

G. 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.

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:

- 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

- 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:

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

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

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