Program Memorandum Intermediaries

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

Transmittal A-03-007 **Date: FEBRUARY 3, 2003**

CHANGE REQUEST 2476

SUBJECT: Payment to Hospitals and Units Excluded from the Acute Inpatient Prospective Payment System (IPPS) for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare+Choice (M+C) Enrollees

This Program Memorandum (PM) outlines intermediary and standard system changes needed to process requests from hospitals and units excluded from the IPPS for DGME and N&AH education supplemental payments for M+C (managed care) enrollees. Transmittal A-98-21 issued in July 1998, explains the methodology for processing DGME and indirect medical education (IME) payments associated with M+C enrollees effective January 1, 1998. During the period January 1, 1998 through December 31, 1998, hospitals received 20 percent of the fee-for-service DGME and operating IME payment. This amount increased by 20 percentage points each consecutive year until it reached 100 percent in calendar year (CY) 2002. However, because hospitals do not bill for managed care days associated with non-IPPS discharges, the methodology outlined in Transmittal A-98-21 has not allowed non-IPPS hospitals and hospitals with non-IPPS units to submit claims for M+C enrollees and receive the appropriate DGME payment. Therefore, this transmittal modifies Transmittal A-98-21 to permit these non-IPPS hospitals and units to submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.

This transmittal applies to the following hospitals and units excluded from the IPPS:

- Rehabilitation units (Medicare provider numbers with a 'T' in the 3rd position)
- Psychiatric units (Medicare provider numbers with a 'S' in the 3rd position)
- Rehabilitation hospitals (Medicare provider numbers in the 3025—3099 series)
- Psychiatric hospitals (Medicare provider numbers in the 4000—4499 series)
- Long-term Care hospitals (Medicare provider numbers in the 2000—2299 series)
- Children's hospitals (Medicare provider numbers in the 3300—3399 series)
- Cancer hospitals (Limited to the following provider numbers: 05-0146, 05-0660, 22-0162, 33-0154, 33-0354, 39-0196, 45-0076, 50-0138, 36-0242, 10-0079, 10-0271).

In addition, this transmittal also applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their M+C enrollees under 42 CFR §413.87(e). These providers would similarly submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the M+C N&AH payment through the cost report. (The instructions for calculating this payment will be explained in a separate transmittal).

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular intermediary in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (Form Locator 24-30). Condition code 69 has recently been modified by the National Uniform Billing Committee to indicate that the claims, in addition to being submitted for operating IME and DGME payment to IPPS hospitals, may now be submitted as no-pay bills to the PS&R report type 118 for M+C enrollees in non-IPPS hospitals and non-IPPS units to capture M+C inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

The intermediary will submit the claim to the Common Working File (CWF). CWF will determine if the beneficiary is a M+C enrollee and what his/her plan number and effective dates are. The plan must be a M+C plan, per 42 CFR §422.4. Upon verification from CWF that the beneficiary is a M+C enrollee, the intermediary will add the M+C plan number and an M+C Pay Code of 0 to the claim. For fee-for-service claims that were previously paid and posted to history for the same period (due to late posting of M+C enrollment data), an L-1002 Automatic Cancellation Adjustment Report will be sent to the intermediary when a DGME-only or a N&AH-only claim from a non-IPPS hospital or unit is accepted for payment by CWF. No deductible or coinsurance is to be applied against this claim nor will the beneficiary's utilization be updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a M+C enrollee, the claim will be rejected and the intermediary will notify the hospital of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. No interim bills should be submitted for DGME-only or N&AH-only claims and no Medicare Summary Notices should be prepared for these claims.

The DGME payments are to be made using the same interim payment calculation intermediaries currently employ. Specifically, intermediaries must calculate the additional DGME payments using the inpatient days attributable to M+C enrollees. (Instructions for calculating payment for M+C N&AH education will be included in a separate PM). As with DGME and N&AH education payments made under fee-for-service, the sum of these interim payment amounts is subject to adjustment upon settlement of the cost report. Note that these DGME and/or N&AH payments apply both to IPPS and non-IPPS hospitals and units.

The effective date and implementation date of this PM are prospective. Outstanding M+C payments for DGME and/or N&AH education applicable to prior periods are addressed in a separate issuance.

Provider Education

Intermediaries must notify, through their Web sites and their next regularly scheduled bulletins, ***all*** hospitals that either operate only GME program(s), only N&AH education program(s), or operate both GME and N&AH education programs, within 30 business days after receipt of the electronic copy of this PM of the above reporting requirements. Electronic billing associations and clearinghouses must be notified within 30 business days as well. Include the following information in this notice:

Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for M+C enrollees. The M+C inpatient days are to be recorded on PS&R report type 118. For services provided to M+C enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their intermediary for these cases in accordance with the instructions otherwise described in this transmittal. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report M+C inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

NOTE FOR FISCAL INTERMEDIARIES UNDER APPASS

Fiscal intermediaries under the APASS system have been given a waiver for the implementation of this instruction. Implementation will occur when APASS can update system or when migration to FISS occurs.

The effective date of this Program Memorandum is July 1, 2003.

The implementation date of this Program Memorandum is July 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2004.

Contact person for this Program Memorandum is Miechal Lefkowitz at 410-786-5316.