CMS Manual System

Pub. 100-19 Demonstrations

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

Transmittal 2 **Date: APRIL 30, 2004**

CHANGE REQUEST 3199

I. SUMMARY OF CHANGES: This Change Request (CR) clarifies certain provisions of CR 2382 which described the changes necessary to implement the Virginia Cardiac Surgery Initiative Demonstration, a demonstration involving a global (physician & facility) inpatient payment to selected hospitals for specified DRGs. Changes include the ability to handle physician claims submitted with demonstration and non-demonstration services, payment of inpatient new technology pass-through payments in addition to the global payment, clarification of handling for unassigned physician claims, and clarification of payment policy for patients transferred from a demonstration hospital after a short stay.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 4, 2004
***IMPLEMENTATION DATE: October 4, 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: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Table of Contents

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-19	Transmittal: 2	Date: APRIL 30, 2004	Change Request 3199

SUBJECT: Virginia Cardiac Surgery Initiative Demonstration – Modifications & Corrections to Change Request 2382

I. GENERAL INFORMATION

A. Background:

Change Request (CR) 2382 (Transmittal AB-02-144 issued October 25, 2002) described changes needed to implement the Virginia Cardiac Surgery Initiative Demonstration. These changes were implemented as part of the April 2003 systems release. Subsequent testing of this CR identified clarifications and additional changes to the claims processing systems that are needed in order to implement this demonstration. This CR provides these clarifications and additional business requirements. Unless otherwise stated, all other requirements as specified in CR 2382 remain.

The demonstration was approved for implementation in December 2003, and is expected to be implemented in 2004. This will be a 3 year demonstration.

This CR only impacts Medicare contractors processing claims on FISS or MCS for hospitals and physicians in the Commonwealth of Virginia.

B. Policy:

Under this demonstration, Medicare will pay hospitals participating in this demonstration a global DRG payment for discharges under the following cardiac surgery DRGs: 104, 105, 106, 107, and 109. Medicare will not pay separately for inpatient physician services associated with these admissions.

As a result of issues identified subsequent to the previous CR being released, the following clarifications and changes are addressed in the business requirements below:

- Requirement for FIs to verify that the provider ID of the hospital billing for the global payment under the demonstration matches the provider ID of the hospital on the notice of admission;

- Requirement for FIs to process and pay new technology pass through payments for hospitals that would otherwise be eligible to receive them;

- Clarification that patients who are transferred from a demonstration hospital after a short stay are not eligible for the demonstration;

- Clarification on handling claims from non-assigned physicians;

- Requirement for carriers to be able to process claims submitted by physicians that include both demonstration and non demonstration services; and

- Modification of carrier's report to hospitals (report # H99PB743) to include indicator for those patients who are dual eligible (have Medicaid and Medicare).

C. Provider Education: None.

This demonstration only affects a small number of hospitals participating in the demonstration and physicians providing inpatient services to selected cardiac surgery patients at these hospitals. The hospitals will be responsible for notifying physicians affected about the demonstration.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3199.1	Upon receipt of a claim from a demonstration hospital, CWF shall check to determine if there is a matching auxiliary record (Notice of Admission or "NOA ") for this beneficiary. • In addition to criteria previously specified in other CRs, CWF shall match the provider ID of the hospital billing for the global payment to the provider ID of the hospital on the notice of admission. • CWF will create a new edit when the provider ID of the hospital billing for the global payment does not match the provider ID of the hospital on the notice of admission for DEMO code 07'.	CWF
3199.2	The contractor shall process and pay new technology add-on payments to demonstration hospitals in addition to the global payment to the same extent the hospital would have received those payments in the absence of the demonstration. • The remittance advice sent to the demonstration hospital shall explicitly list any additional reimbursement due to new technology add-ons.	Standard systems, FI

3199.3	As described in CR 1525, when an inpatient acute care transfer occurs from a demonstration hospital to a non-demonstration PPS hospital and the length of stay at the originating demonstration hospital is short enough such that under traditional Medicare payment processing a per diem less than the full DRG payment would be made, payment shall revert to traditional Part A and Part B processing rules. • If the hospital submits the claim with a demonstration code ("07") or without the appropriate condition code indicating that the demonstration provision should not apply, the claim should be returned by the FI to the hospital. • The hospital shall be directed by the FI to cancel the NOA and re-bill for the claim without a demonstration code and with the appropriate condition code. • If the hospital has billed with the appropriate condition code, but has not cancelled the NOA, then the claim should be returned by the FI to the hospital and the hospital shall be directed to cancel the NOA and re-bill as described above.	FI, standard systems
3199.4	Carriers shall be able to process claims from physicians that include one or more claim lines for services which are covered under the demonstration global payment and also one or more claim lines for services which are not included in the global payment. One example of such a situation might be a claim from a physician that includes both inpatient services covered under the demonstration as well as pre-admission or post-discharge office-based services that are separately payable and not covered under the demonstration.	Local Part B Carrier, standard systems

	The carrier shall split such claims into two separate claims whereby one claim shall include only services and claim lines that are covered under the demonstration, and the other claim shall include only services and claim lines that are not covered under the demonstration. Only the claim with the claim lines only for services covered under the demonstration shall be tagged with the demonstration code ("07"). The claim with the claim lines only for non-demonstration services shall be processed in accordance with traditional Medicare processing rules.	
3199.5	If a physician bills for services on a non-unassigned basis for services for a beneficiary for whom a potentially matching NOA is identified, and a provider site of service is needed to determine if the services are covered under the demonstration, then that claim shall be processed in the same way that a claim submitted on an assigned basis would be handled under the rules of this demonstration. The carrier shall deny the claim with the same message that is used for assigned claims and the provider shall be instructed to provide additional site of service information in order to have the claim processed.	Local Part B Carrier, standard systems
3199.6	A previous CR required that the carrier send a weekly report to demonstration hospitals showing what physician services provided at their hospitals were billed in the previous week and processed on a "no pay" basis under the rules of the demonstration. This report shall be modified to include an indicator showing whether each patient to whom the services were provided is dual eligible (has Medicaid as well as Medicare).	Local Part B Carrier

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	CR 2382- Virginia Cardiac Surgery Initiative. All requirements specified in CR 2382, including CRs referenced in CR 2382, shall apply unless otherwise specifically revised in the business requirements specified in this CR.

B. Design Considerations:

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

Effective Date: October 4, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Jody Blatt (410-786-6921) **Post-Implementation Contact(s):** Jody Blatt (410-786-6921)	These instructions shall be implemented within your current operating budget.